Care UK Community Partnerships Ltd

Echelforde

Inspection report

College Way
Ashford
Middlesex
TW15 2XG
Tel: 01784 255225
Website: www.echelfordeashford.co.uk

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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

Overall summary

The inspection took place on 14 and 18 October 2015 and both visits were unannounced. Two inspectors were present on 14 October 2015 and one inspector carried out the visit on 18 October 2015.

Echelforde provides accommodation and personal care for up to 50 older people, some of whom are living with dementia. There were 48 people living at the service at the time of our inspection. There are five units, each accommodating up to ten people. Two of the units accommodate people with more complex support needs.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were not enough care staff deployed at all times to meet people's needs. This meant that people had to wait when they needed support and that their care was often interrupted. The lack of care staff was a particular

Summary of findings

problem at weekends. On a weekend shortly before our inspection, there were so few care staff on duty that non-care staff, including domestic and activities staff, were called in to provide support.

There were concerns about the management oversight of the service as the staffing rota showed that there were insufficient staff on duty to provide people's care on the weekend in question but no action had been taken to address this. The provider had a quality monitoring system but this was not effective as it had failed to identify that there were insufficient staffing levels to provide safe care.

There were concerns that staff had not received appropriate leadership and that the provider had not responded to the concerns raised by people, relatives and staff. Some staff said they felt the management of the service was not fully aware of the impact staff shortages were having on people and staff. They said they had raised their concerns about staffing levels and high vacancy rates but no action had been taken to address their concerns.

The lack of care staff had reduced the activities available to people as activities staff were often used to support care staff. People told us that planned activities did not always take place and they did not have the opportunities they would like to go out.

The provider had not implemented adequate measures to maintain the safety of people who tried to leave the service. Two people had expressed their wish to leave the service and tried to do so on a daily basis. The risks presented to these people had been identified but the steps taken to mitigate these risks were ineffective as both people had been able to leave the service unaccompanied within the last two months.

Staff had not received regular supervision and appraisal, which meant they did not have opportunities to discuss their support and professional development needs. Some staff said they had never had a supervision meeting with their manager and none of the staff we spoke with had had an annual appraisal since they started work. All staff attended an induction when they started work and had access to ongoing training. The provider's recruitment procedures were robust, which helped to ensure that only suitable staff were employed.

The registered manager understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and training had been provided for staff in this area. Assessments had been carried out to determine whether people had capacity to make decisions and people's best interests had been considered when decisions that affected them were being made. People said that staff asked for their consent before supporting them and our observations confirmed this. DoLS authorisations had been applied for where necessary, which meant that people's care was provided in the least restrictive way.

People's needs, including their dietary needs, were assessed when they moved into the service. People told us that they enjoyed the food provided and that they could have alternatives to the menu if they wished. Staff monitored people's health and supported them to make a medical appointment if they became unwell. Medicines were managed safely.

Staff understood safeguarding procedures and were aware of the provider's whistle-blowing policy. People knew how to make a complaint and we found that any complaints received had been investigated and responded to in line with the complaints procedure.

People received their care from familiar staff and had positive relationships with the staff who supported them. Staff were kind and caring and treated people with respect. People were asked for their consent to the care they received and applications for DoLS authorisations had been made where people were subject to restrictions in the provision of their care.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Summary of findings

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Following the inspection, the provider told us they had begun to take action to address the concerns we identified. We will check the actions taken by the provider at the next inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider did not deploy sufficient staff to meet people's needs.

The provider had not implemented adequate measures to protect people who tried to leave the service.

Staff understood their responsibilities should they suspect abuse was taking place.

People were protected by the provider's recruitment procedures.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not been adequately supported through supervision and appraisal.

Staff received an induction and had access to appropriate training.

People received their care from staff who knew their needs well.

People consented to the care they received and care was provided in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food provided and individual dietary needs were met.

Health needs were monitored and people were supported to obtain treatment when they needed it.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were kind and helpful but did not have time to give people individual attention.

