Abbottswood Lodge Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

Abbottswood Lodge Care Home provides accommodation and personal care for up to 13 older people, older people living with dementia.

The inspection was completed on 11 May 2016. There were 11 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was 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.

Quality assurance arrangements were not robust or as effective as they should be. These had not identified the issues found during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. Checks were not effective to monitor and ensure pressure mattresses were set at the correct setting each day and in accordance with people's weight. Suitable arrangements were not in place to ensure that records were properly maintained, for example, in relation to staff supervision and appraisal, staff training, care planning and end of life care. Systems in place to identify and monitor the safety and quality of the service were inadequate.

The implementation of staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported. Not all staff were able to demonstrate an understanding of how to support people safely with their manual handling needs

and this placed people at risk of receiving poor care and support. Though staff told us that they felt supported by the registered manager, staff had not received a thorough induction or received regular formal supervision or an annual appraisal.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, for example, in relation to manual handling and falls management.

Not all of a person's care and support needs were identified and documented. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Significant improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability.

Although relative's comments about the care and support provided for their member of family was complimentary, the majority of interactions by staff were observed to be routine and task orientated.

Improvements were required to ensure that appropriate recruitment checks were in place which helped to protect people and ensure staff were suitable to work at the service. The management of medicines required improvement within the service to ensure that people received their medication as they should.

Staff had a good understanding of safeguarding procedures to ensure that people using the service were protected from abuse. There was a complaints system in place to manage complaints effectively. The deployment of staff was appropriate to meet the needs of people who used the service.

You can see what actions 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 safe.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

The management of medicines required improvement to ensure that people received their medication as they should and with dignity.

People were protected from abuse as robust procedures were not being followed so as to ensure their safety.

Steps were in place to ensure that the deployment of staff was appropriate to support people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a lack of evidence to show that staff had received a thorough induction or received regular formal supervision.

Staff had not received training updates. This was not always demonstrated in staffs practice and approach through the care and support people received.

Staff did not have a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, significant decisions had not always been recorded.

People's nutritional and hydration needs were met so as to demonstrate that people received a satisfactory diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although people and relatives stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any

meaningful period of time.

Staff communication with some people was poor.

People's end of life wishes and the care to be provided was not recorded.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not regularly reviewed or reassessed. Not all people's care records were sufficiently detailed or accurate.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Effective arrangements were in place for the management of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have suitable arrangements in place to assess, monitor and improve the quality and safety of the services provided.

People were put at risk because systems for monitoring quality were not effective. The systems had also not identified the areas of concern that we had found.

Abbottswood Lodge Residential Care Home

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 11 May 2016 and was unannounced. The inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two people who used the service, four relatives, four members of staff and the registered manager.

We reviewed four people's care plans and care records. We looked at the service's staff support records for ten members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks had been identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

We observed poor staff practice in relation to moving and handling for one person who used the service. We witnessed on two separate occasions, three different members of staff assisting one person to move in a way that was unsafe and put them at risk of harm. On the first occasion staff were seen to try and get the person to sit up from a slouched position. Both members of staff were witnessed to place their arms under the person's armpits and pull the person up to a sitting position. Staff did not provide clear instructions to the person so as to advise them as to what was happening. Neither member of staff had considered to ask the person to position their feet correctly so as to ensure they had a good stable base once they stood up. The person was not encouraged to shuffle backwards or encouraged to stand up and sit back down again so that they were positioned further back in their chair. This meant that there was a risk of 'shearing' to the person's skin which could contribute to pressure areas developing. The 'technique' also placed staff in a poor position which could contribute to injuries to staff.

On the second occasion staff were witnessed to assist the person to a standing position from a comfortable chair in the dining room by placing their arms under the person's armpits and pulling the person up. This did not enable the person the opportunity to take their time to mobilise at their own pace and placed the person at risk of experiencing discomfort and pain especially in the shoulder joint. The person was overheard to state to staff, "Hang on, hang on, give me a bloody chance will you" in a loud and distressed manner. The person looked uncomfortable whilst the manual handling procedure was being carried out. This showed that staff did not understand what constitutes good manual handling and the provider did not have suitable arrangements in place to reduce the risk of injury to people.

