Beechdale Care Limited

Beechdale Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 10 October 2018. The inspection was unannounced and was the provider's first inspection since it was registered.

Beechdale Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beechdale Manor provides personal and nursing care for up to 65 people over three floors. At the time of our inspection, there were 28 people living at the service.

A registered manager was in place but they were unavailable on the day of our inspection. 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.

Staffing levels and deployment of staff were found to not meet people's needs and safety. People had experienced falls and sustained injuries at times when staffing levels were lower at night. Action to manage and mitigate risks had not always been completed in a timely manner. Risk assessments reviewed and guidance updated to reduce reoccurrence.

The audits and checks in place to assess, monitor and review risks were insufficient to protect people's safety. There was no analysis of falls, accidents and incidents to review for themes, patterns and lessons learnt. This lack of oversight impacted on people's safety.

The provider had failed to notify CQC of all reportable incidents they are legally required to do. Where they had completed notifications, these were inaccurate in detail and had not been submitted in a timely manner as required.

The prevention and control measures for infection and cross contamination were not fully met. Equipment was found to be dirty due to a lack of cleaning and there was a lack of oversight of cleaning schedules.

Staff were aware of the action to protect people from abuse and had received safeguarding training. However, safeguarding incidents had not always been reported to the local authority responsible for investigating safeguarding in a timely manner. This was a requirement under the multi-agency safeguarding procedures.

Safe staff recruitment checks were used to assist the provider in making safe recruitment decisions. People received their prescribed medicines and these were stored and managed in line with best practice guidance.

National best practice guidance was used in the form of recognised assessment tools to assess people's needs. Staff received an induction on commencement of their employment and ongoing training and opportunities to discuss their training and development needs. Processes were being implemented to check staff's competency.

People received a choice of meals and drinks and their nutritional needs were known, understood and monitored. Staff worked with healthcare professionals in managing people's healthcare needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. Staff were aware of the principles of the Mental Capacity Act 2005 and further work was in progress to review how best interest decisions were made.

The environment met people's needs and ensured people did not experience any discrimination due to their disability. Equipment to support people's needs was provided and available.

Staff were caring, compassionate and knew people's needs, preferences and what was important to them. Staff respected people's privacy and dignity, encouraged people with choice making, and promoted independence. Independent advocacy support was provided. People and or their relative where appropriate, were involved in their care and treatment as fully as possible.

People's diverse needs, routines, preferences and what was important to them had in the main been assessed. However, care plans that provided staff with guidance was limited in places, such information relating to healthcare needs. When people's needs had changed, care plans had not always been updated to reflect changes in the care and treatment required.

People received opportunities to participate in a choice of social activities including community visits.

People who used the service, relatives, staff and external professionals raised some concerns about the leadership of the service. People received opportunities to share their feedback about the service they received, but it was not clear how this was responded to. Staff meeting records did not show how discussions and actions were agreed to improve the service. The provider had an action plan to improve the service, whilst this was ongoing, some areas identified to have been completed in September 2018 had not been achieved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently Safe.

Staffing levels were insufficient in meeting people's safety. Risks associated with people's needs had not been consistently or effectively assessed or managed.

Equipment was found to be unclean and there was a lack of oversight of cleaning completed.

Safeguarding multi agency procedures had not consistently been followed.

Staff were safely recruited. Medicines were managed in line with best practice.

Is the service effective?

Good

The service was effective.

National best practice guidance was used in the form of recognised assessment tools to assess people's needs.

Staff received an induction, ongoing training and support.

People received support with eating and drinking needs, and nutritional needs were assessed and planned for.

Systems were in place to work with other organisations. People's health care needs were assessed and staff worked with healthcare professionals.

The design and layout of the building met people's needs.

Improvements were being taken to ensure people's rights were fully protected under the Mental Capacity Act 2005.

Is the service caring?

Good

The service was Caring.

People's privacy, dignity and respect was upheld.

Choice, independence and involvement was promoted.

