Nightingale Group Limited

Guardian Care Centre

Inspection report

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Date of inspection visit: 24 October 2014
Date of publication: 10/03/2015

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**

Overall summary

The inspection took place on 23 and 24 October 2014 and was unannounced.

At the last inspection of June 2014 we asked the provider to take action to make improvements to the way they planned and provided care to people, to the staffing numbers and the accuracy of records. We found at this inspection there had been some improvements in all of the non-compliant areas. However there remained concerns about staffing levels on two of the units we inspected against and aspects of the care delivery for some people.

Guardian Care Centre provides nursing and personal care for up to 143 people. The service is divided into three separate buildings and five distinct units. Providing support for older people living with dementia, older people who have nursing care needs. Younger adults with physical disabilities, with complex care needs and who may have suffered brain trauma or injury, and people who have genetic conditions such as Huntington's Disease.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.'

People were protected from the risk of harm, because staff we spoke with knew how to recognise and report suspected abuse. The provider reported any alleged abuse to the local authority appropriately. At the time of the inspection there were on-going investigations of alleged abuse. These investigations were being conducted under large scale investigation procedures.

Risk assessments were in place which supported people to remain safe. Reviews of areas of risk had been undertaken, meaning they were up to date.

Recruitment processes were robust and ensured that prospective staff were fit to work.

Medicines were usually stored safely when not in use, but there were concerns about administration practice, storage of temperature sensitive medicines and disposal procedures. There were examples where it was not evident that people had received their medication as prescribed and concerns that people were having medication administered covertly without best interest agreements.

The principles of the Mental Capacity Act 2005 were not always followed. This meant some important decisions made on behalf of people had been made without their consultation.

Staffing levels had improved since our last inspection and on most units we noted that staffing levels met people's needs, but on Garden Walk and Garden View we observed people not receiving the support they needed. We observed people being left for long periods of time without attention or supervision.

We found improvements had been made to the records management and recording of people's care but we also saw some important documents were not complete and did not reflect people's needs.

Staff had received training and supervision to ensure they were effective in their roles. Although some up-dates to training had not been provided, the provider had a plan in place.

People had a choice of food. Most people we spoke with told us they were happy with the food choices available to them. When people required more support to meet their nutritional needs, plans were put in place to monitor and ensure that people received adequate food and fluids. We observed people had mixed experiences at mealtimes, with some people receiving good levels of support but others left for long periods of time without assistance.

People's health care needs were met. Records showed that people were supported to see a health care professional when they became unwell or their needs changed, but this wasn't consistently applied which meant there were examples where people's health care needs had not been dealt with promptly.

From our observations and talking to people who used the service, people were usually treated with dignity and respect, but we observed examples where people's dignity had been compromised.

There was a complaints procedure for people who used the service and their families and friends to access. Most people we spoke with told us they knew how to complain and who to go to. Some people commented that they hadn't always felt listened to when they had raised concerns in the past.

The registered manager and the management consultancy team were auditing the quality of the service to find where improvements were needed to be made. They demonstrated a good understanding of the improvements needed.

Where breaches in regulation have been identified you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew how to recognise and report suspected abuse. People told us they felt safe.

Staffing levels were not always sufficient to meet people's needs.

Medicines were not managed or administered appropriately to ensure people received their medication as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received a choice of food, but mealtimes were not always a pleasant experience.

Staff were aware of their responsibilities under the Mental Capacity Act 2005 but there were examples where people's consent had not been sought..

Staff told us they had received the training they needed to deliver care and support to people who used the service, but some updates to essential training had not been provided

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives told us people were treated with kindness and compassion, but there were occasions where people's dignity was compromised.

Staff showed caring and compassionate attitudes.

People received care and support that was personalised to their needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have opportunities to engage in hobbies or interests and the provider had not taken account of guidance regarding meeting the needs of people living with dementia.

People's health and care needs were not always responded to appropriately to ensure their welfare.

People and relatives felt they could make a complaint if needed to and it would be listened to.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Systems were in place for monitoring and auditing the quality of the service provided, but had not been effective in identifying breaches to regulations.

People who used the service, relatives and staff told us the management team were approachable

Complaints were appropriately managed and responded to and people and their relatives were being more actively involved in improving the service.

