Four Seasons (Evedale) Limited

The Oaks and Little Oaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 16 March 2016. The Oaks and Little Oaks is a care home with nursing and provides accommodation and personal care for up to 73 older people. On the day of our inspection there were 37 people who were using the service.

The service did not have a registered manager in place at the time of our inspection. The previous registered manager left the service in December 2014. The provider had recruited an acting manager to manage the service who has applied to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were at risk of experiencing harm because risks were not identified and planned for, or the procedures in place to protect them were not followed. Staff knew where and how to report any incidents of abuse.

People did not always receive care and support to meet their needs because there were insufficient staff to provide this. People could not be assured they would always receive their medicines as prescribed.

People did not always receive the assistance they required to have enough to eat and drink. People were supported by staff who had, or were learning to have, the skills and knowledge to meet their needs. People received support from staff who may not understand their health conditions.

People were at risk of decisions being made on their behalf that they may have been able to make for themselves. Some people had restrictions placed upon them without the required authorisation being obtained.

People were supported by staff who cared about them but did not always care for them in a way that met their individual needs and they could not be confident that action would be taken to promote their dignity.

People did not receive the care they require because this had not been properly planned. People did not receive sufficient opportunities to provide them with social stimulation and companionship.

People did not have confidence that if they had any concerns or complaints these would be acted upon. People did not feel there was an open and inclusive culture at the service and systems to monitor the service were not effectively implemented.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People were not protected from avoidable risks because ways of minimising these were not identified or acted upon.

People were not supported by a sufficient number of suitably experienced staff that were required to meet their needs.

People did not always receive the support they required to take their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people were not supported to maintain their health and have sufficient to eat and drink.

People's rights to give consent and make decisions for themselves were sometimes overlooked. People may be restricted without the legal authorisation to do so being applied for.

People were supported by a staff team who received training to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not cared for according to their individual needs.

People's privacy and dignity was not always supported.

People were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support was not planned in a way that showed how their needs should be met. There were limited opportunities for social activity and stimulation.

People were not confident their concerns and complaints would be acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

The culture in the service did not encourage and enable people who lived and worked there to express their views.

Quality assurance systems that were in place were not effective in monitoring and improving the quality of the service.

The Oaks and Little Oaks

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 16 March 2016 and was unannounced. The inspection was carried out by two inspectors, an inspection manager 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the local authority who commission services and fund the care for some people who used the service and asked them for their views.

During the inspection we spoke with 10 people who used the service and five relatives. We also spoke with the nurse on duty, six care staff, a housekeeper, catering staff, the manager and the regional manager.

We considered information contained in some of the records held at the service. This included the care records for nine people, staff training records and other records kept by the registered manager as part of their management and auditing of the service.

Inadequate

Is the service safe?

Our findings

People's choices were restricted because risks were not managed in a way that promoted their independence. One person told us they ate their meals in their room and did not join other people at mealtimes, "Because I'm frightened of falling." The person also told us "I sleep here (indicating the chair they were sitting in) The chair is my bed, if I've tried to get in my own bed, I've slipped and fallen.

People could not be assured they would receive safe care. We found examples where people were at risk of skin damage because there was a lack of guidance to inform staff on how to manage problems with promoting a person's tissue viability. We also found a lack of guidance on how staff should manage a person's healthcare condition. Staff were unclear about the safest way to care for the person and said they would rely on the nurse knowing what to do. However although there was always one nurse on duty they may be occupied seeing to another person's needs or involved in other duties which would cause a delay in the being able to attend to the person. We found that action had not been taken to help staff respond to someone who was at risk of injury through falling.

Some people at the service were receiving end of life care and we found there was a lack of information about how their needs should be met. The manager said this was because they did not prepare a full care plan for people who were receiving end of life care. The manager told us, "If on a full care plan it would have more detail."

