Mrs Shahnaz Abbasi

Murree Care Home

Inspection report

215 Park Road
Uxbridge
Middlesex
UB8 1NR

Tel: 01895313335

Date of inspection visit:
27 November 2018

Date of publication:
15 January 2019

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

This comprehensive inspection took place on 27 November 2018 and was unannounced. The last comprehensive inspection took place in August 2016 and the service was rated 'good'.

Murree Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection six people were using the service who had mental health needs and/or learning disabilities.

The service is owned and managed by a registered individual. The registered individual also had a second care home in Brent. 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.

During the inspection we found risk assessments were not always robust enough to minimise risks and these were not updated to reflect changes and current risks. Incident forms were not completed as required, the staff were using unsafe moving and handling techniques and we identified that processes to manage people's money were not always robust. This meant the provider was not assessing, monitoring and mitigating risks to people to help ensure that as far as possible, they were not exposed to the risk of harm.

The provider did not have checks in place regarding the safety of the environment, including personal emergency evacuation plans.

The medicines policy and procedure was not dated and as required medicines protocols were not in place. As required medicines were regularly being used to manage behaviour that challenges and medicines administration records were not always signed correctly. Medicines management was inconsistent and audits did not identify discrepancies.

Staffing was unsafe as care workers were working long hours and consecutive days without a rest period. Rotas were not a true reflection of the hours people worked and therefore it was difficult to know if the home had enough staff to meet the needs of people using the service. However, we identified one person who needed two people to provide support with personal care and only member of staff was available at night, should they require personal care at night.

The principles of the Mental Capacity Act 2015 were not always followed to help protect people's rights.

The provider did not provide appropriate training for staff. Not all staff members had up to date safeguarding adults or MCA training.

The provider did not always support people to express their views and be involved in decision making. They also used inappropriate language in records that was not very respectful.

Personal care was not always undertaken in a dignified and respectful manner.

The provider had detailed care plans when people first moved to the service, but they were not updated to reflect people's current needs and therefore did not reflect people's needs accurately. Nor did they reflect people's end of life wishes.

The provider did not have effective systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. For example, record keeping was not always complete and contemporaneous and there were no checks regarding the safety of the environment.

Safe recruitment procedures were followed to ensure staff were suitable to work with people. Staff received supervision to support their professional development.

People's dietary and health needs had been assessed and people were supported with these needs and to access healthcare services appropriately.

We found seven breaches of regulations in relation to person-centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found seven breaches of regulations in relation to person-centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Safe recruitment procedures were followed to ensure staff were suitable to work with people. Staff received supervision to support their professional development.

People's dietary and health needs had been assessed and people were supported to access healthcare services appropriately.

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.

Risk assessments were not always robust enough to minimise risks and incident and accident forms were not always completed.

Staff were using unsafe moving and handling techniques and processes to manage people's money were not always robust.

Medicines management was inconsistent, and audits did not identify discrepancies.

Staffing was unsafe and did not effectively meet the needs of people using the service.

Staff did not have training around infection control procedures so they were appropriately skilled at preventing the spread of infection.

Safe recruitment procedures were followed to ensure staff were suitable to work with people using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always act in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights.

Training was not always consistent, but staff were supported through supervisions.

People's dietary and health needs had been assessed and recorded.

People were supported to access appropriate health care according to their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not always support people to express their views and be involved in decision making.

The language used by the provider and the staff was not appropriate for the people they cared for.

Personal care was not always provided in a dignified and respectful manner.

We saw some interactions where the staff were caring and kind towards people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and associated records were not always completed in a timely manner or with up to date information and did not reflect people's individual needs.

People did not have advanced wishes for end of life care recorded.

The service had a complaints procedure but had not received any complaints.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people.

There was a lack of leadership to ensure that an appropriate standard of care and support was provided to people.

Murree 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 took place on 27 November 2018 and was unannounced. We brought the date forward because we had received information of concern regarding the service. The inspection was carried out by two inspectors and examined those concerns in relation to the five key questions we asked of providers.

Prior to the inspection, we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding and quality assurance teams to gather further information about their views of the service.

