Care Quality Commission

Select Health Care Limited

Jubilee Court Neuro-Rehabilitation

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 4 November 2014 and was unannounced.

Jubilee Court Neuro Rehabilitation is a purpose built rehabilitation centre. It provides accommodation with personal care and nursing for up to 30 adults who have acquired a brain injury. At the time of our inspection 30 people were using the service and there was a registered manager at this location. 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.

At our last inspection in June 2014, we found that the provider had breached regulations relating to how

Summary of findings

people at the service were supported and how the quality of the service was assessed. The provider sent us an action plan to tell us the improvements they were going to make to ensure the service would comply with the regulations. At this inspection we found that the provider had reviewed their supervisory and audit processes and introduced monthly residents and relatives meetings however some issues remained with the previous breaches.

The provider did not have robust systems to monitor the quality of the care provided or identify, assess and manage risks relating to the health and welfare of people who used the service. The provider conducted regular audits to review the quality of the service but they were not always fully completed or actions identified to address concerns. The provider had failed to take suitable action in response to our last inspection and we found that some of the concerns raised were still unresolved. Some staff did not have the suitable skills and knowledge to safeguard the health, safety and welfare of the people who used the service. You can see what action we have told the provider to take at the back of the full version of this report.

Three people who used the service and five members of staff who we spoke with, all told us that they felt people at the service were safe. The relatives of four people also told us they felt their relatives were safe at Jubilee Court and that staff understood their needs.

People told us that they felt the provider responded promptly when they had received information of concern, however the action taken was not always effective at protecting people from further harm. Although the provider conducted risk assessments people were not always being cared for in line with their risk assessments. Some staff told us that they were not confident they had sufficient knowledge to stop people from hurting themselves if they exhibited behaviour which might challenge the service or others. Medicines were managed appropriately however audits did not always identify errors in a timely manner.

The provider followed the principles of the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards (DoLS). There was a training programme to support care staff to have the skills and knowledge they needed to meet people's specific care needs however this was not effective. Staff told us they lacked training in some people's specific care needs and they were generally instructed to review people's care plans when they required information. There was limited opportunity for different staff groups to meet to review people's care needs. We saw that people were supported by staff to eat and drink enough to keep them well.

The relatives and people who used the service we spoke with all said the staff were caring, however several relatives told us that staff turnover had made it difficult for them and people receiving care to build meaningful and caring relationships with staff. Staff we spoke with knew the people who used the service well, had learned their likes and dislikes and knew what was important in people's lives. However, some care staff told us that they were not always able to facilitate what people wanted because their time was taken up in the provision of personal care. The provider had a policy to protect people's independence and dignity which staff were able to explain.

People told us that staff were responsive to their needs and we saw that staff routinely responded to people's wishes as required. Some relatives told us that they did not have regular meetings with the provider to identify if care was delivered in accordance with people's wishes or to review their care. Care staff who supported people to engage in activities to promote their rehabilitation were unable to feedback their views about how well the person was responding. Although the provider held monthly meetings with relatives and staff they did not make efforts to capture the views of people who were unable to attend the meetings. Whilst people were given information about how to express concerns about the service some people told us that they had not received a full or prompt response to their concerns.

All the staff we spoke with said they enjoyed many elements of their work. However, several of the staff were dissatisfied with working at the service because a high level of staff turnover had affected morale. Staff received regular supervision but they expressed concerns about how they were supported and the lack of a clear management structure meant that staff did not always know who to contact if they had concerns. Several senior members of staff had not received suitable training in leadership skills.

We met with the manager and senior staff from the registered provider after the inspection and received

Summary of findings

reassurance that the issues raised would be addressed and improvements made. It was a positive meeting in that actions had been initiated by the provider to address some of the issues raised. You can see what action we have told the provider to take at the back of the full version of this report.

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?
The service was not safe. People were not always supported in line with their risk assessments.

Actions taken by the provider to prevent people from hurting themselves were not always effective.

Staff understood and knew how to report safeguarding concerns.