Staff provided care in a sensitive way but care was often interrupted because staff were needed elsewhere.

People had positive relationships with the staff who supported them.

Staff understood the importance of maintaining confidentiality and of respecting people's privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

Summary of findings

People did not have access to activities that met their needs and reflected their preferences.

Planned activities did not always take place and some outings had been cancelled.

People's needs had been assessed to ensure that the service could provide the care and support they needed.

Complaints were managed and investigated appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not addressed the concerns raised by people and staff about insufficient staffing levels and high vacancy rates.

The lack of management response to their concerns and working long hours to cover vacant shifts had led to poor morale amongst the staff team.

The quality monitoring system had not been effective in identifying and addressing shortfalls in service provision.

The registered manager shared information and worked co-operatively with other agencies when required.

Echelforde

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 was 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 took place on 14 and 18 October 2015 and both visits were unannounced. Two inspectors were present on 14 October 2015 and one inspector carried out the visit on 18 October 2015.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This is because the inspection was brought forward due to concerns we received about insufficient staffing at the service.

During the inspection we spoke with 15 people who lived at the service and four relatives. We spoke with 11 staff, including the registered manager, team leaders, care staff and activities co-ordinators. We looked at the care records of ten people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at seven staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

The last inspection of the service took place on 20 May 2013. There were no breaches of Regulation at that visit.

Inadequate

Is the service safe?

Our findings

The provider did not deploy sufficient staff to meet people's needs. The lack of staff meant that people often had to wait when they needed care and support. Staffing numbers also meant that people's care and support was interrupted because staff were required elsewhere.

The service had five units, each accommodating a maximum of ten people. One member of staff was allocated to each unit, supported by two 'floating' staff, usually team leaders. Two of the units were higher dependency units, accommodating people with more complex support needs. Additional staff were employed to carry out domestic duties and to support people with activities. We found that these staff were sometimes deployed to support the delivery of care due to a shortage of available care staff.

People told us that they often had to wait for staff to be available when they needed care or support. They said this meant their care was not provided in line with their preferences, for example about what time they got up and had their breakfast. One person told us, "Breakfast is always late because there aren't enough staff."

Relatives also expressed concern that there were not enough staff on duty, particularly at weekends. One relative told us, "The carers do their best but there's not enough of them. You see one of the carers serving lunch but there are no other staff to help people eat." Another relative said, "There's definitely not enough staff, especially at weekends. Sometimes at weekends I can't even find a member of staff to let me out of the building."

Staff told us that there were not enough care staff on each shift to provide people's care effectively and that staffing levels at weekends were a particular concern. One member of staff told us, "Weekends have been a real problem. Quite a few staff have left and we struggle to cover the shifts. It's more of a problem on the higher dependency units."

We spoke with staff on the higher dependency units and they confirmed that staffing levels were insufficient to provide the care people needed. One care worker on a high dependency unit told us, "There's never enough staff, especially at weekends. The floater is helping people eat today but sometimes it's just me and ten residents." The care worker gave us examples of how the lack of staff affected people's care. The care worker said that they had been helping a person to eat when another person needed support to use the toilet. They had to stop supporting the person to eat while they supported the person who needed to use the toilet.

Staff on the other high dependency unit also told us that staffing levels were insufficient to provide effective care. One care worker said, "We always struggle at weekends. Sometimes the residents get upset because there's no staff around a lot of the time." Another care worker told us, "It's a struggle, particularly at weekends. There's not enough staff to help people eat. I was running back and forth between two units recently to make sure everyone was getting fed. I had to leave things half done."

People told us that they felt safe and staff were clear that people's safety was their main concern. They said that they always prioritised responding to call bells if people used them and that if a person had a fall or became unwell, support was available from their colleagues on other units. However staff explained that responding to emergencies sometimes meant that they had to interrupt the care they were providing to people.

