Vitalbalance Limited

Bank Close House

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

Summary of findings

Overall summary

We inspected this home on 4 December 2017. At our last inspection in June 2015 we found the provider was meeting all the regulations and we rated the home overall Good. However we rated the section welled as Requires Improvement as the provider had not always been pro-active in determining service improvements for people's care. At this inspection we saw that these improvements had not been made and further improvements have been identified.

Bank Close Care Home is a care home. People in care homes receive accommodation and 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. Bank Close accommodates 27 people, at the time of our inspection there were 25 people using the service.

The service had 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 2008 and associated Regulations about how the service is run.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. We have made a recommendation about decision specific assessments to support people when they lack capacity.
There were not always sufficient staff to support people's needs, this meant people often waited for their personal needs to be met. Risk assessments had not been completed to reflect individuals safety and considerations ion how to reduce the risks associated with the environment or people's needs.
The environment did not always reflect measures to reduce infections. However staff used their protective equipment effectively. Some people were not supported to be independent when they received their meals. The rooms used for the dinning and lounge areas were crowded and did not support people being able to use these rooms freely or to have relatives join them. There was limited signage around the home to support people's to make choices or provide them to orientation.
People's care plans were not up to date and did not reflect their identified needs. People's aspirations and aspects which affected them as an individual had not been included in the planned care. People's choices in response to end of life care had not been completed and their wishes documented to so that their wishes could be followed.
Audits had been completed, however they had not always been used to consider trends and to drive improvements or reduce people's risks. There was a mixed response to the support people, relatives and staff received from the manager and provider. Complaints had been responded to, but the actions taken had not been followed up to ensure the complaint had been resolved.

Staff had developed caring, respectful relationships with the people they supported. People's privacy was observed and consideration was shown to people to support their dignity. Relatives and friends were

welcomed to visit freely.

Staff had been recruited safely and they knew how to protect people from the risk of abuse. The staff had received training for their role and felt the training provided them with knowledge and skills. Referrals had been made to health professionals and there was a proactive approach to ensuring people's health needs had been met. Medicine was stored and administered safely, to meet peoples prescribed needs.

People's feedback had been sought and this was planned to be repeated. There had been some partnership working with local organisations, which included schools, churches and health professionals. People received some stimulation to support them to remain active, however it was identified some people would like more opportunities to participate in activities.

We saw that the previous rating was displayed in the reception of the home as required and was displayed on their website. The manager understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken This is the first time the service has been rated Requires Improvement overall and the second consecutive time they have been rated requires improvement in Well Led.

We found 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe
There was not always sufficient staff to support people's needs. People's safety had not always been considered and measures taken to reduce the risks associated with the environment or people's needs. The environment did not always reflect measures to reduce infections; however staff used their protective equipment effectively. Staff had been recruited safely and they knew how to protect people from the risk of abuse. Medicine was administered safely.

Is the service effective?

Requires Improvement

The service was not always effective
When people had not got the capacity to make a decision, there had been no assessments completed or best interest decision meetings to consider how the decision was made. Some people did not receive the guidance for their health care and their meal experience did not always support independence. The environment was limited to support people's choices or provide them to orientate about the home. Staff had received training for their role and when required referrals had been made to health professionals.

Is the service caring?

Good

The service was caring
Staff had developed caring, respectful relationships with the people they supported. People's privacy and dignity was considered. Relatives and friends were welcomed to visit freely.

Is the service responsive?

Requires Improvement

The service was not always responsive
People's care plans were not reflective of their identified needs. People's aspirations and aspects which affected them as an individual had not been included in the planned care. People received some stimulation, but wished for more to enable them

to remain active. Complaints had been responded to, but actions that had been taken had not been followed up to ensure the complaint had been resolved. Care plans to reflect people's choices in response to end of life care had not been completed and documents in relation to individual health wishes did not follow guidance.

Is the service well-led?

Requires Improvement

The service was not always welled
Audits had been completed; however they had not always been used to consider trends and to drive improvements. There was a mixed response to the support people, relatives and staff received. People's feedback had been sought and this was planned to be repeated. The registered manager understood their responsibilities with us and we saw the rating was displayed. There had been some partnership working with local organisations.

Bank Close House

Detailed findings

Background to this inspection

We carried out this inspection visit 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.

Bank Close Care Home is a care home. People in care homes receive accommodation and 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. Bank Close accommodates 27 people, at the time of our inspection there were 25 people using the service.

This inspection visit took place on the 4 December 2017 and was unannounced. The inspection visit was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return as part of the Provider Information Collection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the quality monitoring report that the local authority had sent to us. All this information was used this to formulate our inspection plan.