Requires Improvement

Is the service effective?
The service was not effective. Staff did not always share their knowledge about people's conditions and how they required to be supported by other staff members.

The provider followed the principles of the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards (DoLS).

Requires Improvement

Is the service caring?
The service was caring. Staff knew the people who used the service well and knew what was important in their lives.

People told us that the staff were very friendly and helpful. Although some people advised that the turnover of staff had made it difficult at times to build meaningful relationships.

Good

Is the service responsive?
The service was not always responsive.

People were not getting individual care that met their needs. Some staff were unable to feedback when they thought people's care plans needed reviewing.

The systems in place to listen and learn from people's experience were not effective.

Not all complainants received a prompt or full response.

Requires Improvement

Is the service well-led?
The service was not well-led.

The systems in place to check on the quality and safety of the service were not fully effective, and had not ensured people were benefitting from a service that met their needs.

There was no clear management structure when care was provided out of hours.

The provided had not responded to all the concerns raised at our last inspection.

Requires Improvement

Jubilee Court Neuro-Rehabilitation

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 November 2014 and was unannounced. The inspection was undertaken by two inspectors and a specialist advisor. The specialist advisor had detailed knowledge and understanding of how to communicate with people who may have a learning disability.

Before our inspection we checked if the provider had sent us any notifications since our last visit. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. The provider had also submitted 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. We used this information to plan what areas we were going to focus on during our inspection.

Before our inspection we spoke to a person who commissioned services and a health professional who supported people at the home. During our inspection we spoke with five people living at the home, the relatives of four people who used the service, the registered manager, deputy manager, a nurse, a physiotherapist, five care staff, the catering manager, housekeeper and another person who commissioned services who was visiting. We spent time observing how care was delivered by staff during the day in communal areas. We looked around the home and in people's bedrooms to see if equipment provided met people's specific needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people.

We looked at records including five people's care plans. We also looked at records of staff meetings, medicine administration records, best interest decisions and resident's meetings to see if the provider had addressed our concerns from our last visit. We looked at the provider's records for monitoring the quality of the service including accidents and incidents, and how they responded to issues raised.

Requires Improvement

Is the service safe?

Our findings

Three people who used the service and five members of staff who we spoke with, all told us that they felt people at the service were safe. The relatives of four people also told us they felt their relatives were safe and that staff understood their needs.

People who used the service and relatives we spoke with told us that they had met the manager before they started to use the service in order to find out about their specific care needs. The provider had conducted risk assessments of people before they joined the service and again as their conditions changed. We looked at the care records of two people who required support with their specific conditions. These contained instructions and guidance about the support staff were to provide to people in order to ensure they did not come to harm due to the specific nature of their conditions.

Staff we spoke to understood the concept of keeping people safe and knew what actions to take should they feel someone was at risk of harm. They were aware of the need to 'whistle blow' on poor practice and felt confident to do so. Staff all said that they would report any issues of concern to their immediate supervisor or directly to the registered manager. This meant that the people were protected from the risk of abuse as the staff had an understanding of how to protect people.

We saw evidence that the provider responded promptly when they received information alleging people who used the service was at risk of abuse. For example when a person suffered an accident at the service, the provider followed the appropriate procedures and notified the local safeguarding authority and environmental health department. They also conducted an investigation into the incident and made recommendation how to prevent a similar incident from reoccurring. However when we spoke to a member of staff about a different incident they were unsure if the recommended action had been completed and upon inspection we saw that it had not. This meant that action required to keep people safe from known hazards was not always followed up.

Medicines were stored safely in locked cabinets. Medication records had been completed appropriately and administration had been correctly signed for. Records showed that staff had received training in how to manage medicines appropriately. When a person required medication to be given covertly an assessment had been conducted in line with the appropriate legislation. We noted however that a few days before our visit the provider had run out of one person's prescribed medication and although an alternative household remedy had been administered the person's care plan had recorded they had been in pain and "unsettled" during this period. The arrangements in place to ensure that adequate stocks of prescribed medication were available had not been followed which had an impact on one person who used the service.