People were supported by a visiting independent advocacy service.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

People's care plans varied in detail and guidance was not always up to date.

People had information about the provider's complaint procedure.

People's end of life care had been discussed and planned with them.

Is the service well-led?

Requires Improvement

The service was not consistently Well-led.

The systems and processes to assess, monitor and review risks were insufficient.

People received opportunities to share their views, but it was not clear how these were responded to.

Some concerns were raised about the leadership of the service.

Beechdale Manor 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.

The inspection was prompted in part by notifications of serious injuries where people had fallen and sustained serious injuries. The information shared with CQC about these incidents, indicated potential concerns about the management of risk of falls.

This comprehensive inspection took place on 10 October 2018 and was unannounced. The inspection team consisted of three inspectors, and a specialist advisor who was a registered nurse.

To assist us in the planning of the inspection we used information held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We sought the views of the local authority care commissioners who support people to find appropriate care services, which are paid for by the local authority or by a health authority clinical commissioning group. We also contacted Healthwatch Nottingham, who are an independent organisation that represent people using health and social care services.

During the inspection, we spoke with five people who lived at the service, to gain their views about their experience of the care and support they received. We also spoke with one visiting relative and another relative via telephone following our inspection for their feedback. We spoke with a visiting community nurse. We spoke with the deputy manager, provider's representative, the cook, a housekeeper, activity coordinator, an agency nurse, an agency care staff, three night care staff, a senior care staff and four day care staff. We looked at all or parts of the care records of nine people and checked that the care they received, matched the information in their records. We also reviewed other records relevant to people's care and the

management of the service. This included medicines management, four staff recruitment files and complaint records, management audits and policies.

Requires Improvement

Is the service safe?

Our findings

People were not supported by sufficient numbers of staff, to support their safety and individual needs. We received feedback from two relatives, an external professional and care staff expressing concern about staffing levels. We were told these concerns had been raised with the registered manager, who had determined staffing levels were sufficient to meet people's needs.

We identified night time staffing levels of three staff on the first floor were insufficient to meet people's needs and safety. For example, staff told us and people's care records confirmed, six out of 13 people living on the first floor required two staff to meet their mobility needs. In addition, some people were living with advanced dementia and experienced periods of high anxiety and agitation that affected their mood and behaviour, requiring additional staff to safely support them during these times. People's daily records also showed some people were frequently awake during the night requiring staff observation and supervision for their safety.

Accident and incident records showed during 2018 four people had experienced unwitnessed falls during the night shift resulting in injuries being sustained, two of which were significant. Following our inspection, we were made aware of an incident during the night, where a person had left the unit they were living in unwitnessed, and got to another part of the building which they could not return from. These examples show that staffing levels provided were not adequate to protect people's safety.

We were told night staff were expected to clean equipment, but staff told us there were insufficient time during the night to do this. We observed four wheelchairs and a mobility aid and hoist were soiled and in need of cleaning. This meant there were insufficient staffing available to complete tasks required of them.

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

Risks associated with people's needs had not always been assessed, monitored and mitigated to ensure they were safe. This was particularly in relation to the risk management of falls. For example, one person had fallen approximately four weeks prior to our inspection and their care plan had not been updated to state what the risk was, and what staff were required to do to manage this risk. Another person had experienced a recent fall from their wheelchair, but the risk management assessment did not inform staff of the person's seating position and behaviour that increased their risk of falling. A third person had recently been admitted to hospital following a fall when they sustained a fractured hip. They had since returned to the service, but their care plan and risk assessment had not been updated or reviewed following their return. On speaking to staff, they were aware of people's needs, but information and updated guidance was not recorded. In addition, there were no analysis of accidents or incidents to consider patterns and themes and how lessons could be learnt. This meant there was a risk new care staff would not know people's needs which could impact on their safety.

We found a thickening agent used in drinks where people had been assessed at risk of choking, in a person's

room. Although it was out of their reach it would have been accessible to other people entering the room and presented a safety hazard. We made the deputy manager aware who arranged for it to be moved.