We saw some people did not receive the support they needed to consume their food and drink safely because there were times when there were not the staff available to assist them and on other occasions because they did not provide the correct support needed. In some cases staff were not following guidance provided by healthcare professionals regarding this. This exposed people to risks such as choking through not being in the correct position to eat or not having their fluids at the correct consistency.

There was insufficient detail included in people's care plans about the correct and safest way to protect their skin integrity. For example there was no guidance in place informing staff of the instructions needed on how to use pressure relieving equipment as effectively as possible. This placed people at higher risk of developing a pressure ulcer.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt there were not always enough staff on duty to see to their needs. One person told us that they had to wait to go to the toilet, they said, "I hold myself from going to the toilet, you have to wait till someone goes past." A relative told us, "It gives the impression of being short staffed, there have been new faces over the past few weeks." Another person said there was a shortage of staff and that occasionally things went wrong.

We saw during periods of observation that staff had contact with people when there was a reason to do so,

such as helping someone to the toilet. We did not see staff having time to sit down and engage in general conversation with people, and people spent a lot of time sat staring around or asleep.

People did not have opportunities for a full social experience because there were not enough staff available to assist them with their mobility. We saw people who required staff to assist them with their mobility were given their meals where they were already sat and dining room on the nursing side of the service was not used.

There were not enough staff to spend the time that would be required to encourage and support some of the people who were cared for in their rooms to come to the communal areas for periods of the day, such as mealtimes or to join in activities. We saw that one person was left waiting for their lunch whilst staff were occupied in helping other people with theirs. When a staff member was free to bring the person their meal they commented how hungry they were and quickly ate it.

There were vacancies for registered nurses, and although recruitment was taking place, the provider relied on agency nurses to fill the shortfall until this process was complete. A nurse told us this affected the continuity of the service and placed a burden on the permanent nurses to keep on top of all the nursing issues and keep all the paperwork in order.

Staff we spoke with felt there were not enough staff to meet people's needs in a timely way. They told us they tried to make time to sit with people but this did not often happen as they were so busy with everything else that needed to be done. Staff said they had raised concerns with management team about this but they had been told that there were enough staff. One staff member added, "We don't think that there are."

The provider had a dependency tool for calculating a guide about the number of staff that needed to be on duty to meet people's needs. However this did not take into account that this service operated two separate units. Also we found this had not been used properly and had not been kept up to date with changes in the number and needs of people using the service that would affect this.

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

People were supported by staff who had been through the required recruitment checks to preclude anyone who had previously been found to be unfit to provide care and support. These included acquiring references to show the applicants suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

People told us they felt safe in the service. One person who used the service told us, "I feel safe when I'm dressed and I'm in my chair, I feel safe in my bedroom." Another person said, "We are safe here."

Staff knew the different types of abuse and harm people could face, and how these could occur. Staff were aware that any concerns should be reported to the nurse on duty or to the manager. The manager told us about recent safeguarding investigations that had taken place. They had worked with the local authority and identified where issues had arisen to prevent similar incidents occurring.

Although staff administering medicines had received the required training, people could not always be assured they would receive their medicines as intended. We saw a person was not given their medicines in the way described in their care plan to be the safest and most effective. A record in the person's care plan

stated that the person needed to be supervised when taking their medicines because they were likely to drop tablets in the bed without knowing it. We saw the person had been left to take their medicines unsupervised.

Records made did not always correctly show when some people had been given their medicines or had creams applied so it could not be easily checked whether these had been administered or applied as people required. In addition to this, we also found some external creams and ointments that were applied when needed (PRN) did not have protocols in place detailing where staff should apply these This may lead to people not having their creams applied where they needed to be.

There were separate medicine storage arrangements for the two sides of the service, residential and nursing. We found some of the records in the residential side made did not include a witness signing to confirm the correct medicine had been written on the medicine administration record. This is seen as the safest procedure to ensure there is no mistake made when writing the MAR sheet and is the expected practice within the service.