Requires Improvement

Guardian 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 inspection took place on 23 and 24 October 2014 and was unannounced.

The inspection team consisted of four inspectors, a specialist advisor who specialised in acute care and had experience of managing services, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert we used had experience of people living with dementia and younger adults who had physical disabilities.

Prior to the inspection we looked at information we held about the service including recent inspection reports and notifications the provider had sent us to tell us about incidents that had occurred at the home. The provider was asked to send us a Provider Information Record (PIR) before the inspection. PIR is a document that we ask the provider to complete to tell us about the service and the plans it has to improve and develop the service. We reviewed the information provided and used it to inform our inspection plan.

We spoke with other professionals before the inspections to gain their views about the service including the local authority quality monitoring team, health and social care workers and the safeguarding team. At the time of the inspection the service was subject to a large scale investigation under safeguarding procedures agreed in Staffordshire and Stoke-on-Trent. This meant a number of investigations had taken place into concerns about the care and safety of people who used the service. Placements at the service had been restricted because of the on-going investigations taking place.

During the inspection we spoke with 16 people using the service, 14 relatives and friends or other visitors. We spoke with 17 staff, the registered manager and other members of the management team. We looked at care records and other records relating to people's needs these included care plans, daily records and medication charts. We also looked at relevant records relating to staff and the management of the home. We carried out a Short Observational Framework for Inspections (SOFI) on three of the units we inspected. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

On two units, Garden View and Garden Walk we observed examples where people who used the service did not receive any staff attention or were not supervised for long periods of time. On two occasions on Garden Walk we had to seek out staff to request they support people, and there were periods during the morning when there were few staff visible, other than the nurse who was administering medicines. Other staff told us, "The turnover of staff is still an issue and we're using a lot of agency still" another said, "Things have improved, the agency are still being used but we seem to be having the same one's which means they know what they need to do".

Some relatives and staff told us there were not always enough staff to meet people's needs, or there was a reliance on agency staff to maintain safe staffing levels. One relative told us, "Staff do a wonderful job but staffing levels are not sufficient". Another relative told us, "The staff are brilliant but there is a shortage. There are people who are cared for on a one-to-one basis but there is no one to see to the other people". A relative said, "Sometimes there are one or two staff short, this sometimes happens at weekends". Other relatives did not express any concerns. During the morning on Garden View we were told that three people required one to one support, this meant there were five carers to support the remaining people on the unit. People were left unsupervised due to staff pressures assisting people to rise and having breakfast. We could see and staff told us that they were very busy. Staff told us that the number of staff on duty was not sufficient to meet people's needs.

On Garden Walk we observed the nurse responsible for administering medication was wearing a red tabard that stated 'do not disturb'. The tabard was intended to be a visual reminder to people, care staff and relatives that she was administering medication and should not be interrupted, therefore reducing the risk of administration error. The nurse was interrupted by care staff, by answering the telephone and answering buzzers when they had not been answered promptly by other staff.

We discussed staffing levels with the registered manager and management team, who told us they had determined the staffing levels using a recognised tool. They confirmed that their calculations had not included staff sickness or annual leave. Agency staff were bought in where gaps in staffing numbers were identified.

These issues constituted a continued breach of Regulation 22 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010.

We identified that staffing levels had been increased on two units; Mayfield and Court Walk since the last inspection. We observed on three units; Court Walk, Court View and Mayfield that people's needs were being met in a timely manner by staff who knew them well. Where agency staff were used they were there to support the existing staff team, and they confirmed they had been provided with information they needed to provide appropriate care and support to people.

Two people we spoke with told us they did not have to wait long before someone came to help them. Staff were also visible in all of the communal areas and were supervising people who used the service.

We saw that a person admitted to Garden View had brought medication from home. This had been handwritten on a medication administration record (MAR) chart. The GP had reviewed the person the day after admission. A cream had been brought with other medication but this had not been recorded and not administered. This was resolved with the GP on the day of our inspection which meant the person had not received medication they needed since their admission.

On Mayfield we checked the records of topical medications for two people and checked the medication had been administered as prescribed. One person was prescribed creams but there was no record these had been administered as prescribed. A body map showed where the cream should be applied. In another example it was not possible to determine if a person had the three creams administered as prescribed due to incomplete records. We checked the cream tubes to check if the medication had been administered, but agreed with the unit manager that it was not possible to confirm, because the cream tubes were either not opened or there was little evidence of regular use.