People who used the service and their relatives told us that they felt there were enough staff to meet people's care needs although people were not always consistently supported by the same staff. Staff we spoke to said they felt there were generally enough staff on duty however staff sickness often meant that some shifts were short staffed resulting in some people not being supported to engage in interests they wanted to pursue.

The registered manager told us that they had reviewed people's care plans to ensure there were enough staff to support people in line with their plans and we saw that the provider had recently increased the number of staff employed as people's care needs changed. We saw the registered manager had a policy to employ additional staff when staff who had been booked to work did not attend their shift.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they had received training in managing general behaviour however some said that they had not received training to support some people's specific behavioural needs. They told us that they would either have to find a nurse who had the knowledge and experience of supporting a person when they exhibited a specific behaviour or use their intuition. A member of staff told us that they had learnt when to 'duck or move away' when people presented with behaviour that was challenging. Therefore there was a risk that staff did not have the knowledge and skills to keep people at the service, including visitors and staff, safe. This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

People who used the service told us that they felt the service looked after their needs well. A person told us, "They've been terrific, I can do things now I couldn't before." All the staff and relatives we spoke with said that people received good care from the GP services, the therapists and nursing staff. Relatives of people who used the service said that people's general condition improved while they were at the service. One relative told us, "[Person's name] couldn't walk when they got here, but now they are up and moving about." Another person said that their relative's health had improved so much that they were now able to sit out of bed for periods of time and participate in activities. These improvements had resulted in plans being made to support the person go out on family visits in the near future. We observed how care was delivered at lunch time and saw that staff were unhurried and were able to support people in line with their care plans and responded promptly to requests for assistance.

People who used the service and the relatives we spoke with felt that the staff knew how to support people and were happy with the quality of the care staff provided. The provider had a training programme to support staff to have the skills and knowledge they needed to meet people's specific care needs. One of the senior support workers told us that following the admission of a person with a specific condition, they had learned about the condition and how the person should be supported. Mental health nurses were knowledgeable about supporting people who might exhibit behaviour which could challenge others.

Staff did not always communicate changes or support plans to enable colleagues to carry out their roles and responsibilities effectively. Staff worked closely in their own professional group but did not always share their skills and knowledge with others. For example care staff only received updates on people's conditions at daily handovers and were not included in any review meetings or professional discussions about people's support needs. The senior support workers told us they did not have the opportunity to meet together with other staff groups and plan a coordinated approach to meeting people's care needs. Several care workers we spoke with told us that they did not always receive advice promptly when they approached nursing staff for guidance. A member of staff also told us, "I asked for guidance but I was just told to read the person's notes." This meant that there was a risk that people who used the service could sometimes have to wait to receive the support they required.

The provider followed the principles of the Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We saw that the registered manager had made DoLS applications in the past and that staff understood their responsibilities in relation to the MCA. This meant that people were supported by staff who had the knowledge to ensure that people were safe from having their rights restricted inappropriately.

At the time of our visit three people were subject to DoLS applications in place and where assessments determined a person lacked capacity to make a decision, records showed that the person and other people concerned with their care and welfare had been consulted. However some people who used the service had not had mental capacity assessments in place and had not been reviewed to identify if a DoLS application was required. We noted some

Requires Improvement

Is the service effective?

examples of thoughtful support for people using the service to help the person retain some degree of control about how they received their care. For example, an assessment had not been carried out for a person whose treatment resulted in them being unable to administer their own personal care or feed themselves. However the manager told us and we saw that the provider had discussed the person's care needs with their family and therapists to identify the least restrictive method of support.

The service operated a key worker system, whereby people were allocated a dedicated member of staff to take responsibility for co-ordinating the care they received and provide guidance and advice about the person's care needs to other members of staff. Some relatives we spoke to told us that people's key workers kept changing due to staff turnover and one relative was not aware the provider operated a key worker system however they felt it would improve communication. There was a lack of understanding amongst members of staff about roles and responsibilities of key workers. One nurse told us that key workers were responsible for "tidying lockers and making sure people had toiletries." This was not in line with the provider's understanding of the key worker role and meant that people were at risk of receiving an inconsistent or variable degree of support to meet their needs.

