Four Seasons 2000 Limited

Burgess Park

Inspection report

Burgess Park
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
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 2 March 2015 and was unannounced. At the time of the inspection there were 41 people using the service, who were older people some with dementia.

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 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.

At the last inspection on 12 November 2014 the service was meeting the regulations we inspected.

The provider was in breach of eight regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found a number of breaches. Assessments and care plans were not regularly reviewed and updated to reflect changing need for a person. Professional recommendations made to manage risk were not always acted on by staff, increasing risk to people's health and wellbeing.

Summary of findings

People did not always receive food which met their health and cultural needs. A food quality audit completed in February 2015; found people were unhappy with the availability and quality of food. The registered manager and interim manager had not taken action on people's comments by improving the quality of food provided for them.

There were two current staff duty rotas in use. One staff rota had details of staff scheduled to work. The other staff rota held details of staff that were scheduled to work on each shift and had information on staff sickness, absence and agency staff used. The regional manager, interim manager and the deputy manager were unable to tell us how many staff were on duty; they provided us with three different numbers of staff. People did not always receive care promptly, because staff were not available to assist them.

People were not always treated with dignity and respect by staff.

People and their relatives were asked for feedback on the quality of the service; however, their responses were not acted on by the registered manager or interim manager.

Incidents and accidents were recorded and a report produced of these. The interim manager had not provided staff with guidance on how to reduce the risk of an accident or incident recurring. People were not kept safe.

Medicines were not managed safely. People did not always receive their medicines at the prescribed times or following the prescriber's instructions.

Staff were aware of the signs of abuse and were able to tell us how they would escalate an allegation of abuse.

People were provided with information on how they could make a complaint and how the complaint would be managed.

Senior staff provided training, supervision and an appraisal for staff. Newly employed staff completed an induction programme so they could develop their skills and knowledge in order to meet the needs of people they cared for.

Staff were aware of their responsibilities within the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Some people and their relatives were involved in assessments to determine their ability to consent to care and support.

People were at risk of receiving poor care and support. People did not take account of their comments or acted on them to improve the quality of the service they received. People did not receive medicines in a safe way. The provider did not provide food and nutritional support which met their cultural or medical needs. Staff did not always treat people with dignity and respect. The provider did not send us notifications of safeguarding allegations. People's records were not updated to reflect the needs and support people required and the provider did not have sufficient staff to care for the needs of people living at the service.

We are taking action against the provider for breaches of the regulations in relation to; care and welfare of service users (Regulation 9), assessing and monitoring the quality of service provision (Regulation 10), safe care and treatment (Regulation 12), management of medicines (Regulation 13), meeting nutritional needs (Regulation 14), good governance (Regulation 17), staffing (Regulation 18) and notification of other incidents (Regulation 22A (CQC Registration)).

We will report on it when our action is completed.

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?

Inadequate

The service was not safe. People were at risk of receiving unsafe care because assessments were not accurate and up to date.

Medicines were not managed safely. People did not receive medicines at the prescribed times.

The service was unable to tell us how many staff were required to ensure that people and the service were safe.

Is the service effective?

Inadequate

The service was not effective. People were not always provided with meals which met their cultural and health needs.

People did not have access to healthcare when their needs changed.

Staff were supported with regular training, supervision and an appraisal so they were able to care for people.

Staff were aware of their roles and responsibilities within the framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

The service was not caring. People were not treated with dignity and respect by staff.

People were not supported to be independent as able.

People were not cared for in line with their needs.

Is the service responsive?

Requires improvement

The service was not responsive. People and their family were not always involved in the development and review of care records.

People were not supported to maintain relationships with people that mattered to them.

Staff did not respond promptly to people's changing needs.

Is the service well-led?

Requires improvement

The service was not well led. People and their relatives were encouraged to provide staff with feedback on the service; people's responses were not acted on.

The quality of care was not monitored, reviewed or improved by the registered manager or the interim manager.

Summary of findings

There was a registered manager in post who was not managing the service at the time of the inspection. The service and staff were managed by four managers.

Burgess Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 March 2015 and was unannounced. It was carried out by two inspectors, a specialist professional advisor 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.