On review of the personnel files for the three members of staff who had provided manual handling, these showed that staff had completed manual handling in 2007 and 2010 respectively. The third member of staff's training had expired in May 2015. There was no evidence to show that staff had received up-dated manual handling training and this was confirmed as accurate by the registered manager. One staff member could not remember when asked by us as to when they had last undertaken manual handling training. They stated, "I know it has been a very long time" and were visibly shocked when told by us that it was in 2010. This showed that staff providing care to service users did not have the qualifications, competence or skills to carry out the above tasks safely or to the required standard.

Our observations showed that two people were assessed as at risk of developing pressure ulcers. We checked the setting of one person's pressure relieving mattress and found this to be lower than the lowest setting on the item of equipment. Although the equipment was seen to be 'on' and the pressure mattress inflated, we found that it was not possible to determine if the equipment was correctly set in relation to the

person's weight as no weight records had been maintained. We discussed this with the registered manager and although they looked through the person's care file they could not find any weight records for them. The registered manager confirmed that the weight records for this person were not held somewhere else and they could not tell us when the person was last weighed. The registered manager confirmed that weight records for the second person had also not been maintained. This meant that we could not be assured that the amount of support either person received through their pressure relieving mattress was correct according to their actual weight and would aid the prevention of pressure ulcers developing or deteriorating further. This showed that care was not provided in a safe way for people using the service.

We could not be assured that people received safe care and support that met their needs, in particular, where people were nursed in bed and required their body to be repositioned at regular intervals. For example, the care records for two people detailed that they required their body to be repositioned at regular intervals. No records were available to confirm if this was happening or not as the records for both people were left blank. One person was observed to have remained on their back from 11.00 a.m. to 5.00 p.m. without their body having been repositioned. This meant that we could not be assured that people were receiving suitable care and support from staff that met their individual care needs or were being repositioned as part of a fundamental component of pressure ulcer prevention and treatment.

The arrangements for the management of medicines were not consistently safe. Medicines were stored safely for the protection of people who used the service. We looked at the medication records for all people who used the service. In general these were satisfactory, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Although the above was positive, observation of the medication round showed that this was not always completed with due regard to people's dignity. For example, a senior member of staff was seen to administer liquid medication to one person via a syringe. Some of the liquid medication was noted to seep out from the person's mouth and instead of wiping the person's mouth using a tissue, the member of staff was noted to wipe the excess liquid from the person's mouth using their fingers. This was unhygienic and did not ensure appropriate arrangements were in place to control the spread of infection.

No evidence was available to show that people's topical creams were administered as prescribed. For example, the Medication Administration Records [MAR] for one person showed that they were prescribed a topical cream to be administered twice daily. The MAR form over a four day period showed that this had not been signed by staff to demonstrate that they had administered the person's topical cream as prescribed. This meant that there was no confirmation to show that staff had applied the topical cream to the person. Additionally, where people were prescribed a variable dose of medication, for example one or two, the specific dose administered had not always been recorded. This meant that people could be at risk of receiving too much or too little medication.

A list at the front of the medication folder confirmed that nine members of staff and the registered manager administered medication to people using the service. However, on review of eight members of staff's training records we found that training completed had been undertaken between 2010 and 2014 respectively. Evidence of up-to-date medication training was not available and the registered manager confirmed that the above information was accurate. Although the registered manager confirmed that staff had been visually assessed as to their continued competency to administer medication, a written record had not been completed or maintained to evidence this.

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

Staff and relatives told us that they felt people living at the service were kept safe at all times. One person living at the service confirmed that staff looked after them and that their safety was maintained and they had no concerns. One relative told us, "I don't need to worry when I leave and I feel that my relative is kept safe." Another relative told us, "I am 100% sure that my relative is well looked after and kept safe."

Staff were able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. However, the staff training records for five members of staff provided by the registered manager showed that only one member of staff had up-to-date safeguarding training. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required. Staff confirmed they would do this without hesitation in order to promote people's safety and wellbeing. One member of staff told us, "If I suspected abuse I would go straight to the manager." The staff member confirmed that they were confident that the registered manager would take all appropriate actions necessary.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for staff appointed since February 2015 showed that the provider's recruitment arrangements were generally appropriate. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with people. The registered manager was advised to ensure that a recent photograph and proof of identification was sought for all prospective employees. In addition, records relating to the information collected during the interview should be maintained so as to assist in evaluating and comparing different applicants.