Where people had been assessed with risks associated with their nutritional needs and skin, risk assessments were in place that provided staff with guidance of the care and treatment required. For example, where people required pressure relieving equipment such as bed mattresses and cushions, these were in place and being used. Where risks had been identified with people's weight or swallowing, this had been reported to the GP or speech and language therapist for assessment. When bed rails were used to prevent people from falling out of bed, risk assessments were completed to ensure they could be used safely. Individual plans were in place to support people in the event of an emergency if people required to be safely evacuated. Health and safety checks had been completed on the environment and equipment and these were in date apart from the review of wheelchairs, records showed these had not been recorded as checked since February 2018. This lack of checks could impact on wheelchairs being unsafe to use.

The registered manager had not always reported safeguarding incidents to the local authority safeguarding team responsible for investigating. This meant the registered manager was not consistently following safeguarding multiagency procedures to protect people.

People told us they always felt safe living in the service. One person told us they had a pendent around their neck and if they needed anything or felt unsafe, they only had to press the button and staff would attend.

Staff were aware of the signs of abuse and said they would report any concerns to the registered manager or deputy. One member of staff described their understanding of how to recognise abuse and what they should do if a safeguarding issue arose. They knew the procedure for reporting concerns, including contact to external bodies such as, the local authority. Information about safeguarding and who to contact with concerns was displayed on a noticeboard for all to see.

Some people were living with advanced dementia and could become agitated during times when staff were providing care and treatment. Staff worked with external dementia community nurses in how to best support people and had recently received training in managing challenging behaviour. However, staff were not confident the training received, fully addressed the training required in how to manage some behaviours that required the use of physical intervention. The deputy manager told us how they had plans to support staff's awareness and understanding, and to review staff's competency. This meant people were supported effectively with any behavioural needs that could be a risk to themselves or others.

People were supported by staff who had been through the required recruitment checks as to their suitability to provide safe care and support. These included references and criminal record checks. A new system had recently been introduced to ensure nursing staff employed or through an agency, had an up to date registration with the Nursing and Midwifery Council that enabled them to practice. Recruitment files showed the necessary recruitment checks had been carried out. Staff also confirmed they commenced employment after checks had been completed. Staff told us how a person who used the service had been involved in the recruitment process of a nurse. They said, "We encourage people to be involved in the recruitment process, because it is them the staff have to care for, so relationships are important."

Medicines were ordered, stored, administered and managed safely and in line with best practice guidance. People told us they received their medicines on time. Staff had information and guidance on the safe administration of people's prescribed medicines, including any allergies and preferences of how they liked to take their medicines. Staff had received medicines training and had access to the provider's medicine policy and procedure to support them.

Good

Is the service effective?

Our findings

Assessment of people's needs, included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination. Staff worked with external specialist healthcare professionals in the care and treatment of people living with dementia. Assistive technology was used to support people's needs, whilst promoting their independence. For example, sensor alarms were used where people were known to be at risk of falls, these alert staff when people are independently mobile and at risk of falls.

People were supported by staff who had an induction, ongoing training and opportunities to discuss and review their work and development needs. People told us they considered the staff were well trained and understood their needs. A person said, "I attended one of the training sessions with staff because it was relevant to my needs. I shared my experience of what it meant for me that staff were trained in how to support me correctly with the equipment I use."

Staff gave examples of the training they had received and about refresher training booked, this included nursing staff who had received clinical supervision and training. Staff felt well supported by the deputy manager. Comments included, "The deputy is really nice, supportive and very experienced and knowledgeable." The staff training and supervision plan confirmed staff had received an induction and refresher training in a variety of subjects relevant to the needs of people using the service. Staff were clear about their roles and responsibilities and had systems and processes in place to share information about people's needs. We found staff were organised, communicated effectively with each other and were knowledgeable about people's needs. This meant people could be assured staff received training and support to effectively meet their care and treatment needs.