We observed during our inspection that the allocation of one member of staff to each unit was insufficient to meet people's needs. Staff told us that four of the nine people on one unit needed support to eat. At lunchtime we saw that there was only one member of staff available to support people to eat their meals. We also observed that care staff were deployed to carry out domestic tasks, which meant they were not available to support people with their care. For example, we observed that the one member of care staff on each of the units spent approximately 30 minutes after lunch washing up. People told us that this was a common occurrence and that it affected the availability of staff to support them. One person said, "It is short staffed and the carers are often doing menial jobs. They shouldn't be doing that; they should be focusing on us."

Staff told us that the number of care staff on duty had been particularly low on a weekend shortly before our inspection. They said that due to the lack of care staff on duty, they had had to enlist the support of non-care staff to provide support. Staff told us that domestic staff had not been asked to support people with personal care or moving and handling but had supported people to eat their meals. One member of staff told us, "We were ringing around the cleaning staff. We had four care staff for the

Is the service safe?

whole building when we should have minimum five care staff and two floaters. We didn't let them do personal care or use the hoists, just helping people to eat and making beds."

The provider had failed to deploy sufficient numbers of staff to ensure that people's care and support needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not implemented adequate measures to maintain the safety of people who tried to leave the service. Two people had expressed their wish to leave the service and tried to do so on a daily basis. The risks presented to these people by leaving the service had been identified and risk assessments had been carried out. However the steps taken to mitigate these risks were ineffective as both people had been able to leave the service unaccompanied within the last two months. On two occasions, the most recent of which was the day before our inspection, people had left the service unnoticed and had been found by members of the public in the local area. The registered manager told us that risk assessments relating to keeping these people safe would be updated and that staff would be reminded to remain vigilant of people trying to leave the service unaccompanied.

The provider had failed to mitigate risks to people's health, safety and well-being. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that they were treated well by staff and would feel comfortable in reporting any concerns they had. Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to protecting people from harm and abuse. They were able to describe the different types of abuse, what might indicate that abuse was taking place, and the reporting procedures that should be followed. A copy of the local multi-agency procedures was in place and staff had been given information about whistle-blowing, which enabled them to raise concerns with external agencies if necessary. The registered manager reported incidents to the local safeguarding team appropriately.

People were protected by the provider's recruitment procedures. Prospective staff were required to submit an application form with the names of two referees and to attend a face-to-face interview. Staff recruitment files contained evidence that the provider obtained references, proof of identity, proof of address and proof of eligibility to work in the UK. In addition, staff were required to obtain a Disclosure and Barring Service (DBS) certificate before they started work. DBS checks identify if prospective staff had a criminal record or were barred from working with adults at risk.

People's medicines were managed safely. Following medicines errors in July 2015, steps had been taken to improve practice in the management of medicines. The registered manager had compiled an action plan to address the shortfalls in medicines practice identified through a safeguarding investigation. This action plan had been implemented and included the retraining of staff and assessments to ensure staff were competent to administer medicines safely. The provider had carried out an internal audit of the arrangements for managing medicines since the errors occurred, which had identified further improvements. These improvements had been made by the service and included updating the photographs on people's medicines profiles and reviewing medicines care plans.

People told us that staff helped them take their medicines safely. They said they received their prescribed medicines according to instructions and that they had access to pain relief if they needed it. We observed that staff followed appropriate procedures when administering medicines. Medicines were stored securely and in an appropriate environment. Staff authorised to administer medicines had completed training in the safe management of medicines and had undertaken a competency assessment where their knowledge was checked. There were appropriate arrangements for the ordering and disposal of medicines. Staff carried out medicines audits to ensure that people were receiving their medicines correctly. We checked medicines administration records during our inspection and found that these were clear and accurate. Each person had an individual medicines profile that contained information about the medicines they took, any medicines to which they were allergic and personalised guidelines about how they received their medicines.

Staff attended fire safety training and were aware of fire procedures. The provider had carried out a fire risk assessment and developed personal emergency evacuation plans (PEEPs) which detailed the support

Inadequate

Is the service safe?

people would require in the event of an evacuation. The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency, such as flooding, including the provision of alternative accommodation if necessary.