We observed how people were supported at lunch time. Staff knew the specific support each person required to eat and drink and we saw that people were supported in line with their care plan. This included preparing soft foods and providing crockery and cutlery which enabled people to eat independently. The catering manager told us that they received regular updates about people's nutritional needs and we saw them asking people what they wanted to eat for lunch and supper during our visit. They told us, "I enjoy looking after the people here. I really try to give them what they like to eat." During our inspection we saw the catering manager visit people in the lounge several times to ask what they wanted to eat and we saw that relatives were invited to take part in food tastings so they could comment on the quality and choice of food being served to their loved ones. People were offered a choice of food and hot and cold drinks and staff were patient and regularly provided verbal prompts to ensure they ate a sufficient quantity to maintain their wellbeing. Care records for a person who required feeding through a tube into their stomach (PEG feed) included guidance for how staff were to ensure they received sufficient nutrition. Feeding was conducted by nursing staff who had received training in how to support a person with PEG feed system. Therefore people were supported to eat and drink enough to keep them well.

Good

Is the service caring?

Our findings

A person who used the service told us, “This is by far the most satisfying home I have been in. It’s head and shoulders above the rest.” They stated that staff always provided the assistance they wanted on time and that the furniture in their room had been arranged to meet their personal preferences. Another person who used the service told us, “The staff are good, some are my friends.”

We spoke with the relatives of five people who used the service who said that the staff were caring and they looked after their relatives very well. The relatives we spoke with said that their family members had improved in their well-being since using the service which they felt was due to the support of the staff. Several relatives however, told us that a turnover of staff had made it difficult for them and people receiving care to build meaningful and caring relationships with the staff. A relative told us that they regularly had to introduce themselves to new members of staff. Another relative said, “They have had three different key workers since coming here. I spend a lot of time explaining to new staff how they need to look after [person’s name].”

It was evident from the staff we spoke with that they knew the people who used the service well and had learned their likes and dislikes. They knew what was important in the lives of the individuals. A member of staff spoke affectionately about a person they supported and told us how they had worked with the person to build a trusting relationship so that personal care and support could be provided in a way which met their needs. However, some care staff told us that they were not always able to facilitate interests people wanted to pursue because most of their time was taken up in the provision of personal care.

There was a relaxed atmosphere in the home and staff prompted and supported people’s social interactions. People told us that they were regularly supported to express their views of the care they received at regular meetings and told us that they felt listened to. We saw that people were relaxed with staff and confident to approach them throughout the day. Staff we spoke with told us they enjoyed supporting the people living there.

The provider had a policy to protect people’s independence and dignity. We saw that people were provided with suitable equipment in order to maintain their dignity. These included mobility aids, crockery and cutlery which enabled them to be as independent as possible. A person who used the service told us that the provider had ensured they had received their mobility aids before they joined the service to support them to be independent as soon as they arrived.

Staff were able to explain to us the provider’s policy and the actions they would take to protect people’s privacy when delivering personal care. Staff told us that they would not enter people’s rooms without knocking and introducing themselves first and we observed that this is what happened before staff entered bedrooms.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us that staff were responsive to their needs. They told us that staff took time to find out what they liked and supported people in line with these wishes. One person told us, "They help me when I want, they help me to go shopping when I need things. " Another person said, "They are helpful, I ask for something and they do it."