People received sufficient to eat and drink, and choices were offered. People were positive about the choices and supply of meals and drinks. A person said, "I get plenty to eat and there are always snacks and drinks whenever we want them."

We found staff were attentive to people's nutritional and hydration needs and preferences, during our inspection drinks and snacks were offered throughout the day. Where people required assistance, staff were patient and unhurried in their manner. People who required special equipment, such as, plates to stop them spilling their food and coloured plates and cups to support people living with dementia were available and used. We saw food offered on the day of the inspection was the same as the menu on display. Food stocks and storage were found to be managed well and kitchen staff had important information about people's nutritional needs and preferences. People's care plans showed their preferences, and nutritional needs had been assessed and planned for, including any dietary needs associated with religious and cultural needs. Where people required their food and fluid intake monitored due to concerns about their health, records were in place and up to date.

Care records contained a hospital passport to provide information for NHS staff in the event of the person's

admission to hospital. This is important in the ongoing care of a person. People were positive their health needs were met and that staff worked with healthcare professionals such as the GP. Care records showed people had access to healthcare services when they needed such as opticians and chiropodist.

The environment met people's needs. For example, lighting, decoration, space and signage was good, this included consideration of people's needs associated with the mobility and for people living with dementia. There was a pleasant safe and secure garden for people to use that was easy to access.

The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw examples of assessments where concerns had been identified that a person may not have mental capacity to consent to their care and treatment. However, it was not always recorded how best interest decisions had been made and that least restrictive practice had been considered. We discussed this with the deputy manager who was aware there were some shortfalls. Plans in place to review people's care records including capacity to consent to specific decisions about their care and treatment. We concluded there was no negative impact on people and action was being taken by the provider to take corrective action in ensuring the MCA was fully adhered to.

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 hospital are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for authorisations where required. This meant people were not unlawfully deprived of their freedom and liberty.

Staff were aware of the MCA and DoLS and how this was relevant to people living at the service. A staff member said, "We ensure we speak to people at their level and get their permission before we provide care and support."

Some people had a decision not to attempt resuscitation order (DNACPR) in place and this information was available for staff. Some people had lasting power of attorney (LPA) that gave another person legal authority to make decisions on their behalf and this was recorded and known to staff. This is important information to ensure people receive effective care and treatment.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion from staff that knew and understood what was important to them. People were positive about the care and treatment and approach of staff. A person said, "The staff here are lovely, they go out of their way to make sure you have everything you need, they are always very kind." Another person said, "The care is very good, staff are very friendly." Relatives were equally positive about the staff. A relative said, "They [staff] are excellent. They always share information, we have a good relationship."

Staff spoke with knowledge, interest and care about the people who lived at the service. A staff member said, "I treat people how I would want my mum to be treated." Another staff member said, "Staff are all caring and want the best for people. We are busy but make sure we have time to talk with people, just five minutes holding hands with a person, listening to them and comforting them can make all the difference."

We observed some kind and respectful interaction between staff and the people they were supporting, it was clear that they knew them well. People were offered choices about activities they wished to participate in during the day. For example, joining in with an outdoor chair-based exercise class, whilst others chose to remain inside and watch the television.

A staff member told us how they had developed a good relationship with a person and understood what was important to the them. For example, the person had complex needs, and staff had found positive ways to engage with them. The person's lifestyle had been such that their job meant they were up very early in the morning. Their routine of waking early in a morning continued which made the person very tired during the day. Staff understood this and supported the person with their routines. They also told us how they spent time talking with the person about their past working life, and told us this gave the person great comfort. We saw how a staff member spent time with this person who looked happy and relaxed and interacted well with the staff member.

There was a 'tuck shop' which was running throughout the inspection day, with sweets and snacks available to people. This also provided a discussion point between several people, remembering when they used to go and buy certain sweets when they were young and for their families. This shows how positive and meaningful engagement was encouraged.