Requires improvement

Is the service effective?

Our findings

Staff had not been adequately supported through supervision and appraisal. This meant they did not have opportunities to discuss their training, support and professional development needs. Staff told us that they did not meet regularly with their managers to discuss their performance and support needs. Some staff said they had attended "one supervision meeting" with their manager, other staff told us they had never had a formal supervision meeting. None of the staff we spoke with had had an annual appraisal since they started work at the service.

The registered manager told us that a system of one-to-one supervision for staff had been introduced in June 2015. The supervision record showed that most staff had received one supervision since that time, although eight staff had still not received supervision. The registered manager confirmed that no staff had received an annual appraisal and that there was no system of annual appraisal in place.

The provider had failed to provide appropriate support, professional development, supervision and appraisal for staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their care from staff who were familiar to them and that staff knew their needs. Relatives said that the staff who supported their family members provided their care in a consistent way. One relative told us, "They know him very well." Staff told us that they had an induction when they started work, which had included shadowing an experienced colleague. They said this had enabled them to develop an understanding of people's individual needs. Staff said they had also familiarised themselves with people's care plans during their induction, which provided guidance about how people preferred their care to be provided.

All care staff attended elements of core training including health and safety, moving and handling, safeguarding, infection control, fire safety and first aid. Staff also attended training in areas relevant to the needs of the people they cared for, such as diet and nutrition and dementia awareness. Staff told us they had received training in the safe use of any equipment they used when providing people's care, such as slings and hoists.

The registered manager understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and training had been provided for staff in this area. The MCA protects people who may lack capacity and to ensure that their best interests are considered when decisions that affect them are made. DoLS ensure that people receive the care and treatment they need in the least restrictive manner.

The registered manager had applied to two local authorities for DoLS authorisations where people were subject to any restrictions in the provision of their care. One local authority had approved the DoLS authorisation for the person concerned and had recently reviewed the arrangements in place to protect the person. The other local authority had advised the registered manager that the application for DoLS authorisation had been received but had not yet made an assessment of the application. There was evidence that assessments had been carried out to determine whether people had capacity to make decisions and that best interests meetings had been held if people needed support in decision-making. People said that staff asked for their consent before supporting them and our observations confirmed this. People's care plans contained evidence that they or their representatives had recorded their consent to the care provided.

People told us that they enjoyed the food provided and that they could have alternatives to the menu if they wished. One person told us, "I enjoy the food, there's plenty of choice" and another person said, "The food's pretty good." A third person told us, "My dinner was lovely." Relatives said their family members enjoyed the food provided and that their dietary needs were met. Although people enjoyed the food provided, we observed that there were not enough staff available to support people who needed help to eat their meals. The one member of care staff on each unit was responsible for serving the meals and washing up and, as a result, had little time to support people. Where people had individual needs related to their diet and nutrition, these were recorded in their care plans. For example, care plans recorded when people needed soft diets, food supplements, high fibre or high calorie diets. Where necessary, food and fluid charts had been implemented to monitor people's nutrition and hydration.

People told us that staff helped them to make a medical appointment if they felt unwell. They said they were always able to see a doctor if they needed to. Relatives said that

Requires improvement

Is the service effective?

staff monitored their family members' health and took appropriate action if their health deteriorated. We found evidence that referrals had been made to healthcare professionals when necessary, including GPs, district nurses, speech and language therapists and the community mental health team. The outcomes of any healthcare appointments were recorded in people's care plans.

People had access to appropriate private and communal spaces. Bedrooms were personalised and reflected the interests of their occupants. Each unit had a lounge, dining area and kitchenette. There were quiet spaces available if people wished to spend time in private with their visitors outside their bedrooms. The service had a large activities space which was available for activities and events.

Requires improvement

Is the service caring?

Our findings

People had positive relationships with the staff who supported them. People told us that staff were friendly and cheerful. One person said of staff, "They're really friendly. They talk to you. I enjoy having a chat with them" and another person told us, "They're very good, I get on with them very well." People said that staff were kind and caring. One person told us, "They're all very caring people" and another said, "They really do care about the residents."