We spoke with five people who used the service, three family members and two visitors. We did this to gain people's views about the care and to check that standards of care were being met. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.
We also spoke with four members of care staff, the cook, the domestic, the deputy manager and the provider. We also spoke the District Nurse. The registered manager was off site on the day of the inspection; however we spoke with them during the day of the inspection on the telephone and afterwards to provide feedback.

We looked at the care records for six people. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the home ensured the quality of the service, these included audits relating to accidents and incidents, infection control audits, complaints, compliments and surveys to reflect feedback.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with felt there was not always enough staff available to provide support when they needed this. One person said, "There isn't enough staff for all these people. You get people asking for help all day and they're pushed to the limit." A relative commented, "They've got more staff on at night time now, which is good, but they need to do the same for the day staff. They're rushed off their feet non-stop all day." We observed several periods throughout the day when the lounges were unsupervised and this was also confirmed by visitors and relatives we spoke with. One relative said, "You don't see staff in the lounge unless they're bringing drinks. Some people need help so there should be more carers around I think." Another told us, "I visit a lot and I do feel I act as a carer sometimes, because there is often no staff in the lounge so I end up dealing with people who need help, trying to find out what they want and finding staff."

We saw that people had to wait for their support. During the morning a person had requested to go to the bathroom. They waited 20 minutes. The staff member said, "I've got to find someone else to help me, so you'll have to wait a bit longer." The person became agitated, but after a few more minutes was supported. When they returned from the bathroom they said, "This always happens. I have to wait for ages. I have a medical problem which is uncomfortable and people don't know what that's like." Staff we spoke with all identified the concerns they had in relation to the level of staffing. One staff member said, "Some days it's a rush we don't have enough time to assist people, we could do with an extra staff member to take the pressure off." Another staff member added, "We also have to do the laundry and if the night staff have not got up to date there is a back log and people run out of items." A health professional told us, "Staff are rushed; we often feel we are an additional burden as we have to ask staff to take people to their rooms. We have also noted there are a lot of people have skin tears following a fall."

We discussed the staffing levels with the provider during the inspection and the registered manager by telephone after the inspection. They both told us that the staffing levels had not been raised as a concern with them. They told us, the staffing levels had increased in June 2017 by an additional staff during the night, however since this increase they had not evaluated the impact, to reflect if it provided the level of support required by people. In the PIR, the registered manager stated, 'staffing levels are consistently maintained with the appropriate skill mix to ensure our residents remain safe. The staffing levels are reviewed regularly with the Operations Director.' However, there was no documented evidence of these discussions and the dependency tool we saw had not been updated to reflect people's level of needs. A dependency tool provides a guide to the level of support each person requires.

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

The environment was not always safe. We saw that the stair gate at the bottom of the main stairs was broken. The stair way was situated within the main hall and accessible by people living in the home. This had been reported in the maintenance book four days before our inspection; however no measures had been put in place to consider the safety of people. At our request the gate was fixed by the provider during the inspection. At the top of this stairway, it was identified a bedroom opened out onto these stairs. There was no safety gate in place to prevent a person from falling. The person currently using this room mobilised

using a walking frame and required assistance to navigate this area safely. To descend the person would have to open a fire door to the upstairs landing to access the lift. We saw that other risk assessments were not in place or they were not up to date. One person chose to smoke cigarettes. They had been identified as not safe to manage their own cigarettes or lighter, however there was no plan in place. We saw this person accessed the outside area without a coat, this placed the person at risk from the cold. This meant these areas of safety had not been considered or reflected on to identify how they could ensure people's safety.

We saw some people were transferred safely and comfortably from and to their wheelchairs. However, on four occasions we saw some people were moved by staff lifting them from under their arms. Lifting people by placing a hand or arm under the person's armpit could result in potential of injury to the shoulder and soft tissues around the armpit. It is not in line with Manual Handling Operations Regulations 1992 (MHOR) (as amended 2002). This meant that people were not always moved safely.

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

Plans were in place to respond to emergencies, such as personal emergency evacuation plans. However, these had not been updated. For example, one person's had not been reviewed since December 2016 and the person on respite had not had their plan reviewed. Therefore we could not be sure the plans reflected the level of support people would require if an emergency was to occur. However staff we spoke with were aware of individual's needs.

The premises were not always clean and hygienic, so that people were protected from infections. The home had a mal odour on entry and one bedroom had a strong smell even after the carpet had been shampooed by the domestic staff who confirmed when this had been completed. One visitor said, "Sometimes the chairs in the lounge aren't clean, so I always bring some wet wipes so I can clean a chair before I sit on it." There was a floor to ceiling height cupboard which stored kitchen and dining items that would not fit into the kitchen. These included catering packs of sugar and other powdered goods, packs of supplements, bottles of squash, plastic and glass bowls and glasses. People had access to these items as they were not stored securely and this area was not always supervised. The kitchen had recently had their kitchen inspection from the food standards agency. They were awaiting their star rating, however the registered manager told us following the inspection several areas of cleaning had been identified. These included high up cleaning and the extractor fans within the home. They told us these areas have been addressed. The food hygiene rating reflects the standards of food hygiene found by the local authority.