People were involved in their care and treatment as fully as possible. We saw how staff encouraged people in discussions and decisions, they used effective communication, were patient and encouraging. People and or their relative where appropriate, had received opportunities to review care plans that provided staff with information about their care and treatment. The deputy told us and records confirmed, arrangements were in place for people and or their relative to meet with staff to review the care and treatment provided.

People were supported by an independent advocacy representative from a registered charitable organisation who visited the service regularly. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. The advocate attended resident meetings to support

people to have their views raised. An example was given how the advocate had supported a person with a specific need. The deputy manager told us this independent support was important and supportive. This meant the provider ensured people were effectively supported to have their views and wishes represented.

People were treated with dignity and respect. People confirmed staff were always respectful and protected their dignity when supporting them.Staff gave examples of how they upheld people's dignity, privacy and respect. A staff member said, "If I need to provide personal care, (if a person has had a toileting accident.) I say to them discreetly, so not to embarrass the person [name] would you like to come with me I need some help." We observed this during the inspection. This showed great care, sensitivity and respect.
Another staff member spoke about the importance of maintaining people's dignity when using the hoist and ensuring they were covered appropriately.
Information about people's individual needs was protected under the general data protection regulation. This is a new law that has strict rules of how people's information is managed. Information was held electronically and on paper, and people had access to their information if they wanted to. This meant people's confidential information was managed appropriately.
People had family and friends to visit without any restrictions. On the day of our inspection a person was visited by their relatives, who confirmed they could visit their relation without giving notice.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained an initial assessment of their care needs and a range of risk assessments and care plans, providing information about the person's ongoing care and support needs. This is important information for staff to support them to provide an individualised service based on people's needs, routines and preferences.

Care plans and risk assessments were reviewed monthly and whilst some contained personalised information and detailed instructions for staff, there were inconsistencies in the level of information provided. For example, care plans were not always in place to identify the support people required to manage their health conditions such as diabetes. Care plans did not always reflect the support that staff gave to people, or give clear, consistent advice. Some of the information was contradictory. For example, one person had recently been discharged from hospital with a change in need, but their care plan had not been updated. This person had also been referred to the community rehabilitation team in relation to their falls, but there was no evidence of pro-active falls management of the person at this current time. There were also inconsistencies relating to people's life and social history. Whilst we found staff were knowledgeable about people's needs, the lack of recorded information meant new staff may not have sufficient information impacting on consistency in the care provided.

The deputy manager told us they were in the process of reviewing and updating people's care records, to ensure all required information was provided to staff. We saw examples where this had been completed and these care plans better reflected people's care and treatment needs.

Staff told us about people they cared for and how information about people's needs were communicated to them. A staff member said, "Care plans are being updated and we also have a handover at each shift. This is to ensure we know what has been happening, such as, any falls or change in people's needs."

People's communication and sensory needs had been assessed and care plans provided staff with guidance of people's needs. The deputy manager told us pictorial menus were being developed and information could also be provided in alterative formats such as large print if required. This meant the provider had considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

People's diverse needs including their preferences in relation to religious, spiritual and cultural needs were known and understood by staff. A relative told us how staff supported their relation whose first language was not English. Whilst they said staff attempted to support their relationship with their communication needs, they had concerns this was not consistent. We shared this with the deputy manager who agreed to discuss this with staff.

People received opportunities to participate in social activities and community opportunities. One person said, "I can go out when I want, as long as staff are available. We asked if there had been any time they were

denied the support of staff or the opportunity to go out and they said, "no". Another person and their relative told us they had choices in how they spent their time.

The activity coordinator told us how they spent time with people when they first moved to the service discussing their interests and activities they enjoyed. A monthly programme of activities was on display which consisted of an activity, scheduled each morning and afternoon. A range of activities were provided and we saw people were encouraged to participate in activities, or listen to music and spent time in the company of staff. Activities also included external visiting entertainers. The activity coordinator told us how they supported people to access the local community up to four times a month including visits to the local park and to the shops. This meant people received opportunities to engage in meaningful activities and stimulation.