Although people gave positive about the staff who supported them, they said that they sometimes felt rushed when staff provided their care. People told us that staff were kind and helpful but did not have time to give people the individual attention they needed. One person said, "I need help with washing and I always have to hang on. I'd like a bath more often than I get one. I usually just have a wash and even that was very rushed this morning."

Relatives told us that their family members were supported by caring staff but also said that staff did not have sufficient time to spend with people. One relative told us, "The carers are very kind, they're all nice people, but there just aren't enough of them." Another relative said, "The carers are really nice. Dad gets on really well with them." Some relatives singled out individual members of staff for particular praise. One relative told us, "They're all good and one or two are exceptional." The relative identified two care workers on the unit and said, "They're great, they are really caring. They're all nice but those two stand out for me." Relatives told us they could visit their family members whenever they wished and that they were made welcome when they visited. One relative told us, "The staff are always friendly and welcoming when I visit" and another relative said, "We can visit any time and we're always made welcome."

The atmosphere in the service was calm and staff spoke to people in a respectful yet friendly manner. Staff were attentive to people's needs and proactive in their interactions with them, making conversation and sharing jokes. We observed that staff supported people in a kind and sensitive way, ensuring their wellbeing and comfort when providing their care. Staff communicated effectively with people and made sure that they understood what was happening during care and support. When one person became distressed, we observed that staff calmed and reassured them.

Staff told us that they encouraged people to do things for themselves if possible to promote their independence. Staff said that they encouraged people to make decisions about their day-to-day lives, such as what time they got up and went to bed, what they wore and what they ate. People told us that staff knew their preferences about their daily routines. We observed that staff encouraged people to make decisions for themselves and respected the choices they made.

People had access to information about their care and the provider had produced information about the service, including how to make a complaint. The provider had a written confidentiality policy, which detailed how people's private and confidential information would be managed. Staff understood the importance of maintaining confidentiality. People told us that they could have privacy when they wanted it and that staff respected their decisions if they chose to spend time in their rooms uninterrupted.

Staff understood the importance of respecting people's privacy and dignity. They spoke to us about how they cared for people and we saw them attending to people's needs in a discreet and private way. Staff said that staffing levels sometimes impacted their ability to ensure that people's dignity was respected, for example if they had to interrupt the support they were giving to one person to respond to the needs of another.

Care plans demonstrated that people's preferences regarding end of life care had been discussed and recorded. Staff had signed a confidentiality agreement and were aware of the need to keep people's confidential, personal information secure. The confidentiality agreement stated the requirement to comply with the Caldicott principles, which set out how confidential, personal information should be managed.

Requires improvement

Is the service responsive?

Our findings

People told us that the availability of activities had reduced from previous levels and that planned activities did not always take place. One person told us, "There used to be more activities but there's not a great deal going on now." Another person said, "There is an activities board but they don't always happen now." Relatives told us their family members would enjoy going out more often but that there were few opportunities to do so.

Staff told us the range of activities available to people had been affected by the shortage of care staff. They said the service employed two activities co-ordinators but that these staff were often required to support care staff. One member of staff told us, "The home is short staffed all the time. Activities for residents aren't happening as a result." Another member of staff said, "They're not getting their activities because the activities co-ordinators have to help out the care staff. It's worse in the afternoons when the care staff have their breaks." Staff also told us that some outings had been cancelled because there were insufficient staff to support them.

The provider had failed to provide appropriate support that met people's needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had been assessed before they moved in to ensure that the staff could provide the care and support they needed. Where care needs had been identified through the assessment process, these were recorded in people's care plans. Care plans were in place for areas including communication, nutrition, personal hygiene, continence, mobility and pain management. Care plans had been reviewed to ensure that they continued to reflect people's needs.

People told us that they had opportunities to attend residents meetings at which they could give their views. The registered manager told us that residents meetings had been introduced and would take place each month in the future. Relatives told us that they were able to discuss their family members' care if they needed to and that their views were listened to. People who used the service and their relatives said they could request changes to their care plans and that their wishes were respected.