There was a locked medicines room in each unit and we saw that medicines were stored securely in a locked trolley within the rooms. However on Garden Walk we saw a box of

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Is the service safe?

drugs for disposal left unsecured in a box in the medicines room. None of the medicines were included in the disposal log book. The nurse disposed of the medicines at lunchtime but didn't know how long they'd been there. This meant in this instance the procedures for the safe disposal of medicines were not followed.

On Garden View we were told that medicines were mixed with food or drink. When asked if the pharmacist had cleared individual medicines as suitable to be crushed the unit manager said she was in the process of discussions with the pharmacy but had not had confirmation of the outcome. This meant appropriate action had not been taken to ensure medicines were safe or suitable to administer in this way.

These issues meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010.

We looked at records of staff recruitment and which showed the provider had recruitment procedures to ensure staff were safe to work in the service.

All the people we spoke with on Court View said they felt safe and secure. People on Guardian Walk said they felt content and safe. Two people told us, "It's a nice place to be." A relative on Mayfield told us, "This is the best place". Another relative told us they felt their relative was safe. Staff spoke with knowledge about what constituted abuse and what actions they would take to report any concerns they may have. It was confirmed that appropriate procedures for reporting suspected or actual abuse were in place.

Staff we spoke with were clear about how they should support people to keep them safe from harm. One risk assessment detailed a hazard for a person who had previously moved furniture to block their bedroom door. We saw and were told that appropriate action had been taken to remove this risk.

On Court Walk we found a number of people who had complex care needs had detailed risk management plans in place, with established links with NHS health specialists. Emergency procedures were documented and we confirmed with staff we spoke with that they were familiar with the procedures they should follow. One person's emergency alarm for their ventilator activated and we observed that suitably trained staff responded promptly and in accordance with the risk assessment.

We saw that personal emergency evacuation plans (PEEP's) had been written for each of the people whose records we looked at. PEEP's contain relevant information about the support a person would need to be assisted to evacuate the building in an emergency. Staff we spoke with were aware of the plans for people they supported.

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Is the service effective?

Our findings

Staff were aware of and had received training in the Mental Capacity Act (MCA) 2005. The MCA sets out the requirements that ensure decisions are made in people's best interest when they are unable to do this for themselves. We identified that although there was an understanding of the MCA there was some evidence that the requirements of the Act hadn't been put into practice. We saw that some people had do not attempt to resuscitate agreements (DNAR's) in their care files. In the sample we looked at we saw one person had a DNAR in place but there was no evidence of discussion with them and staff confirmed the people we identified had some capacity to understand what this would mean. We spoke with the unit manager who told us she was going to review them all and make sure that all documentation and evidence of discussion and consent was there including discussions.

We saw five people on Garden View had their medicines administered covertly. The records we looked at showed the decision had been made with the GP and nurse or unit manager. We were told one family member had been involved in the decision, but there was no documentary evidence of this. We were told that medicines were mixed with food or drink. There were no care plans to address how and in what circumstances the medicines should be covertly given and no evidence of best interest assessments or agreements.

These issues meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010.

At the last inspection the provider had introduced new care plans for people who used the service relating to Deprivation of Liberty Safeguards (DoLS) where it was necessary to do so. DoLS are part of the MCA, and set out the legal requirement and code of practice that ensures where appropriate; and people are not deprived of their liberty. Any restriction or decision must be agreed and be in the best interests of the person. We saw that DoLS documentation and Court Protection Order documentation was in place. A number of authorisation requests had been forwarded to the local authority who were in the process of reviewing them. We noted an example where the DoLS restrictions agreed were being appropriately implemented to ensure the person's rights were met.

A relative raised concerns about the number of appropriately skilled nurses available to meet the needs of their relative's complex care needs. We looked at the care of the person who used the service and spoke with staff allocated to support the person. The staff we spoke with demonstrated a sound knowledge of the person's care needs. Another relative said, "I have no problem with the permanent staff but have concerns about the competency of some of the agency staff. I have asked that agency staff are not used to support my relative". One care staff said, "I asked one agency staff what training in care they had received and was told they had not had any training. I told the unit manager about it and she said she would report it to the clinical lead who organises the agency staff". The care staff went on to say, "We have two other agency staff who are brilliant".