One person was prescribed a PRN medicine in the event they had a seizure and when we spoke with a member of staff they could not tell us at what point during the seizure the medicine should be administered. This meant that the person might not get the correct support they require when having a seizure.

Medicines were stored in the required way and we found that controlled medicines were checked daily to ensure the correct amount was in stock and all medicines that had been administered were accounted for.

We also found that when medicines were required to be kept at a certain temperature in the fridge that this was taking place and staff were checking the temperatures of the fridge daily to ensure the effectiveness of the medicines were not compromised. Furthermore we found that when medicines needed to be returned to the pharmacy, records were available to demonstrate that this process took place in line with good practice recommendations.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People were not always properly assessed to determine if they had the capacity to make some specific decisions for themselves. We saw some people had been assessed as not having capacity but the assessment lacked detail in showing how this decision had been reached. In addition the assessment did not show how a decision had been made in the person's best interest, for example who had been consulted with about the decision.

We also found decisions had been made about people's care, and the decisions had been made without the required mental capacity assessment to determine if the decision was required in the person's best interest. For example, a decision had been made about the method of administering medicines to one person and this had not been assessed in line with the MCA 2005. We found errors had been made in completing MCA assessments. One assessment had been completed for a person, which had another person's name on. Another assessment had been carried out and staff had recorded the person was under constant supervision, however we saw that they were not.

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

People were not protected from unauthorised restraint. We saw that staff used physical intervention to restrain one person, in order to provide them with their personal care. This was included in a care plan for the person. However there had been no mental capacity assessment completed to determine if this was in the person's best interest. Additionally a DoLS had not been applied for to ensure this restriction was authorised. We asked the manager about this restraint and they were unaware this took place.

The manager had applied for a DoLS for some people who had restrictions placed on their liberty. However there were some other people whose liberty was restricted and the required application had not been made to ensure the restriction was authorised. The manager said they knew these needed to be applied for and would be done. They notified us after the inspection that these DoLS applications had now been submitted.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive the support and encouragement they needed for them to eat well. We saw

one person had not eaten any of their lunch. This had not been presented in a way that followed the information in the person's care plan that would encourage the person to eat this. The person was not offered an alternative when they did not eat their meal and there was no guidance in their care plan about how staff should respond in those circumstances, such as offering an alternative which the person might eat.

There were systems to monitor people's nutritional intake and to enrich people's food if required to ensure people were receiving adequate nutrition to maintain their wellbeing. However, these were not always used. For example, one person who was at high risk of weight loss was not being weighed and action had not been taken to prevent further weight loss such as fortifying their diet to increase their calorie intake Although it was recorded that the person was unlikely to gain weight, action should have been taken help them maintain their weight. We saw a chart used to monitor the fluid intake of another person showed they had not been given any fluids for a period of 16 hours. Staff were not able to provide an explanation for this so we were unable to ascertain if the person had received fluids during this time or not.

We saw staff respond to people who made differing requests during the mealtime. We saw some people had the hot option and others made a choice from a selection of prepared sandwiches. One person requested another filling and this was provided for them. A person who used the service told us, "They feed you well." People's specific diets were catered for, although there was a limited choice of pudding for people who required a low calorie option.

Newly introduced catering arrangements meant that the menu and food ingredients were chosen externally with the meal then prepared in the service. This meant people's individual preferences could be catered for to a certain amount but they were not involved in menu choice.

Some people did not feel staff were always suitably trained. A person who used the service told us, "They get new ones (staff) who haven't got a clue what they do, well it's what they don't do." Another person said, "You can tell how experienced they are by how they position the pillows and the beds." However another person said that they thought that staff were excellent and well trained.

The manager said new staff had an induction and that all new staff would be enrolled onto the care certificate as part of their induction. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care. We found that staff were following a training programme to ensure they undertook the required training to equip them with the skills to undertake their job role.