Before the inspection we received information of concern from the local authority about the quality of the care and support the service provided to people. During our visit we spoke with17 people, four relatives, one nurse, six staff, an activities co-ordinator the regional manager, the interim manager and two deputy managers. We observed care and support provided in the communal areas of the home. We spoke with one kitchen assistant and looked at the kitchen. We reviewed the records we held about the service including notifications of incidents at the service. We looked at a range of records about people's care and support needs, these included; 12 care records, 41 medicine records, 38 accident and incident reports, three staff records and one staff rota. We looked at other records for the management of the home such as the 2014 customer survey and the 2015 internal audit. 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.

After the inspection we spoke with two nurses, a safeguarding manager, a social worker and a commissioner of services from the local authority.

We asked people's permission before using their quotes in this report.

Inadequate

Is the service safe?

Our findings

People did not always receive a service which was safe and met their needs. Care records, risk assessments and management plans were in place for people. However, risk assessments were not always accurate to reduce the risks of harmful incidents occurring. For example, a person's mobility risk assessment stated they had had partial use of their arms. However, the person was mobile; they used a walking frame and were able to transfer out of bed without any assistance. The person's mobility needs were not updated correctly, and was at risk of receiving inappropriate care and support.

Another person was at risk of developing a urine infection due to their use of a catheter. The person's care plan had not identified the support they required to care for their catheter to reduce the risk of infection. People's needs were not always correctly assessed increasing the risk of deterioration in health.

People's assessments and care plans were not always updated to reflect their changing needs or professional guidance. For example, one person's care records showed that a tissue viability nurse had made recommendations regarding the care they required to reduce the risks of pressure sore development and pain management. People were at risk of unsafe care because staff did not follow professional guidance to meet people's needs.

Staff did not act on the advice of health professionals to ensure that people were supported safely. For example, a speech and language therapist made recommendations about how to manage the risk of choking. A person was assessed as being safe with drinking out of a cup without a spout and this would reduce the occurrence of choking. We found that staff had not adhered to the professional guidance and had used a spouted beaker to support them to drink, increasing the likelihood of the person choking. This increased the risk of unsafe care increasing the risks of poor health.

A referral was made to a dietician for a person with unintentional weight loss a food plan was developed for them. Staff had not put this plan into practice. When we spoke to the person they told us that they did not like the food provided. When we discussed the food plan recommended by the dietician with them, they told us that they were not provided with the food recommended. Food and drink records did not show whether meals provided were those recommended by dietician. Relatives told us that they brought in home cooked meals so that the person could eat food they liked. The person's weight was not routinely monitored. Staff did not provide support to the person with their nutritional needs and did not adhere to professional guidance about their nutrition. This person did not have access to meals which met their nutritional needs, increasing the risk of unintentional weight loss and deterioration of health. We found that the registered person had not protected people against the risk of poor nutrition and hydration. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their medicines safely according to the prescriber's instruction. For example, one person was prescribed a cream which was to be applied to their skin each day. Daily records showed the cream had not been applied daily to the skin since 21 January 2015 and the medical condition that the cream was prescribed for had not resolved. People could not be confident that they would be supported to have treatment as prescribed, increasing risk to their health.

Staff did not take adequate precautions to ensure people had their medicines at the correct times. We observed that a medicine round was in progress at 10.50am. Peoples medicine administration records (MAR) showed that they should have been given their morning medicines between 8am and 10 am. People were at risk of unsafe medicine administration because they were at risk of medicines given close together.

People did not receive medicines required to maintain health. One person was purchasing medicines for themselves on a weekly basis. Prior to living at the home, this medicine was prescribed by the person's GP. Staff had not followed this up with the GP to prescribe this medicine for them. We checked the MAR for this person and this medicine had not been prescribed. We discussed this with the regional manager, interim manager and two deputy managers. They told us they would investigate this and let us know the outcome. At the time of writing this report we had not received any further information regarding this. People were at risk of not receiving medicines to maintain their health and were risk of deterioration in health. We

Is the service safe?

found that the registered person had not protected people against the risk of the unsafe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two staff rotas in use. One was used to plan the staffing levels for each shift and the other staff rota was used to add details, such a as staff sickness and agency cover. We were given a copy of one staff rota and it showed that there were gaps in the staffing levels. For example, on Sunday 15 February 2015, there were no nurses on duty at night and one nurse on duty during the day. We were told by the deputy manager that there were two nurses on duty on each shift and this information was in the second staff rota. We asked for a copy of the second staff rota so we could establish the level of staff, we were not provided with this. We spoke with the regional manager, interim manager and two deputy managers about the level of staff available at each shift. We were provided with three different numbers of staff that should be on duty. People could not be confident that they would be cared for by a suitable level of staffing to meet their needs.