The registered manager and management team told us the provider had agreed to them using a recruitment consultant to improve the induction of new staff. This would mean staff received a three day initial induction, before working on the units and then completing a programme of common induction standards. We were told that agency staff received an induction on the unit they were allocated to work on, but it was unclear if this was a formal process.

The care staff said they had received the right kind of training and support to meet people's needs. One care staff told us, "I have recently received training in the management of aggression and manual handling training". Care staff were positive about their training experiences and said they had improved, but expressed concerns that the provider had stopped paying staff for the training the provider classed as 'essential' and they had to come in on their days off. Staff commented that this was unfair, and made them less likely to want to attend the training sessions they needed to meet people's needs effectively. We have since consulted with the Health and Safety Executive for their interest.

Staff we spoke with confirmed they received supervision on a regular basis during which they recapped on anything outstanding from the previous supervision of their practice. Supervision is a one to one meeting with a senior staff to

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Is the service effective?

discuss their performance and personal development and to discuss any concerns. One senior care staff told us, "I supervise care staff they have supervision every two months. One of the nurses provides me with mine". Another care staff told us, "I do a lot of training and feel supported here". This meant staff received the support they needed to ensure they were trained and competent to meet people's individual needs.

We noted that when people became agitated and verbally aggressive, staff managed behaviours appropriately and well. This avoided confrontation with others and people were kept safe. We spoke with staff about the techniques they used to support people. A care staff told us, "We have received training in managing challenging behaviour; we tend to use distraction and conversation to good effect. It is very rare we have to use any holding techniques". The actions we observed staff had taken to support people at times of anxiety matched what we had seen recorded in their risk assessment and care records.

We received mixed comments from people who used the service and relatives. Comments included, "I like the food here". "The food is alright, but could be better". "Lunches are OK, could do with more variation at tea-time," and "The girl in the kitchen is a little marvel!" "The food can be cold and is often mundane".

There were individual cooked breakfasts for people including toast and cereal. There was a list of people's food and drink likes and dislikes and special diets. Pureed meals had been prepared separately so that people could taste the distinct flavours on their plate. People had choices of two meals at each mealtime. People who were at risk of malnutrition or dehydration had care plans in place and referrals to dieticians were seen.

At lunchtime we noted that people had a varied experience. On three of the four units lunchtime was an unhurried, quiet, relaxed experience for people using the service. Visitors were encouraged to support their relative and told us they were pleased to be able to make a positive contribution to the care of their relatives. We observed staff assisting people with eating and drinking and offering people a choice of meal. On Garden Walk we noted the dining room space was not adequate for everyone to eat together. People who needed assistance were served first but other people wandered into the dining room ahead of their scheduled 'time' to eat. Staff either let them stay but they had to wait for food or they were asked to come back later. It was not a positive meal experience for people. Most staff were task orientated with little interaction with people. Some people waited in their chairs for over an hour for their meal.

We observed staff care practice when they were providing food to people who needed to be fed artificially. Some people had difficulties swallowing and had a percutaneous endoscopic gastrostomy (PEG) tube fitted. This is usually a soft plastic tube that is put into their stomach. We observed good practice on all of the units where this happened.

A single GP practice provided the community health support for the service and undertakes regular visits to the home. We saw evidence in the records we looked at that health concerns were usually referred promptly to the relevant professional this included, dieticians and speech and language therapist. We looked at a sample of care records relating to people's health care. We found examples of positive healthcare, particularly where people had complex health needs and we saw people's health needs had been assessed and regular reviews were carried out.

Requires Improvement

Is the service caring?

Our findings

On all of the units we inspected relatives and people who used the service were very complimentary about care staff. A person who used the service told us, "I get good care, I can have a laugh with staff, I've improved 100% since coming here," and "I can be independent but the staff are there for me." Another told us they were happy. A third person pointed out a member of care staff and said, "That individual is not too bad," and another that, "They [the staff] are very patient, I get on with everybody".