During the inspection we spoke with three people using the service, one care worker and the registered individual who was also the owner. We viewed the care records of three people using the service and four staff files that included recruitment, supervision and appraisal records. We looked at training records for all care workers. We also looked at medicines management for people who used the service and records relating to the management of the service including service checks and audits.

Inadequate

Is the service safe?

Our findings

The provider did not always have effective systems and processes and did not ensure that appropriate practices were in place to help protect people from the risk of harm Policies and procedures we saw were not up to date or not suitable. For example, the 'Working Alone', procedure was not written for a care environment.

During the inspection, we found the provider did not always have robust arrangements so that risks associated with people's care and well-being had been identified, monitored and managed to ensure they were safe. For one person who required support to move, there was not a moving and handling risk assessment. Staff were using an unsafe manual handling technique, instead of using aids to support transfers. Furthermore, the person required two people to move them safely but at times there was only one member of staff working in the home.

From the care records we looked at, we saw that people had a risk assessment when they moved to Murree Care and after that there was a line that said 'review and updated' with an annual date beside it. There was no indication that people's needs had changed and this was not reflective of what we saw. For example, one person who was able to stand with support when they were admitted was no longer able to do this, however their risk assessment was not updated to acknowledge this. Instead of having a moving and handing risk assessment they had a 'Risk of falling down' assessment which was not relevant to their current situation. Under mobility, it was recorded for the person, 'I don't like to use a hoist to go to bed or come out from bed. I help staff to go to bed or come out from bed.'

Another risk assessment for going out in the community stated the need to check wheelchair brakes but did not consider if the person required their lap belt. One person had a risk assessment regarding a 'Tendency to grab' but there was no indication of what the person's triggers were or what strategies could be employed to help manage this behaviour.

We saw another risk assessment for 'Risk of violence and aggressive behaviour' that recorded the risk could be mitigated by, 'When [person] shows his aggressive behaviour then staff should try to convert his mind and talk to him to divert his thoughts. Sometimes he raises his hands in front of staff and other people, at that time staff should divert his mind.' This did not indicate what the triggers were and how to prevent the reaction. The risk management plan did not contain information about the action to take to mitigate the risk but rather directed what to do when the situation had already occurred. We saw that this strategy was not effective as the person was regularly receiving PRN (as required) medicines to address their behaviour. The provider's strategies to support the person were based around trying to intervene when the person was already presenting challenges rather than supporting them so they felt safe and less likely to become challenging. The risk assessments did not include references to the recent incidents or evidence that the provider had learnt from these incidents to develop interventions to support the person.

The provider did not have any incident forms completed after 2015, which indicated they were not recording incidents of behaviour that challenged, so that they could identify patterns and update the risk assessments

and care plans to reflect the strategies implemented. We know there were incidents of behaviour that challenged because the ABC charts were recording it and staff were using PRN medicines as their way to resolve the situation. The incident and accident book had nothing recorded in it since 2014.

The provider did not have checks in place regarding the safety of the environment. No one living in the home had a personal emergency evacuation plan (PEEP) to provide guidance to staff on how to evacuate people from the building in the event of an emergency, for example a fire. There was no evidence of fire drills. We did not see evidence of checks on fire equipment such as doors or fire extinguishers and although we asked for a gas safety certificate, the provider was unable to show us one.

The provider did not have an infection control policy that was specific to their service and no one had undertaken infection control training. In addition, there was no cleaning schedule or monitoring of the cleanliness of the service.

The provider showed us their 'Medication Policy and Procedure' but this was not dated and it was not possible to tell when it had been reviewed or updated. It did refer to Royal Pharmaceutical Society guidance on handling medicines in social care. We saw separate guidance for staff on administering medicines that had been reviewed in December 2018. However, not all individual PRN (as required) medicines protocols were in place so staff were clear when to administer these medicines.

Medicines were stored satisfactorily in a lockable cabinet attached to the wall in the office. Some medicines were in a blister pack and others were contained in the original packaging. We found staff did not always record when they administered medicines. One person was prescribed a medicine as, 'Take one in the morning and take one at night'. The medicines administration record (MAR) was signed for the morning but not in the evening for 13 consecutive days. We saw the blister pack did not contain the medicine to be administered in the evening for the nights prior to the inspection. This indicated that the medicines had been given to the person but staff had not signed the MAR sheet. Staff confirmed this to be the case. As it was always the same staff member signing the MAR and no one else was auditing the MAR, the care worker had not identified their recording mistake.