People's health was not always closely monitored. A person who used the service told us, "I've not had hearing checks recently I want my eyes and ears tested." Records did not always evidence that some people received regular routine health checks. For example two people's care records showed they had seen the optician in 2013 and were to do so again the following year, however there was no record to show they had seen the optician since.

Staff did not know all they needed to about people's healthcare needs because these had not been fully documented. There was insufficient information about how people's healthcare conditions would impact on them. We asked a staff member about the terminal healthcare condition of one person they looked after and they did not know sufficient detail about this to ensure they could tell if the person's condition deteriorated and also to ensure they would be able to support the person appropriately.

Other people's records did show that when people were unwell the GP was contacted and healthcare advice was sought. One person had been visited regularly by the district nurse after they had an operation to ensure they recovered and their health care needs were met during this period of recovery.

We saw where necessary people had been referred to the speech and language team and the dietitian when advice had been needed in regard to their swallowing and dietary intake.

Requires Improvement

Is the service caring?

Our findings

Some people who were cared for in their room did not feel they were valued and important. We were told by someone who was cared for in the room, "They don't like me using it (their call bell) because they have got to come." Another person who was cared for in their room had a television remote to hand but was unable to watch television because it was switched off at the plug in the wall. We also saw that one person who had limited communication did not have any aids, such as picture cards, that would assist staff in communicating with them. This person did not have a communication care plan detailing the best way to communicate with them. We also saw the person had some care plans that were not relevant for them, and others ones which would provide staff with support in meeting their needs had not been completed.

Improvements had been made to the environment but these were not always to the benefit of people who used the service. A relative told us, "[Manager] has made improvements to the environment but it has lost its homely bit." We saw that one dining area was laid out nicely for a meal, but no-one was taken there for lunch or at tea time. Staff served meals to people in the lounge where people were already seated. This meant people missed out on an opportunity to mobilise, have a change of scenery and enjoy the social aspect of the mealtime. One person told us, "I didn't realise you could go to the dining room, no one said." A staff member told us the dining room was left, "Laid up for show," but people did not eat in this room.

People did not always have a positive experience because there was a lack of attention paid to detail. We saw one person was brought a cup of tea by a member of staff with a considerable amount of water spilt in the saucer. The person did not know what to do with this and ended up pouring the water onto the carpet.

People were not always offered the opportunities to take advantages of the menu choices available. The main meal was provided in the evening and lunch was soup followed by either a hot option or a choice of sandwiches. There was also a pudding provided. Most people we asked were unaware of the lunchtime choices. One person told us, "I've no idea what's for lunch." Another person told us they had left most of their corned beef hash because they did not like it. They said, "I wish I had had sandwiches, I've never had it before and I thought I would try it." They were not offered any alternative to this.

People's dignity was not always respected. We observed one person was hoisted with a lack of dignity. The staff concerned explained to us that the reason for this had been because the person was wearing ill-fitting clothes. As this person required assistance from staff with dressing in the morning which meant staff had used clothing which might compromise the person's dignity when using the hoist. This meant the person was at risk of receiving further care and support in a way that compromised their dignity.

On another occasion we noticed how a member of staff sensitively protected a person's dignity by discreetly pulling down their jumper which had ridden up, exposing their midriff. The staff member asked the person's permission before they adjusted their clothing.

People spoke positively about the staff who cared for them. One person who used the service told us, "The nurses are gems we couldn't wish for better care." Another person said, "You couldn't get any nicer people

to look after us." A relative told us about two of the nurses, they said, "They are gems, different styles but good nurses, both have been a bit tired out, very friendly and very cheery with us." We were told by one person that, "There has been a big improvement with the facilities, the rooms are nicer and tidier, excellent nurses, you couldn't wish for better."

We heard staff speak with people in a kind and caring way. One person told us as they were being assisted with their mobility, "There are always nice ladies (staff) helping me." We saw they were provided with the support they needed by staff who engaged them in conversation and laughter. We heard staff compliment people on their appearance and offering them choices, such as when would people prefer to visit the hairdresser who was in the service. We heard the same friendly rapport as drinks were served to people who were in their rooms.