We observed that there were staff available in the communal areas to support people. People and their relatives had varied views on the level of staffing at the service. For example, a relative told us they believed there were enough staff in the service to meet people's needs. However, another relative said, "There are no experienced staff at the weekends." A relative told us they had seen a member of staff sleeping in a chair at a weekend. This had been reported to senior staff and was being investigated. The interim manager told us the home was "short of nurses" by one, on the day of our visit. An agency nurse, who was unfamiliar with the home, was working to cover the gap. They were providing nursing cover for the ground and first floors where 20 people lived. A member of the staff said the staffing numbers were adequate, but another said they felt there was, "too many agency staff." Another member of staff said, "It was difficult to build up a sense of team working because, "good staff come and then they go." People were at risk of receiving unsafe care because there were not enough staff to meet the needs of people.

The home had mice infestation at the time of the inspection. We were told by the interim manager that advice had previously been sought from a pest control service. We asked the provider for a copy of the pest control policy and plan during the inspection. At the time of writing this report we were not provided with this information. People were at risk of an unsanitary environment because appropriate pest control had not resolved the pest control issues.

The service had a safeguarding policy in place for guidance for staff in managing an allegation of abuse. Staff had regular updated training in safeguarding; they were knowledgeable about how to protect people from the risk of abuse and harm. Staff told us they were aware of the signs of abuse and what actions they would take to protect people at risk of abuse. Staff we spoke with explained how they would escalate a safeguarding concern to a manager and, if appropriate to the local authority.

At the time of the inspection there were seven safeguarding allegations which were investigated within the local authority's safeguarding adults' process. The interim manager had not informed us of the safeguarding allegations. We spoke with the safeguarding manager at the local authority who informed us that the safeguarding cases were being investigated. At the time of writing this report the safeguarding manager has informed us of three additional safeguarding cases at the service. The interim manager had not informed us of these. We found that the registered person had not protected people against the risk of poor management of safeguarding allegations because they did not tell the Care Quality Commission of notifiable incidents. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 22A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents and accident were not accurately recorded. This information was put into a system online which staff had access to. The interim manager was unable to access this and we waited for a deputy manager to provide access to this information. We found that staff had recorded incidents and accidents which occurred at the home or when outdoors, for example when at a hospital appointment. There were 38 incidents recorded for December 2014 and January and February 2015. However, the registered manager and the interim manager had not provided guidance to staff on how to reduce the risk of an accident or incident recurring. For example, one person

Inadequate

Is the service safe?

had cut their hand on a piece of metal on the bedroom door. There was no action taken. Another entry showed that the person had a sacral sore; there was no other additional information such as, how, when or where the sore developed. People were at risk of harm or injury and the registered manger and the interim manager did not have guidance for staff to reduce those risks identified. We found that the registered person had not protected people against the risk from harm because incidents and accidents were not recorded correctly; plans were not in place to reduce the recurrence of risks identified. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff records demonstrated that newly appointed staff had completed the service's application process. References and police checks were carried out before the person was employed and worked at the service.

Inadequate

Is the service effective?

Our findings

People did not enjoy the meals provided by the service. 17 out of 41 people we spoke with did not like the quality of food. In the provider's survey in December 2014, 55% of people were unhappy with the quality of food. One person said, the meals were; "so repetitive and dull." Another said, "The food has no appeal whatsoever."

A person told us they did not like the choices of food available. They described the food provided as "Badly prepared and tasteless." Another person told us "The meals are repetitive and sometimes I forget what I've ordered." Another person told us, "the food is ok, it's warm."