Another person using the service was prescribed another medicine as, 'Take one or two daily when required' but the MAR showed four tablets given on 24 November 2018. We discussed this with the provider and one of the care workers but they could not tell us why they had exceeded the prescribed dosage. This meant we could not be assured that people were receiving their prescribed medicines safely.

The Antecedent Behaviour Consequence (ABC) chart which recorded people's behaviour demonstrated that PRN (as required) medicines might have been used inappropriately to help manage behaviours without any reference to other interventions to help manage people with a behaviour that challenged. For example, for one person we saw on one day, it was recorded, 'He was sitting in tv lounge on the floor. Staff tried to send him to bed and he started screaming. Staff gave him PRN and he was sent to bed.' The same person received PRN medicines on 5, 6, 8, 10 and 12 September 2018, relatively often but there was no referral made to review the person's medicines and medical condition or to refer to a behavioural specialist

The above paragraphs were a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we also had concerns about how people's money was managed. When we discussed our concerns with the provider, they did not acknowledge it was their responsibility to ensure that people were supported to manage their budget effectively and to help protect them from the risk of financial abuse.

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

On the day of the inspection, we arrived at the home at 9:30am. We looked at the rota for the week beginning 26 November 2018. This showed the provider was due to work from 10am to 7pm but she did not arrive until after the staff called her to let her know we had arrived. We spoke with the support worker who was due to start at 7am on the rota and they told us they had started at 9am as their child was unwell. They described the owner as 'very flexible' with their shifts.

The rotas for the week beginning 8 October 2018 showed the owner, her husband and son were on holiday. During this time the provider had not made suitable arrangements to deploy staff appropriately in the care home. Staff were working long hours on consecutive days, without adequate rest. For example, one care worker worked five consecutive 11 hour shifts followed by two days of sleep ins. A second care worker worked 29 split shift days and 25 night shifts from 8 October to 5 November 2018. A third care worker worked 31 days from 8 October to 7 November 2018 without a day off.

We saw the medicines administration records (MAR) for 15 to 27 November 2018 had all been signed by the same member of staff on every occasion, morning, lunchtime and evening. The member of staff confirmed they had signed on every occasion even through the rota for 20 and 21 November 2018 showed the member of staff who had signed the MAR sheet for the administration of medicines at 8pm and 10pm was working from 8am to 4pm. This meant the provider was not keeping appropriate staffing records as the rotas were not a true reflection of the hours staff actually worked. This made it difficult to ascertain if the home had enough suitable staff available to meet the needs of the people using the service.

We discussed the rota with the provider who told us night staff did not have a bed to sleep in and they stayed in armchairs in the lounge, checking people through the night and changing pads when needed. They agreed that the night shift was a waking night but said they did not mind if staff slept as long as checks were completed. However, when we looked at the nightly logs there was no indication people were being checked or their pads changed.

In addition, one of the people using the service required two people to support them with personal care, so if they did require this support during the night, there were not enough staff available to safely support them.

The above paragraphs show that the provider was not deploying staff adequately to meet people's needs and ensuring that they had enough rest between their shifts so they could provide safe care to people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the provider had systems in place to ensure support workers were suitable to work with people using the service. The files contained checks and records including, two references, identification documents with proof of permission to work in the UK if required and criminal record checks.

Requires Improvement

Is the service effective?

Our findings

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

We saw that best interest decision forms had been completed for individual decisions such as a wheelchair lap belt and bedrails. However, we found the provider was not always following the principles of the MCA. For example, we saw a best interests form had been completed for one person which stated they could not express their views but we did not see a mental capacity assessment had been completed to confirm this. Their relative had signed consent forms but it was not clear that they had the legal authority to do so. A second person had a combined mental capacity assessment and best interests record that noted, '[Person] is able to make decisions by himself, and for his health issues we prefer to take consent from his brother.' This did not respect the principles of the MCA.

In the files we looked at, we saw that DoLS authorisations had initially been applied for two people. However, when they expired, an application to renew had been made for one person but not for the other person. There was no explanation why the second application was not made. There was therefore a risk that people might have been deprived of their liberty unlawfully.