We saw evidence that showed people had been involved in preparing and reviewing their care plans. People had signed care plans to show they had been involved in preparing these.

Requires Improvement

Is the service responsive?

Our findings

Some people felt there were not enough opportunities for any social activities. One person said, "It's 10% laughter and 90% misery." We asked the person what they had meant and they said, "It's boredom I think. We get bingo once a week and that's it."

There were a high number of people who were cared for in bed or in their bedrooms. The reasons for this were not always explained in people's care plans and there was not always evidence to show that different approaches as to how people were cared for had been considered. This meant that some people who may be able to join in the daily life in the communal areas of the service were not given the opportunity for social interaction and stimulation. We saw one person who was cared for in their room had a record in their care plan which stated the person should sit in the lounge so that they could be supervised by staff. There was no explanation why this was not done in the care plan and staff were unable to tell us the reason for this.

There was an activities coordinator employed who we saw talking with people and encouraging them to join in activities, but this did not include anyone who was cared for in their room. There were twelve people who were cared for in their rooms. The manager told us people in their rooms were visited frequently throughout the day by staff when carrying out observational checks. We saw that these were taking place, however there was no evidence to show these people received any further attention and company on a regular basis. A staff member told us that people who were in their rooms did become isolated. Activity charts in people's rooms showed they were offered few opportunities for social activity. We found some of the people we visited in their rooms were keen to engage with us and we saw they had looks of pleasure when we spent some time talking with them.

People could not rely on staff knowing and meeting their needs. We asked a staff member about the repositioning regime for one person to protect their skin integrity as they had been assessed to be at high risk of pressure damage to their skin. The staff member was unclear whether the person needed to be repositioned or whether they were able to reposition themselves. There was no documentation to complete to show when and how this person was repositioned. In another person's file we saw an assessment and consent form for the use of bedrails, which the person had signed. However the manager told us the person did not use a bedrail and removed these from the file saying they should not have been in there.

One person had been assessed to be at very high risk of pressure damage to their skin and had been prescribed a pressure relieving mattress to sleep on. We saw from the daily notes that the person regularly chose to sleep in a chair. There was no reference to this in the person's care plan to guide staff on how to respond when the person did not want to go to bed. The manager said this was because they did not prepare a full care plan for people who were receiving end of life care. The manager told us, "If on a full care plan it would have more detail."

This person's risk assessment in their care file had not been reviewed for five months to determine if there had been any changes of risk to the person's tissue viability. Also the person's care documentation had not been updated to take into account the additional risk to the person through not sleeping on their pressure

relieving mattress. This meant the risk to the person's tissue viability may have increased but no measures were identified to reduce this.

There was a lack of detail in people's care plans about essential care and support people may require. We found staff were unaware of practices to follow to monitor and manage the risks to people's skin and these details were not included in people's care plans. There were no details about the support a person who had been assessed to be at high risk of choking may need if they did start choking.

We found one person had a dressing applied to a wound on their toe. The nurse on duty had been unaware of this and it was not known when the dressing had last been changed. Additionally the person did not have a care plan describing the treatment they needed for this. This presented a risk to the healing of the person's would and of causing an infection.

We noted that the care plan format used required staff to read through all the updates made to see if there had been any changes made to people's care. This was time consuming and staff told us they did not have the time to do this. This meant staff did not have the information they needed to know how to support people appropriately and safely.

All of the above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received some positive comments about the care some people received. One person and their relative who was visiting told us that the care was very good and that they were very happy with the service. We saw there were some people who took part in the activities on offer. There was a poetry reading in the morning and a crafts session in the afternoon for some people. Some people had a manicure and visited the hairdresser who was in the service that day. We also saw some people followed their interests independently. This included reading newspapers, completing word searches, drawing and watching TV.