Comments about staffing levels from relatives and staff confirmed that there were sufficient numbers of staff available to meet people's needs. One relative told us, "I think there are sufficient available. Staff are around when you need them." Our observations showed that communal lounge areas were supported by staff throughout the day. Care was also taken by staff to ensure that people who were immobile and who spent the majority of their time in bed or in their room were monitored and checked at regular intervals.

Requires Improvement

Is the service effective?

Our findings

Although staff had positive comments about working at Abbottswood Lodge Care Home, staff were not complimentary about the training provided. Staff confirmed that they had not received regular training opportunities since being employed at the service despite requesting this. Staff told us that the lack of training provided did not provide them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard. One member of staff told us, "Training really needs to be improved." Another member of staff told us, "I would like more training." The member of staff confirmed that they had discussed this with the registered manager but were still waiting for training to be provided.

The registered manager confirmed that the staff training matrix was not up-to-date. On review of five staff member's staff personnel file, we found that the majority of training attained was no longer up-to-date and refresher training had not been provided or booked. Gaps in staffs' training and our observations showed that people's needs were not consistently met by a staff team who had the right competencies, knowledge and skills to meet people's diverse care and support needs. Evidence provided to us at the time of the inspection showed that not all staff were suitably trained. The staff personnel file for one member of staff showed that the only training they had received since being newly employed at the service was safeguarding, infection control and medication. The member of staff confirmed that this was accurate. This was also demonstrated in staffs' care practices and attitude towards the support individual people received. For example, if staff had received appropriate training relating to manual handling, poor manual handling techniques would not have been deployed therefore placing people at risk of harm. Additionally, if staff had received appropriate pressure ulcer management training, staff would have been able to recognise the importance of repositioning people at regular intervals so as to maintain good skin integrity and the significance of why people should have their pressure mattress set at the correct setting and their weight recorded.

Staff told us they received an induction when newly employed at the service. Staff confirmed that they initially worked alongside an experienced member of staff as part of the induction process. However, there was no evidence to show that staff had received a comprehensive induction that provided them with the skills and training to undertake their role or an 'orientation' induction. Although the registered manager was aware of the new Skills for Care 'Care Certificate' and how this should be applied, no-one had completed this or an equivalent.

Staff told us that they were supported by the registered manager. One member of staff told us, "The registered manager is very supportive and is always there if you need them." However, although staff told us that they felt supported not all staff had received regular formal supervision. Not all staff were able to tell us when they last received supervision. The supervision records for one member of staff showed that within the last 12 months they had received only one supervision and an annual appraisal of their overall performance. The staff personnel file for another member of staff showed that they had not received formal supervision since December 2014. Not all staff had received an annual appraisal and this was confirmed as accurate by the registered manager.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Not all staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Not all staff were able to demonstrate that they had a good knowledge and understanding of MCA and DoLS and how these applied to the people they supported. Records showed that each person who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been assessed and recorded. Where significant decisions were required in their best interests, meetings had been held so as to consult openly with all relevant parties and prior to decisions being taken. No significant best interest assessments had been formally completed. We discussed this with the registered manager in relation to one person who had their medication crushed and covertly administered. An assurance was provided by the registered manager that this would be completed. Where people were deprived of their liberty, for example, due to living with dementia, appropriate applications had been made to the local authority for DoLS assessments to be considered for approval. This meant that the provider had acted in accordance with legal requirements.

People told us that they liked the meals provided. One person told us, "The food is very nice." Another person told us, "I can't complain about the food. It's adequate and I am happy with it." Relatives told us that they were happy with the quality and quantity of food provided for their member of family. Our observations showed that people received a choice of two meal options. Meals provided were presented nicely and in sufficient quantity. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided. Where appropriate people had specialist equipment, such as plate guards and people were able to use cutlery of their choice such as spoon and fork. This ensured that people could maintain their independence whilst they ate and that they received sufficient nutrition and hydration.