Although care staff knew people's care needs, they told us that they were not always able to respond to people's wishes or needs in line with their care plans as there was not always enough staff available. Examples included staff not being able to take people out into the community as often as they requested or support people to undertake exercise as part of their rehabilitation care plans. A member of staff told us, "We are meant to take [Person's name] to the gym each day but sometimes there are not enough of us to do this." A relative of a person who used the service also expressed concerns that people were unable to take part in activities they wanted to do because transport was not always available to take people swimming. Relatives told us that there were regular meetings with the provider to express their views about the service but felt they were not supported to discuss concerns about people's individual care. A person told us, "We just end up talking about the laundry every month." Several people said this was the only opportunity they had to speak to the registered manager about the care their relative received and were frustrated that they could not raise issues which were important to them. The provider did not have suitable systems in place to capture and respond to people's views about the quality of the service. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

Relatives we spoke with said that the service responded to people's needs although several people told us they had not been approached for information about their relative's personal history, individual preferences and interests. They told us that they did not have meetings with the provider to review people's care needs unless they were arranged by the local authority. The relative of a person told us, "The only time I get to meet the manager is if I complain." Care staff we spoke with all said they did not take part in meetings to review the care and support needs of the people who used the service. Care staff who supported people to engage in activities to promoted their rehabilitation were unable to feedback their views about how well the person was responding or if their care plans needed to be reviewed. Failing to seek the views of relatives or staff to identify if care was delivered in accordance with people's wishes or if care plans required reviewing meant that opportunities to introduce or make changes were not identified or acted upon.

We saw that the provider held a meeting each month with all the people who used the service and their relatives so they could review if the service was meeting people's needs. We noted from records that these meetings were poorly attended and only three people had attended the last meeting. A relative of a person who used the service told us that the registered manager would not review people's specific care needs but talk about the service in general. Minutes of the meetings showed that the views of people who were unable to attend were not represented and therefore these meetings did not provide a robust system to gather and respond to people's views about the service.

People told us that information about the provider's complaints policy was given to people and their relatives when they started to use the service and we saw that this information was also available in public areas for visitors. This enabled people to express concerns about the service and gave the provider the opportunity to learn from people's experiences. There was a system to ensure complaints and incidences were responded to. The registered manager had taken action when concerns were raised in order to protect people from harm or the risk of harm. We noted that the response to one incident was not effective because the action identified to prevent a similar incident from re-occurring had not been completed. We saw that the provider responded to complainants however some responses were not provided in a timely manner in line with the provider's policy. For example one person stated they had not had a response to concerns they raised about a person's bed for several weeks and said that they felt, "Fobbed off." Another person said they had raised concerns that their relative was not receiving support to engage in activities in line with their care plans and advised these had still not been resolved after several weeks. We spoke to the manager about these issues. Although the registered manager had responded to several

Requires Improvement

Is the service responsive?

complainants they had not included details of further actions complainants could take if they felt their complaint had not been resolved. Some other complaints had been addressed and resolved but the complainants had not been advised of the outcome of their complaints and were unaware that changes had been made.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we raised concerns with several aspects of the service such as the out of hours management structure, training for supervisory staff, record keeping, staff supervisions and the quality review process. At this inspection whilst we noted that some of these issues had been addressed or changes had been introduced, but some shortfalls were still unresolved. The provider did not have regard for reports raised by the Commission following previous inspections when some of these issues had been identified as needing to be resolved. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

All the people who used the service, their relatives and staff we spoke with said the registered manager was very caring and a good person. They all said the service tried to support people as much as possible and staff knew people's care needs very well. Everyone said the manager was friendly and would listen to their concerns.

Staff whose role included leadership and management tasks such as the deputy manager and supervisors had not gone through a formal interview process to identify if they had the ability to lead people. The manager and staff told us that these people already worked at the service and had been "asked" to take up their new management roles. Staff did not always feel they received feedback from managers and supervisors in a constructive and motivating way. Staff told us that they often felt "told off," when the managers and supervisors spoke to them and that this was sometimes done in front of other staff members. The provider held supervision meetings with staff however feedback at these meetings did not always give clear direction. For example, records of supervision meetings for two nursing staff stated they were both to rewrite all care plans and risk assessments which were over a year old. But there was no direction as to how this would be done, by when or which nurse was to review which records. We saw that another person had received two supervision meetings with different supervisors within three days of each other. When questioned about this, the registered manager told us that the second meeting must have been a mistake. At our last inspection we were concerned that supervisors had not received any management or leadership training and we saw that this was still the case. The registered manager told us that leadership training was arranged for these staff in the new year.