We observed many examples where people were treated with care. We heard and observed a person who used the service shout out on three separate occasions and each time a care staff responded to reassure the person. Care staff were seen to communicate in the ways each person could understand by touch and stroking hands, eye to eye contact and speaking clearly. This resulted in positive interactions with people and demonstrated caring attitudes.

Although we observed some helpful, caring communication between care staff and people who used the service. We also noted that that some care staff did not engage with the people they were supporting. We saw that some care staff were often focussed on delivering the task and did so way with a minimum of interaction or communication between them and the person. The interactions did not demonstrate caring attitudes.

Relatives told us they could visit the service at any time, some relatives had a shared care arrangement meaning they spent large parts of the day with their relative, providing emotional support and assisting with some care needs, including at mealtimes. We spoke with two relatives who told us there were no restrictions on the time they visited. Relatives we spoke with told us the provider had started to introduce relatives meetings. This gave them an opportunity to discuss their views about the service and any improvements that could be made. One relative said, "I'm happy with the set-up, staff are efficient, caring, kind and they listen." Another relative told us they thought staff were helpful and, "Some are really good, I can ask them anything." A third relative told us, "I can't fault the regular staff".

We observed staff knocking on people's bedroom doors before entering and relatives told us that their relative's privacy and dignity was respected at all times. We noted on one occasion where care staff made sure one of the people who used the service was properly dressed when their blouse had fallen open therefore preserving their dignity. We noted care staff supported one person with their artificial feed; this was done discreetly in one area of the lounge where others could not see. We also saw when a nurse administered medication through the PEG of another person; attention was given to dignity and privacy.

We also observed some situations where people's dignity was compromised, for example on Garden Walk we saw one person being wheeled through reception area naked with a small towel over their middle, after being showered. Later in the morning we saw another person taken through the reception in wheelchair, covered with a large towel but still obviously naked. We spoke with a senior member of care staff who confirmed this was normal practice as, 'It was too difficult to dress people who required hoisting in the bathroom'. We also observed other people being hoisted without explanation or reassurance from staff and people left in stained clothing after they had lunch. This demonstrated a lack of respect, privacy, dignity and human rights. We shared these concerns with the management team for their attention and action.

In another example we observed a person who had breakfast in the lounge asked care staff for a drink. A care staff brought a drink and also a cloth as the person had food on their face and clothes. The care staff gave the cloth to the person who wiped the food from their face. The person then kissed the hand of the care staff. This was a spontaneous and humorous response, the person clearly feeling at ease with the care staff. They both laughed.

Where people had specific cultural or pastoral needs staff told us how they ensured they were respected and received the support they needed. A relative we spoke with confirmed this citing how their relative had prayers played on their CD at times during the day, in keeping with their religious beliefs.

Requires Improvement

Is the service responsive?

Our findings

On four of the five units there was no evidence of active social engagement. A relative told us, “I have never seen any activities taking place” and “Most people just sit all day”. A member of staff said, “People sleep a lot during the day. A lot of them are happy to watch TV”. During large parts of the day most people in Garden View and Garden Walk were observed sleeping in front of the television. During our SOFI observations we noted there was no evidence of any social or therapeutic intervention for people who were living with dementia. We were unable to ascertain that specific one-to-one activities, vital to people living with dementia had taken place. A unit manager told us they suggested music, stimulation, aromatherapy and CD/Karaoke so that staff and relatives could sing with people using the service but this had not been provided. Records we looked at did not contain any record of activity and people, relatives and staff confirmed this. There was no evidence that people were engaging in hobbies and interests they had previously enjoyed.

The provider advertised that the service has a spa facility for people to use and a range of therapies available. The registered manager told us that the spa had not been operational for some time and wasn’t used. This meant people who used the service had not had access to facilities they expected to. A relative told us, “They don’t do what they say on the tin”. Two relatives expressed concern about the lack of physiotherapy input, stating ‘physiotherapy is non – existent’, and that ‘carers were not confident in performing physiotherapy’. Physiotherapy was reported to be available every three days and as a result nurses and relatives reported delays in treatment. In some of the records of people we pathway tracked there was no evidence they had received therapies they were assessed as needing.

On Court walk we saw there was a protocol for assisting one person to their chair however, the relative reported that the person was unable to sit in the chair as a wheelchair assessment for the person had not been performed due to staff sickness. As a result we were told the person never got out of bed and was unable to socialise.