We received mixed comments about whether people felt confident in making any complaints. Some people did not have confidence their complaints would be dealt with. One person who used the service told us," It's no good making a complaint, because I don't think it would be taken notice of." The manager said one relative would not speak with them directly and repeatedly left concerns on the digital complaints system located in the entrance areas of the service. On the other hand a person who used the service told us, "I would talk to the head of the unit, [manager] their notices are well publicised." A relative told us, "We are very happy and satisfied and would talk to [manager] if we had any concerns, we've never had any. [Relation] is settled."

Requires Improvement

Is the service well-led?

Our findings

People lived in an environment which was not open and inclusive. One person who used the service said, "When it comes to inspections they don't tell the truth, they are what I call creeps." Prior to the inspection we received information that the manager was not approachable and did not listen to staff. We asked the provider to investigate and address this. The provider made attempts to provide support and give staff opportunities to speak out about their concerns. However these initiatives had not been taken up and staff told us they had not felt comfortable enough to raise their concerns. During our inspection we found it was clear this had not been resolved and some staff still did not feel listened to.

The regional manager showed us the dependency tool they used to calculate the staffing levels. This showed that the staffing levels were two staff short. A while later the regional manager informed us that there had been an error with how the dependency tool had been used as changes in occupancy at the service had not been included, and this meant that the staffing levels were in fact correct. This meant that the dependency tool had not been used as required by the provider to monitor the staffing levels.

Following the inspection the provider's named representative, who we refer to as the nominated individual, told us the dependency tool was a guide for managers to use to determine their staffing levels. The nominated individual told us staffing arrangements were flexible if the manager was able to present a case to increase their staffing if the staffing levels were not sufficient. However our evidence showed that staffing levels were not being considered in line with feedback from staff and by the manager assessing the care and support people needed. Care plans were not accurate in relation to people's support needs and this would distort any dependency assessment carried out to determine staffing levels.

We saw systems to audit people's care files were not effective. For example, one person had not had their tissue viability assessment reviewed for four months. The manager showed us the audit records that indicated this person's tissue viability assessment was up to date.

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

We also received some positive comments about the service. One person told us, "I get on well with [manager] and they have done a lot to improve things." The manager and regional manager told us in their view things were better in the home. The environment had been improved and the atmosphere was better. The manager told us they called a 'flash staff meeting' when they found any documentation that had not been completed correctly to emphasise the importance of this and make sure it was completed. We looked at the records made of flash staff meetings and saw these did not show which records had not been completed. This would help identify if there were any common problems in completing the documentation and enable solutions to be found. The manager said they would add these in future.

There were limited opportunities for people to give their views on the quality of the service. The manager said they had not held any residents meetings as the most recent ones had been organised and chaired by a

representative from the local authority. The manager added that they regularly spoke with people to find out how they were and if they wanted to raise anything, as part of their management role included speaking with people on a daily basis. However these were not recorded and so we could not assess if people's views were acted on if they made suggestions for improvements.

The provider had not complied with the condition of their registration to have a registered manager in post to manage the service for over 12 months. However the manager told us they had recently submitted their application to become the registered manager and our records confirmed this application had been received.

There were various other audits carried out in the service using the provider's quality assurance system which identified how the service was operating and if any improvements were needed. The regional manager showed us comments made by people who used the service, relatives and staff. These contained a mixture of views about people's experiences of living, visiting and working in the service. The regional manager told us they were looking to address any issues raised in these.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People's rights to give consent and make decisions for themselves were sometimes overlooked. People may be restricted without the legal authorisation to do so being applied for.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not assessed and not everything that was reasonably practicable to mitigate any risk was done. Regulation 12(2)(1)(a) 12(2)(1)(b)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Not assessing, monitoring and improving the quality and safety of the services provided or mitigating the risks relating to the health, safety and welfare of service users. Not maintaining securely an accurate, complete and contemporaneous record in respect of each service user. 17(2)(a) 17(2)(b) 17(2)(c)

The enforcement action we took:

Warning Notice