People told us that their healthcare needs were well managed. People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments and to see their GP. Relatives confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments.

Requires Improvement

Is the service caring?

Our findings

Overall people and their relatives told us that staff cared for people in a caring and kindly way. One person told us, "The staff here are very nice." Relatives were very complimentary about the care provided for their member of family. One relative told us about the care provided for their member of family, "It is excellent care and I cannot fault it. My [name of relative] gets all the care and attention they need. The staff are lovely and very friendly. I am confident that their needs are being met." Another relative told us, "I think the care they provide to my relative is 100%. The staff here do a marvellous job. I truly believe that my relative receives the right care and support. The staff are brilliant, kind, caring and I cannot praise them enough." However, our findings in terms of how staff were supported to ensure people's well-being and support functions did not concur with people's comments about a caring service. The service needed to improve the way they delivered personalised care to people so as to ensure it was tailored to the individual. This was hindered by the provider's existing arrangements to ensure that people received good care relating to their manual handling needs, pressure ulcer management and ensuring that they received appropriate opportunities for social stimulation.

Although staff knew the people they supported, their care needs and the things that were important to them in their lives, staff interactions with people were variable. We noted that the majority of interactions were routine and task focused, for example, the majority of staff only spoke with people or interacted with them when providing personal care, assisting them to eat and drink or when providing assistance with manual handling.

Staff's communication with people living at the service was variable. Some staff, for example, were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided in an appropriate way. Other members of staff were observed to have difficulty communicating with people and understanding their needs, such as not enabling people to make choices or providing clear explanations to a person prior to undertaking a specific task. Where interactions were positive, staff rapport with people living at the service was observed to be friendly and cheerful. This was clearly enjoyed by people and there was positive chit-chat between both parties.

People's preferences and choices for their end of life care were not clearly recorded, communicated and kept under review. We found that the needs of one person approaching the end of their life and associated records relating to their end of life care needs were not recorded or robust. For example, the care plan provided little or no information detailing their pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded to identify to aid care planning arrangements and discussions with the person and those acting on their behalf. This meant that people's 'end of life' wishes were not recorded in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care. No information explaining what treatment should be provided for people's health if they were no longer able to make decisions for themselves was recorded (Advanced Directive). This meant that we could not evidence that people and those acting on their behalf were involved in the assessment and planning for their end of life care or supported to make choices and decisions about their preferred options.

People told us that they were treated with respect and dignity. Relatives confirmed this as accurate. Our observations showed that staff respected people's privacy and dignity, such as, we saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs.

The registered manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times. One relative told us, "I visit most days and am always made to feel welcome. I am able to stay as long as I like and do not feel pressured to leave."

Requires Improvement

Is the service responsive?

Our findings

Arrangements were in place to assess the needs of people prior to admission. This ensured that the service was able to meet the person's needs. However limited evidence was available to show that where appropriate this had been conducted with the person or those acting on their behalf.

We found inconsistencies across the service in the quality of the information included in people's care records. Some provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs. However, others were not fully reflective or accurate of people's care needs as they contained contradictory information or had not been reviewed at regular intervals. For example, the care plans and risk assessments for one person had not been reviewed since September 2015 and October 2015 respectively. The care plan relating to their dietary needs recorded that the person had a good appetite and was at low nutritional risk. This did not concur with the person's daily care records which stated in April 2016 and May 2016 that the person regularly declined their meals. The care plan had not been updated to reflect a change in the person's needs.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Daily care records for the above person detailed that they could be anxious or distressed towards staff. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Although specific incidents had been recorded where people could become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes.

Not all people using the service or people's relatives were complimentary about social activities provided at the service. One person told us that the opportunities provided to engage in meaningful activities was limited and that they could get bored sometimes. Two relatives told us that they did not think that there were enough things going on for people so as to keep them socially stimulated. They told us, "Nothing goes on here at all. There is no stimulation for people living here. In all the times we have been coming here we have never seen any activities." Staff told us that they had equipment such as colouring books, puzzles and reading material readily available for people's use. However, staff told us that they did not have the time to sit and spend quality time with the people they supported. One person told us, "Staff do not come and chat to me because they don't have the time. I know that staff are really busy. Anyway, there is nothing here to interest me." The rationale provided by staff was that people's needs were complex.