The training records for four staff indicated that only two had completed MCA training. This meant that not all staff were being supported to have a working knowledge of the MCA and its principles.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw training that was provided to staff, was not consistent. Not all staff members had up to date safeguarding or MCA training. Although there were people using the service who had behaviour that challenged, mental health needs and learning disabilities there was no relevant training undertaken in these areas to give staff the skills they needed to support people in these specific areas. Therefore, the provider had not ensure that there were adequate numbers of appropriately skilled, experienced and trained staff to care for people using the service.

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

Care plans included a section on nutrition that indicated how the person liked their meals prepared and

what assistance they required with meals, but we did not see any food preferences or dislikes included in the care plan. We also saw people had monthly weight charts as required and their weight was monitored monthly to help plan how to meet people's individual needs.

People were supported to access health appointments and records indicated people using the service attended appointments with GPs, care co-ordinators, the podiatrist, psychotherapist and various hospital appointments. One person had a hospital passport completed in August 2015 when they joined the service, but it had not been updated since to reflect any changes in their health needs.

The staff team was small and included the provider and her family. We saw that the provider undertook regular supervisions which included personal development and training, care practice, annual leave and any other issues. Staff signed their supervision notes after each meeting. We did not however see any appraisals to review development and performance of the member of staff during the year and set targets for the next year.

People's needs were assessed prior to moving to the home. We saw assessment forms that recorded people's health, personal care needs, medicines, domestic skills, communication, and risk management. People using the service had been placed by local authorities which also provided background information and assessments as part of the provider's assessment process to ensure the service could meet the needs of the people.

The environment was suitable to meet the needs of the people who lived there. Each person had their own bedroom which had been personalised by the person. There was a comfortable communal lounge and kitchen and people had access to the garden.

Requires Improvement

Is the service caring?

Our findings

The provider did not always support people to express their views and be involved in decision making. One person's care plan indicated they could use basic Makaton, which is a type of sign language, and that they should be asked about their choice of food by showing them pictures. When we asked to see the pictures, staff showed us pictures and Makaton symbols that were in a folder in the office and therefore not accessible to the people who required them. This was not person centred as the symbols could only be used when staff wanted to use them to communicate and meant people had to find other ways of communicating their needs to staff. At no point did we observe staff using Makaton to communicate and this was not included in their training so they were confident in using this form of communication.

In terms of meeting people's emotional needs, the staff team were not always caring and had little insight into people's needs and what caused certain behaviours or how to manage them. The DoLS application for one person stated, He is seeking attention all the time and when somebody doesn't notice he becomes angry.' Instead of having effective strategies to manage each individual's behaviour in a caring way, staff were often using PRN (as required) medicines to manage challenges.

The above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider and their staff did not always show people respect and that they maintained their dignity. For example, they consistently used inappropriate language that was not respectful of the person's age. Care plans talked about 'feeding' individuals, the Lorazepam protocol record for one person noted that they took off their 'nappy' on 18 and 20 November 2018, the DoLS renewal application for another person said, 'We put a baby monitor into his room to observe him at night' and the continence section of the care plan recorded, 'We put cream on to prevent nappy rash.'

Staff told us for one person, they sometimes undertook personal care while lifting the person from their chair instead of using more appropriate techniques such as lying the person down because they could not stand. This was neither appropriate or comfortable for the person and shows the person was not being treated in a very dignified manner. In the care plan under 'Dressing' we saw staff were directed to 'use short words' like 'stand up', 'go back' and 'seat properly.' This did not show that people were always being treated in a caring and respectful manner

The above was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, we saw some interactions where the staff were caring and kind towards people. We observed when one person became upset and agitated staff were gentle and offered reassurance. Several members of staff were able to speak with people in their first language to help with communication. Care plans included a 'Who am I' section that provided some social background and we saw sections in the care plan that indicated if people had religious needs and what social activities they were interested in. We

also saw that some people had regular contact with relatives.

Requires Improvement

Is the service responsive?