A person on a specialised diet told us, "I don't think the staff here know about diets." They told us, "Soup is made with flour, it has no nourishment whatsoever and that's all we have to look forward to." We were told by this person that they purchased shopping for themselves such as bread as this was not provided for them to meet their dietary needs. We discussed this with the regional manager and interim manager who told us they would find out whether this was happening and let us know the outcome. At the time of writing this report, we have not received any further information regarding this. People were not protected from the risks of inadequate nutrition and dehydration, because there was not a choice of suitable and nutritious food that met people's health needs.

We found examples where people requested a meal that met their cultural needs, but these were not always provided by staff. One person told us, "I requested fish and I was told by staff that this was not available." Another person told us that it was recommended by the dietician that they have access to a meal each day that met their cultural needs. Their care records reflected this. When we spoke with the person they told us, "I get that choice of meal only occasionally. The food is generally not good." People were at risk of not having a choice of meals that met their cultural needs.

We spoke with the kitchen staff on duty and asked them which people required a special diet. They told us they did not know which people were on a special diet. We saw a display board in the kitchen, which had names of all the people living at the home and it displayed some information regarding people's nutritional needs. However, we noted that the board was last updated on 4 January 2015 and the information therefore may not have been accurate and people were at risk of receiving inappropriate meals. We found that the registered person had not protected people against the risk of poor nutrition and hydration. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have support to access the healthcare they required. For example, we saw that the GP had made a request to nursing staff for a blood test for a person. A note from the GP showed that 11 days had passed since the request and blood had not been taken for testing. The person's care records did not record whether the blood test had been.

We noted two people who required assessments due to their changing health care needs. On person required an assessment from an occupational therapist and the other from a wheelchair assessor. We checked their records and these assessments had not been completed for them. We spoke with both of the people and they both told us that they did not have an assessment. People were at risk of not receiving healthcare when their needs changed because staff did not act promptly or made referrals to appropriate health professionals when required. We found that the registered person had not protected people against the risk of poor access to healthcare. This was in breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with said that they were happy in their jobs. One staff member told us, "I really enjoy this job." Another said, "People who use the service always come first." Staff received regular supervision and an annual appraisal. Staff were able to discuss areas for improvement in how they cared for people and a plan was developed so that staff were able to develop and achieve their professional goals. Training needs were met and staff had access to online E Learning, staff training records were up to date.

The registered manager had followed the requirements of DoLS and had submitted applications to a 'Supervisory Body' for an assessment within the MCA and DoLS. The service had not received an outcome from these

Inadequate

Is the service effective?

assessments submitted to the local authority. The provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS. Staff told us that they had completed training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training records reflected this. Staff told us and were aware of their responsibilities in line with the MCA and DoLS.

Staff were supported through a programme of induction to develop their skills in meeting the needs of people. Staff had regular access to training and there was a room where staff completed online learning training.

People were supported to make decisions where needed. Where people had difficulties in making a decision they were supported to do so. We found that staff had not always involved people and their relatives in making decisions. For example, a person who lacked the ability to make a decision was assessed regarding Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) their relatives were not involved in this assessment. We saw two DNACPR's were people had relatives that were not consulted in making this decision.

Requires improvement

Is the service caring?

Our findings

Staff did not treat people with dignity and respect. We observed interactions between staff and people in the lounge and dining room areas were people were sitting and relaxing. It was clear from the chatter that people were relaxed.

Staff were not consistently caring. Staff focused on tasks to be completed and did not take account of people's individual preferences and did not always respect their dignity. For example, we observed people who were vocal and could ask staff for assistance would get attention from staff. However, we saw people who were less vocal or had communication difficulties received less attention or support.

We also saw a person whose clothes needed to be rearranged as their upper legs were exposed where they sat for 20 minutes, staff walked past and did not notice this. Another example was at a lunch time, a person was being assisted by a member of staff with eating and drinking. The staff member left the room saying loudly to another staff member "I'm going to wash my hands." We found that the registered person had not protected people against the risk of a lack of dignity and respect. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always support people to be as independent as possible. One person's hearing aid was taken for repair in June 2014. We were unable to ascertain from the records whether the hearing aid had been returned to the person. The person did not have their hearing aid in when we visited them in their room. The person was at risk of isolation because they were unable to hear what was happening around them and limited the activities they could participate in.