On Garden View we looked at records of a person who had been recently admitted to the service. The person’s skin had been assessed on admission as having ‘blemishes'. On admission the pressure area risk score very high risk. We saw in records that the condition of the person’s had deteriorated. resulting in a pressure ulcer. This meant the persons assessed needs had not been planned and delivered in a way as to meet the person’s needs and to ensure their health and welfare.

These issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010.

Visitors were welcome at any time and the relatives confirmed this. We did not see any notices advertising residents’ meetings. Some relatives told us they had been to a meeting and there was another planned. Other relatives were not aware meetings had been arranged.

We asked people and their relatives what they would do if they had any concerns about the service they received. One person told us they would talk to staff if they had any concerns. A relative told us, “I have complained before and have had a response from the manager”. Other people and relatives said they able to raise concerns if they wished to.

Information on how to complain was available in the main foyer and in information leaflets located throughout the home. We looked at how complaints and concerns were handled. The registered manager provided evidence that complaints were managed appropriately and responded to within the timescales stipulated in the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who was supported by a management consultancy team at the time of the inspection. The management team also included two clinical leads, who took responsibility for day to day monitoring of the service.

Our records confirmed that the registered manager notified us of reportable events as required. We were informed of deaths that occurred at the service and incidents that resulted in a serious injury and of potential safeguarding incidents. This showed that they understood their CQC registration responsibilities. We had asked the provider to send us a Provider Information Record (PIR) to tell us how the provider was meeting the five domains and any plans for the service's improvement. We had received this information when requested and used it to help with our inspection planning.

People we spoke with made positive comments about the registered manager telling us they was approachable and they felt they could talk to them. People and relatives also commented that improvements had been made to the service since our last inspection and they had noted this.

A relative told us she had noticed an improvement saying, "Staff are no longer running around like headless chickens". Another said, "I have no concerns about the care at all, it is very good. I did have a concern about some of the food, but the new unit manager has arranged for me to have a meeting with the catering manager".

A number of staff, relatives and people made positive comments about the unit managers, for example, "I think she will do a good job. It's early days but things are looking a little better" and "I have confidence she can put things right".

Staff we spoke with told us staff meetings were now being arranged regularly and they had access to staff supervision.

There were still some mixed comments about the levels of improvement, with some staff saying more was needed to be done, but they were more confident they were being listened to and improvements for people who used the services were being planned

The provider had introduced a number of audits to determine where improvements needed to be made. For example we saw an audit of the staff recruitment records had taken place that clearly showed any deficits or omission in the required records. We saw evidence of care plan audits and regular management meetings to discuss areas for development. These included a daily 10 to 10 meeting where unit managers, the clinical leads and the registered manager met to discuss any concerns. We also saw that the registered manager and management team were working toward an overall action plan to improve the service. This meant that the manager was working to continually improve the service for people who lived there.

Despite these developments and the audits of quality taking place, we were able to determine the provider was in breach of some of the regulations we inspect against which meant the audits had not identified breaches of regulation we found.

We found that the provider had not taken decisive action to ensure sufficient staffing levels were provided on all units to ensure people's needs were safely met and people's care was delivered as planned. There were examples where people's privacy and dignity was not always respected and continuing concerns about the completeness and accuracy of records.

We saw that complaints and incidents and accidents were being monitored and there was evidence of learning from them. This meant the provider was making improvements to the service based upon the outcomes of any complaints and incident investigations.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the regulation was not being met: People who used the service were not protected because medication was not always managed correctly and they did not always received medication as prescribed.**

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulation was not being met: The provider did not have suitable arrangements for obtaining and acting in accordance with the consent of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **How the regulation had not been met: The registered provider had not taken appropriate steps to ensure there was always sufficient staff in numbers to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met: because the provider had not always taken appropriate steps to ensure people's welfare and safety. Regulation 9 (1) (b) (i).**

This section is primarily information for the provider

Action we have told the provider to take

Because the provider had not always ensured people's individual needs had been met. Regulation 9 (1) (b) (ii).

Because the provider had not always reflected where appropriate, published research evidence and guidance for people living with dementia. Regulation 9 (1) (b) (iii).