Our observations at the time of the inspection concurred with what people told us. No meaningful activities were provided throughout the day and on review of people's records there was no information recorded detailing how people's social care needs were met. We found little evidence that activities provided were linked to people's past hobbies or interests and involved 'everyday tasks' such as assisting staff to lay the table, help with laundry, dusting or gardening. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and life story work was used to help trigger memories or enable people the opportunity to independently entertain themselves. This meant that people were not

encouraged to keep active or to stay involved in their surroundings.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints process and procedure in place that identified how people could raise concerns and what would happen. One person living at the service and those acting on people's behalf confirmed that they would feel comfortable and able to make a complaint if the need arose. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. The registered manager confirmed that since our last inspection in February 2015 there had been no complaints. A record of compliments was available to recognise and capture the service's achievements. One compliment recorded stated, 'Thank you for everything. The staff here have been smashing to me.' A further positive review was recorded on an external website which people could access to provide comments about a care home or care home provider.

Inadequate

Is the service well-led?

Our findings

Our findings at this inspection showed that although the registered manager was available Monday to Friday and 'on-call' at weekends, there was a lack of clarity and understanding of their key roles and responsibilities in leading the service so as to drive improvement.

The registered manager did not have an effective system in place to monitor the quality of the service. Although the registered manager undertook a tour of the premises each day to ensure that the premises were appropriately maintained, they confirmed that no quality monitoring of the service or audits were formally completed. This demonstrated that as a provider the systems to actively monitor the provision of care and support to people using the service and staff was not effective in identifying any issues or concerns that may develop. This showed that the provider's arrangements were not effective or used as an opportunity for learning or improvement and had not highlighted the areas of concern we had identified at this inspection.

Systems were not in place to ensure people's safety or mitigate risks relating to their health, safety and welfare. For example, the accident records for one person recorded that since their admission to the service they had experienced seven falls, of which two falls had resulted with them sustaining an injury. No analysis of this had been undertaken by the registered manager to mitigate future risk. The registered manager was asked to provide specific data detailing the overall number of falls undertaken for the period January 2016 to May 2016 for all people using the service. The registered manager confirmed that they could not provide the requested information as data relating to falls had not been maintained. In addition to this the registered manager confirmed that they did not have any information detailing the incidence of pressure ulcers or have specific information relating to people's weight gain or loss which could impact on a person's overall health and wellbeing. This meant that there was no evidence to show that the provider's own quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety for people using the service was compromised, to drive improvement and to respond appropriately. Although a staff training matrix was available this was not up-to-date. The registered manager did not have an effective system in place to determine where there were gaps and the actions to be taken to address this.

It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008. This showed that there was a lack of provider and managerial awareness and oversight of the service as a whole as to where improvements were required.

The registered manager confirmed that the views of people using the service and those acting on their behalf were last completed in 2014. They also told us that formal meetings for people who used the service and relatives were not undertaken. The rationale provided by the registered manager was that as they were at the service most days, this is when they took the opportunity to speak with relatives.

Staff meetings were not held at regular intervals so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. The registered manager confirmed that these had not been completed for some time, "probably a year." The last staff meeting minutes available as confirmed by the registered manager were dated 2012.

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

Relative's comments relating to the management of the service were complimentary. One relative told us, "There is a very good manager here and they are approachable." Another relative told us, "The manager is very nice and they are approachable."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured that people's assessments included all of their needs that they were reviewed regularly and an accurate record of care and treatment provided remained accurate. The provider had not protected people against the risks of receiving care and treatment that was inappropriate and did not meet their needs. This was in breach of Regulation 9(1)(a)(b) and 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found that the registered provider and manager had not protected people against the risks of inappropriate or unsafe care as the arrangements to assess and monitor the quality of the service provided was ineffective. This was in breach of Regulation 17(1)(2)(a)(b)(c)(e) and 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff received appropriate training, supervision and appraisal to fulfil the requirements of their role they are employed to perform. This was in breach of Regulation 18(2)(a) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.