We looked at the care records for a person with diabetes. The records did not state what treatment the person was on for diabetes, whether it was injection or tablet controlled. People with medical conditions were not assessed or support implemented to manage the condition. Increasing the risk of deterioration of the person's health, due to a lack of monitoring and support.

We heard some positive comments from people which demonstrated that staff treated people with care and concern. A person said "We have a laugh and a joke." A visitor said they had "no complaints" and their relative "gets on with staff, they know each other." Another relative told us "The staff are kind and gentle." One person told us that staff were "very nice." Another person said, "The care workers are very kind caring people and good people." Another person told us, "The GP is very good." Another said "the GP is kind and gentle and always comes when I need her."

Requires improvement

Is the service responsive?

Our findings

People did not receive a service which was responsive to their needs. Staff did not respond to people's changing care needs or the way in which they delivered care and support to them. For example, we saw one person whose leg wounds had deteriorated. Staff had not recognised that this person's mobility had been affected by this. Staff had not sought advice from health care professionals to meet the changing need. People were at risk of deterioration in their health and support because staff had not assessed, reviewed and monitored people's changing needs. We spoke to this person and they said, "My legs are aching." and "the chair is uncomfortable."

We spoke with the nurse about a person's pressure area care. They confirmed that the person's skin was intact. However, care staff told us and care records showed that a dressing was in place. We discussed this information with the nurse who then told us the dressing was in place, "for protection of the skin, although the skin was intact." People were at risk of unsafe care because they received care which did not reflect their current needs.

People were not supported to maintain or develop relationships outside of the service. The home did not have strong links with local community services. We spoke with two people who practiced a religion, staff had recorded that the people practiced a religion. The registered manager or the interim manage had not made links with the local church so that people could access this within their home if they wanted. One person said, "I don't think my priest knows I am here."

People were not encouraged to take part in activities which met their needs or interests. One person told us, "I prefer to stay in my room." Another person said, "They don't do anything interesting, I just watch tv or read in my room." During our observations in the lounge it was difficult for people to hear what they were saying to each other. Both the radio and the television was turned on. One person said "The t.v and radio are on all the time." We spoke to a member of staff about this and they turned down the radio, while the television remained on at the same volume. People's wishes were not responded or acted on by staff.

We asked the activities co-ordinator about activities available to people. We were told there were seasonal activities such as making Easter eggs and paper chains at Christmas. There was a garden party people made decorations for, keep fit and quizzes. However, an audit identified that people requested an improvement in the quality and variety of activities provided. We found that this had not been implemented for people. We found that the registered person had not protected people against the risk of poor quality care because the provider had not taken account the views of people to improve the care they received. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's bedrooms were clean and decorated in accordance to their wishes; each room was individually decorated with personal items such as photographs of their family. Relatives were encouraged to come to the home. For example, one visitor told us they visited their relative regularly and was able to share a meal they bought in to the home with them.

People and their relatives were provided a copy of the complaints form, which people could complete with support. The complaints policy and procedure was displayed in the hallway of the home. The registered manager investigated complaints and informed the complainant of the outcome of the investigation. Follow up actions were taken when necessary. For example, one relative told us that they had to make a complaint to the registered manager about their relative's missing clothing. They told us that the complaints procedure was easy to follow. Following an investigation into the complaint the registered manager organised for the purchase of clothing that went missing and gave the clothing to the person, without charge. The person and their relative was happy with this outcome. The relative told us the registered manager listened to their complaint and they were satisfied on how their complaint was managed.

Requires improvement

Is the service well-led?

Our findings

People did not always receive a service that was well-led. The registered manager was not managing the service at the time of our inspection and an interim manager and a deputy manager were managing the service for the foreseeable future. People who lived in the home did not know who was managing the service. One person told us, "When the manager came back for a visit, everyone's face lit up." Another said, "I'm not sure who is in charge here" and another person told us, "There are quite a few managers around now, the regular manager hasn't been here for a while."

There were no effective quality assurance systems in place. The registered manager and the interim manager undertook internal audits on the quality of care and support, food, activities and the home environment. These had not identified the areas for concern that we found in each of those areas. People did not receive a quality service because the registered manager and the interim manager did not monitor the quality of service or take action to improve care provided to people.