Our findings

The provider completed care plans when people initially moved to the home. These were comprehensive and covered a range of areas including personal care, health care, mental health needs, communication, daily living skills, social and emotional needs and medicines needs. The care plans recorded what people's routines were, what they could do for themselves and what support they required. People appeared to be involved in planning their care and consented to this by signing their original care plans. However, there was no record of an updated needs assessment as people's needs changed with time to reflect the changes. For example, one person's care plan under medical health needs stated, 'Staff must be aware when I get out of bed at night and encourage me not to crawl on the floor.' Staff told us the person could no longer get out of bed independently and now required two staff to support them with moving this person, but this was not reflected in their care plan.

Staff also logged daily and night notes. The DoLS application form for one person stated they were checked through the night to manage any incontinence. However, their daily care notes did not include any checks during the night. We discussed this with a care worker who told us they did check and change the person before they went to sleep and then checked them during the night. We looked at the notes for four other people and saw there was no record of them being checked during the night. All of the daily care notes we checked were very similar. Staff recorded every day for each person, '[Person] had their night time drink and went to bed for sleep' and '[Person] woke up in a good mood then he/she finished his/her morning routine with the help of the staff.' This did not demonstrate that people were receiving person centred care.

At the time of the inspection no one was receiving end of life care from the provider and the care plans did not contain any information around people's wishes, views and thoughts about end of life care as this had not been considered as part of the care planning process. When we discussed this with the provider, she said end of life care had been discussed but they did not produce any evidence of this during the inspection.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the records that people had one to one key working sessions with the provider that gave them the opportunity to discuss any concerns they had. Notes had been taken of these sessions to record the discussions but it was not evident that they had been used to update people's care plans to reflect their current situation.

On the day of the inspection most people attended a community day service for the day. Some people told us they went out to the shops. People were supported to be a part of their community through activities and attend activities that were of interest to them.

The provider had a complaints procedure but did not have the document in any other format such as in an easy read format for people using the service to access and understand. The complaints records showed

that no complaints had been recorded since January 2015.

Inadequate

Is the service well-led?

Our findings

During the inspection we found the provider did not have effective quality assurance systems to monitor the service delivery. We saw only one audit, dated 12 November 2018, had been completed by the provider. This audit indicated the provider had reviewed a selection of files for people using the service including their care plans, activities, the recording of personal care and health appointments as well as the risk assessments and reviews of people's support needs. The audit also included incidents and accidents, complaints and people's finances. As part of the audit the provider had recorded, 'I have checked all service users' blister packs, medicine cupboards, MAR sheets, PRN and audit books'. The provider's conclusion of the audit was, 'All good'.

Our findings showed that the provider's audits and checks lacked detail, depth and had not identified the issues relating to the quality of the service raised during the inspection. These included out of date policies and procedures, a lack of robust risk management plans, unsafe moving and handling procedures, poor recording, no analysis of behaviour that challenges and weak processes to manage people's money. Medicines were not safely managed and in some cases were used inappropriately to manage people's behaviour when that challenged the service. There were no checks regarding the safety of the environment including a lack of personal emergency evacuation plans.

We found the provider did not have systems in place to monitor the staffing levels and deployment of staff to ensure the safety of staff and that of people. As a result staff worked long hours or consecutive days without a break. In addition, checks were not carried out to ensure staff had up to date or relevant training, so they had the skills and knowledge to care effectively for people using the service.

There were no audits and checks to identify whether the provider and their staff were adhering to the principles of the MCA and that these were being followed. The provider also did not have arrangements to ensure that information was provided in an assessible format to support people so they could be included in the planning of their care.

Processes were not in place to identify when staff practices did not respect people's rights, freedom or dignity. Personal care was not always being provided with dignity and the use of language was not always appropriate for the people being cared for.

These practices were allowed to continue because there appeared to be a lack of leadership in the home and the staff did not receive the training and support needed to improve.

Some of the records, for example rotas, did not reflect what we saw or what was recorded in other documents. Therefore, we could not be confident that records were contemporaneous, accurate and complete.

We found throughout the inspection that the provider did not have robust systems in place to identify when shortfalls in relation to the quality of the service occurred which meant they could not take action to address

these and improve the care provided to people.

The provider was an individual who was also managing the service but they were not always available. When we spoke with the provider, there was no indication the she had an overview of the service as she often had to refer to a staff member for answers, indicating her involvement in running the service was not as active as it may have once been.

The above shows that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.