The registered manager arranged regular monthly meetings with people who used the service however these were poorly attended. Records of the last resident's meetings showed that only three people attended. Relatives told us that they had stopped attending because the registered manager only discussed operational issues and these were not always felt to be relevant to the specific care people received. Some relatives also told us that they only attended meetings with the registered manager when they had been arranged by the local authority who commissioned the care provided to their relative. The provider did not have a robust system to capture the views of the people who used the service and their representatives.

All the staff we spoke with said they enjoyed many elements of their work. However, it was evident that several of the staff were dissatisfied with working at the service. Relatives and staff told us that staff turnover had affected morale. Care staff expressed frustration that they did not always have time to provide care which met people's rehabilitation or social needs and they could only focus on delivering personal care. A member of the care staff told us, "I thought I was going to help people get better, but I just look after their personal care. I might as well work in a care home."

Concerns with staff attitude had been identified by the registered manager and we saw that this issue was an agenda item which they had planned would be discussed at a staff meeting however the meeting had not taken place. Staff told us and records showed that several meetings between the staff and management team had been cancelled or poorly attended. For example head of department meetings between the registered manager and staff groups had not always been attended by representatives of all staff groups. Records showed that nursing issues were not discussed at the last meeting because no nursing staff attended. Records of the most recent staff meeting showed that no nursing or care staff attended and therefore the registered manager was unable to share important information. Staff told us that they thought the meeting had been cancelled and several stated that they were reliant on their peers to pass on

Requires Improvement

Is the service well-led?

information from the registered manager. This meant that the provider did not have an effective system in place to capture the views of staff and communicate their vision, values and beliefs for the service.

The service had a management structure in place but it was not always clear who was responsible for the service outside of office hours. The registered manager told us that they did not have a formal management "on call" rota but staff had been told to call the deputy manager if they had concerns with people's nursing care and to call the registered manager for all other issues. There was no formal arrangement which staff could refer to in order to identify who to contact or what to do if the contact was unavailable. Care staff told us that during the day they would normally raise issues with their supervisors, however they there unclear who to contact if their supervisor was unavailable. Staff told us that when they went to nursing staff for support and guidance they were normally told to review people's care plans for the information they required. Several people told us that the registered manager was approachable but they could not always speak to them when they needed to. People were at risk of not receiving the support and care they needed because the provider did not have clear guidance about who staff should contact for advice or to share views about the service.

The provider conducted regular audits to review the quality of the service, however we saw that they did not always identify what action to take. For example, when an audit had identified that staff were not recording where on a person's body medication patches had been placed, there were no actions identified to address this concern or prevent it from happening again. During our inspection we identified that a person had recently run out of their prescribed medication and that the manager was unaware of this incident. Therefore there was a risk that medicines were not managed safely because the providers systems for ordering repeat prescriptions and reporting serious incidences had not been identified as ineffective.

The provider's review of care records were not always effective to ensure they were up to date and fit for purpose. We noted that records of when people were turned were not always completed or recorded that people were not being turned in line with their care plans. Records of a person who required support with their feeding showed that care was not being delivered at times identified as necessary in their care plan. However these omissions had not been identified in the provider's quality checks.

The provider did not always conduct effective checks to ensure concerns raised had been responded to appropriately. We saw that actions required from a recent safeguarding investigation had not been carried out although the deputy manager told us that they thought they had. A review of the provider's response to complaints showed that some complainants had not received details of external agencies they could contact if they remained concerned in line with the provider's policy.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to regularly assess and monitor the quality of the service provided. Regulation 10 (1) (a). People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to identify, assess and manage risks relating to the health and welfare of people who used the service. Regulation 10 (1) (b). People who used the service were at risk of inappropriate or unsafe care because the provider did not have regard for reports prepared by the Commission. Regulation 10 (2) (b) (v) People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements for seeking the views of the people who used the service, their relatives or staff. Regulation 10 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not ensure that staff had the appropriate skills and knowledge to safeguard the health, safety and welfare of the people who used the service. Regulation 22.