People told us they felt confident to raise any concerns with the staff. Relatives told us they felt able to raise any concerns or complaints. The complaints procedure had been made available to people, relatives and visitors. At the time of our inspection the deputy manager told us no complaints had been received. We saw compliments had been received praising staff for providing good care and treatment to people.

People who were nearing the end of their life had detailed care plans in place that identified their wishes and preferences in relation to their care. These were person centred and considered how they would be kept comfortable and their needs met. The care plans also provided details of their important relationships and how family members wished to be involved. People confirmed end of life plans had been discussed with them. A person told us they had had a discussion recently and signed their care plan to identify this. Another person said, "I don't like talking about it, but it has to be done."

Requires Improvement

Is the service well-led?

Our findings

The provider did not have effective systems and processes in place that assessed, monitored and reviewed risks, safety and quality.

There was no analysis of falls, accidents and incidents to consider themes, patterns and trends that enabled the provider and registered manager to review for lessons learnt. This meant there was no clear oversight of risks and impact on people who used the service. The registered manager and provider had not sufficiently considered people's dependency needs, and reviewed the occurrence of falls, accidents and incidents to inform their decision making.

People's risks assessments and care plans had not been consistently reviewed following falls, accidents and incidents. For example, a person had recently experienced a fall where they sustained an injury. A sensor alarm had been purchased as a method to help reduce the risk of further falls. However, the alarm had not been installed and was still in its box. This meant staff did not have current detailed information and guidance to safely support people. This was a significant concern because people's safety was at risk of being compromised.

There were checks in place to monitor safety in relation to the environment and equipment. However, wheelchair checks had not been reviewed since February 2018 and the provider's checks on quality and safety had not been completed since June 2018. This meant the provider's frequency of audits and checks had not been kept up to date, possibly impacting on people's safety.

The provider's representative told us they visited the service most weeks, but acknowledged whilst they did a walk around and completed some checks, this was informal. The provider's representative told us they were aware of shortfalls in the systems and processes that monitored safety. They told us of new reporting systems and documentation they were implementing to address this. An example of action already taken was the introduction of a 24 hour report staff completed, as a method to inform the registered manager of what had occurred at the service. Whilst the provider was taking some action to improve how risks were assessed, monitored and reviewed we were not sufficiently assured.

During the inspection we identified a concern with how the registered manager had applied for a DoLS application. The registered manager had made an application to the supervisory body correctly, but had not received confirmation the application had been received. This was followed up during the inspection and it was found the supervisory body had not received the application and this was resubmitted. This meant there was a delay in the assessment by the supervisory body that was avoidable, due to an error by the registered manager.

Policies and procedures were not all under the current provider's name, but the previous provider for the service. This was a concern because this information may not have been correct in accordance with current legislation and best practice guidance.

Staff meeting records showed following discussions, there was no action plan that identified timescale and responsibility of action required. It was noted in September 2018 meeting records, staff had consistently raised concerns about staffing levels and safety. This meant there was a lack of service development and clear direction.

We were aware that the local authority had been working with the provider, to make improvements to the service and the provider had an action plan. On reviewing this we noted the action to have people's care records reviewed by September 2018 had not been completed. The deputy manager told us the timescale for completion was now October 2018. This delay was a concern, the service was significantly under occupancy and there was no reason why this action had not been completed.

People received opportunities to share their views about the service. Meetings were arranged three monthly and dates were on display to inform people. From reviewing meeting records dated March and September 2018, we saw people gave feedback about activities and menus. However, there was no action plan to record what action had been taken in response to feedback provided. This meant it was unclear if people's feedback had been acted upon.

The provider and registered manager had not always reported notifiable incidents or notifications had not always been completed by the registered manager in an accurate and timely manner. This information is legally required to enable CQC to effectively monitor services. For example, one person had been granted in September 2018, an authorisation to restrict them of their freedom and liberty, but this had not been reported to us. Three death notifications had the date of submission incorrectly recorded.

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

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare were not effective. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet people's needs. Regulation 18 (1)