An audit plan carried out in February 2015 by the interim manager identified that care records and risk assessments were out of date and needed to be reviewed in line with the person's health and care needs. The two deputy managers were identified to support nurses to update people's care records. During our inspection we found that care records had not been updated according to the action plan from the audit. The 12 care records we reviewed were out of date or had gaps in them. For example, a continence assessment was last updated in June 2014, a risk assessment had not been updated since 9 January 2015, a pressure area care plan was last updated on 6 November 2014, this person was assessed as having a pressure ulcer, another person's wound care plan had not been updated since 29 December 2014, this person was assessed as having multiple pressure ulcers. For some people who were on fluid charts, these were not completed correctly, for example one person's daily fluid chart was not completed from 19 February 2015 to 22 February 2015. People were a risk of receiving unsafe care which did not meet their needs because quality assurance systems in place were not effective and the registered manager and the interim manager did not take action to improve care delivery for people. We found that the registered person had not protected people against the risk of poor quality care because there were no effective quality assurance monitoring carried out at the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A customer satisfaction survey was carried out in December 2014. The results showed that 58% of people had raised concerns regarding the punctuality and variety of meals, presentation, and assistance people received with their meal. People received meals which did not meet their needs or expectations and the registered manager and interim manager did not act on their responses.

The survey highlighted also that there were improvements to be made in the activities provided. This highlighted that 76% of people were dissatisfied with the level of outside activities being provided at the home, and 50% were unhappy with the variety of activities provided in the home. We found that actions had not been taken to improve the quality of activities for people. One person said, "It's boring here." and another told us, "There's nothing to do here, I'm lonely." There were two employed activities co-ordinators at the service; one was supporting people with activities and one was not working at the time of our inspection. People were not provided with activities which met their interests or their needs. The registered manager and interim manager had not acted on people's comments regarding activities.

The survey indicated that 64% of people were unhappy with aspects of their care, for example the quality of personal care they received. There was no action plan in place to address this issue The registered manager was not available for us to discuss the outcome or a plan of action. The regional and interim managers were unable to tell how they were going to make improvements so people received care which they were happy with.

The interim manager had not sent all the appropriate notifications to the Care Quality Commission (CQC). For example, there were seven safeguarding alerts at the service and we were not informed of this. We did not receive notification of these. The local authority safeguarding team alerted us to these safeguarding allegations so we were made aware of these. The provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (CQC Registration) Regulations 2014.

Requires improvement

Is the service well-led?

Staff told us that the registered manager was supportive. One member of staff told us, “Our manager is not here, but the regional manager, the interim manager and two deputy managers provides support when needed.” A member of staff told us, “Staff work well together” there were a number of policies in place for guidance for staff. We saw copies of the safeguarding, care planning and whistle blowing policies. Staff were aware of how to raise a concern about the service and were aware of how to use the whistleblowing policy, if needed.

We were unclear who was providing overall clinical support for nurses, who was supporting other staff and who was overseeing the management of the service. We discussed this with the four managers who told us they had different tasks to complete. The interim manager was not able to manage the service for a further two weeks, they were going on leave and would not be able to provide structured clinical support for nurses. One of the deputy managers was asked manage the service during this time. People were at risk of receiving care which did not meet their needs as the clinical competency and practice of nursing staff was not assessed and evaluated consistently by a suitably qualified member of staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, and dispensing, safe administration. People did not have access to healthcare when their needs changed. Increasing the risk of the deterioration in their health and well-being. Regulation 12(f) & (g)(2)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not provided with appropriate nutrition. People did not have access to meals which met their cultural and medical needs. Regulation 14.

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 People who used services were at risk of inappropriate or unsafe care and treatment. The provider did not regularly assess and monitor the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	People who use service were at risk of poor care because their records were not updated, accurate or met people's needs. Regulation 17(2)(d).
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to tell us about notifiable of any abuse or allegation of abuse in relation to a service user. Regulation 18

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 (RA) Regulations 2014 Person-centred care **People who use services were not protected against the risks associated with unsafe care.** **Regulation 9 (3)(a)(b)-(h).**

The enforcement action we took:
We issued a Warning notice. The service is required to become compliant with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use services were not treated with dignity and respect.** **Regulation 10.**

The enforcement action we took:
We issued a Warning notice. The service is required to become compliant with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.