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies people could contact if they were not satisfied with the provider's response. Information about how to complain was provided to people and was displayed around the service. We checked the complaints record and found that any complaints received had been investigated and responded to appropriately. Complainants were advised how they could escalate their concerns if they were dissatisfied with the initial response. There was evidence that the provider monitored the management of complaints as part of the quality assurance system.

Inadequate

Is the service well-led?

Our findings

Staff understood the values of compassion and respect and demonstrated these values in their work but their ability to promote people's dignity, independence and safety was compromised. There were concerns that staff had not received appropriate leadership and that the provider had not responded to the concerns raised by people, relatives and staff about the care people received. Staff told us they had raised their concerns about staffing levels and high vacancy rates on several occasions but there had been no increase in the number of staff deployed and the majority of staff vacancies remained unfilled. Some staff said they felt the management of the service was not fully aware of the impact staff shortages were having on people and staff. One member of staff said, "We've been saying for a long time that we can't cover the shifts but nothing's changed." Another member of staff told us, "I feel the manager doesn't understand how important this is. She's arranged training but the main issue is the lack of staff."

Some staff said that the lack of response to their concerns had led to poor morale because the core staff team were working long hours to cover vacant shifts. It was clear that staff felt under pressure to work extra shifts because they were committed to providing the care people needed. One member of staff told us, "Staff are tired, everyone's doing a lot of hours." Another member of staff said, "I've been covering lots of extra shifts. I find it hard to say no because I don't want the residents to suffer." Relatives told us that staff worked hard to provide the care people needed but that there appeared to be issues regarding their morale. One relative said, "The staff are great, they really do their best, but some of them seem miserable and that is having an effect on the residents."

There were concerns that the provider did not have adequate management oversight of the service. On a weekend shortly before our inspection, the shortage of care staff had been particularly acute, which led to non-care staff being called in to support care staff. When we discussed this with the registered manager, it became apparent that it was known prior to the shifts that there would be insufficient staff on duty to provide people's care. The registered manager explained that the situation had been caused by a member of administrative staff authorising leave to too many staff simultaneously but had not taken action to ensure there were enough staff to meet peoples' needs. The registered manager advised, "It was an administrative error that left us terribly short."

The provider had a quality monitoring system but this had not been effective in addressing the areas of concern around staffing levels and vacancies. The registered manager submitted regular service audits to the provider's assistant regional manager and clinical director. These included monthly reports of deaths, safeguarding issues, pressure ulcers, choking incidents, hospital admissions and medicines errors. The assistant regional manager also carried out quality audits and the provider had carried out a regulatory governance audit in May 2015.

The provider had failed to effectively assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had opportunities to contribute their views about the service through questionnaires, which were distributed annually by the provider. The questionnaires for 2014 were available in the service and provided generally positive feedback about the care provided, the staff and the activities. Questionnaires for 2015 had been distributed by the provider but the results had yet to be collated.

Records relating to people's care were accurate, up to date and stored appropriately. The registered manager shared information and worked co-operatively with other agencies when required. For example, any safeguarding allegations had been referred to the local safeguarding authority and the registered manager had worked with the safeguarding team to investigate the allegations. The CQC had been notified of reportable incidents and the service had established effective links with local healthcare professionals to ensure that people had access to any treatment they needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1)(a)(b)(c)** The registered provider had failed to provide appropriate care and support that met people's needs and reflected their preferences.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) The registered provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons. to ensure that people's care and support needs were met. Regulation 18(2)(a) The registered provider had failed to provide appropriate support, professional development, supervision and appraisal for staff.

The enforcement action we took:
We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(b) The registered provider had failed to do all that was reasonably practicable to mitigate risks to people's health, safety and well-being.

The enforcement action we took:
We served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(a) The registered provider had failed to effectively assess, monitor and improve the quality and safety of the service.

The enforcement action we took:
We served a Warning Notice