When people received personal care or meal support we saw that staff always used personal protection equipment. They were observed to change them frequently and between tasks. One staff member told us, "We have plenty, along with paper towels and hand gel". We saw that infection control audits had been completed and small items which required replacing had been, for example, pedal bins. However these audits had not identified other areas of concern within the home.

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

People felt they and their possessions were safe. One person said, "I feel safe at night because the carers come and ask if I'm okay, so that's nice." Another person said, "I would tell a care worker and feel sure they would deal with the problem." Staff had received training in safeguarding and understood the different

possible signs of abuse around safeguarding and how to raise a concern. One staff member "I would go to the senior and if it was not resolved go to higher management." We saw when safeguards had been raised they had been investigated and worked in conjunction with the local authority to resolve any concerns.

People and their family member's said their medicine was administered appropriately and on time. We observed a member of staff giving medicine; they discussed their medicine with them as they supported them to take it and provided them with a drink.

All medicine was administered by the senior staff who had received training and a competency check to ensure they understood how to administer the medicine and record the details on the medicine administration record (MAR). We saw all the MAR sheets had been completed appropriately. We checked the stock and found these were correct, which meant there were the suitable amounts available to support individual's prescriptions.
The registered manager had made some changes to the layout of the reception area. This was to provide a more visual focus of the staff. For example, the staff used to complete care records at a table under the stairway, this table had been removed and a small table placed in between the two lounges. The feedback we received from relatives about this change was positive. This showed they used some situations to consider learning, however as noted in other aspects of the report not all areas had been reflected to learn lessons and identify themes to drive safety and improvements.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and 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 homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

We checked to see if the provider was meeting the requirements as required by the Act. Some people had been identified as being restricted and had been referred to the local authority. However, the assessments completed to reflect people's level of capacity were not clear in identifying how the decision had been made. The assessments did not reflect the decision the assessments related to and no best interest meetings had been completed. Staff we spoke with had received training, however not all could provide an understanding of the requirements or details of people who were subject to a DoLS. This meant we could not be sure people received the correct support in line with the Act.

We recommend that the provider researches current guidance on best practice, to assess the capacity in relation to specific decisions for people living at the home.

A relative commented that when people were seated in the lounge there was not always space for people to place their cup or snacks on a table. When people received snacks they were not offered plates or serviettes. A relative said, "On one occasion a person received a piece of malt loaf with butter in their hand, which became a gooey mess, with nowhere to put it, and I had to find a bin and then clean them up." We saw some people were sat with cups in their hand or once empty, on their laps. We saw that one person who only drank coffee was given tea, during the morning trolley round. They drank some of it, but when they cleared away the cups they told the staff they had been given the wrong drink. We observed they were not then offered the correct drink.

We observed the mid-day meal. We saw that some people were not supported with their independence. For example, one person was struggling with their meal and they were not offered a plate guard or different cutlery to enable them to remain independent. Within the PIR the registered manager told us, 'We ensure that our residents receive a quality dining experience. We encourage staff to take their meals with them and actively promote family and friends to enjoy meal times with the service users.' Within the two dining areas every chair and space at the tables was taken. This meant there was no opportunity for staff to sit with

people or relatives to join their family member.

The environment was not always able to support people's needs. The two lounge areas were not set out to be conducive to conversation and we saw there was not always adequate seating space to support people's choice. For example, one lounge was designated for the viewing of the television , the other for music or the radio. We saw one person wished to be seated in the television room, however all the seats had been taken. Those seated in this lounge could not all view the television screen. There were no spare chairs to access when visitors called. One person had requested a room change and this had been facilitated. However they now shared a room and there was little space for personal possessions and no chairs for visitors. The visitors had to stand up during their visit.

People were able to personalise their space, and we saw that photographs and items of people's choice had been accommodated in their room. However there was no signage around the home to help support people to orientate. During the afternoon we saw one person asking for directions and becoming confused about their location. Staff did support this person and guide them to the persons area of choice.

People told us they enjoyed the food and said there was always a choice. The lunch was home cooked and people made gestures and noises of appreciation. We saw the meal was served in a timely manner so it remained hot. We saw people's weights had been monitored and when required referrals had been made to health care professionals for guidance and support.

Staff told us they received training for their role. One staff member told us about some training they had completed in relation to understanding Dementia. They said, "It covered different types of dementia and how people respond to these. I found it helpful and it opened my eyes to understanding people more."

New staff had received training which included the national care certificate. The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills to provide high quality care. The staff member told us, "The training was good and I shadowed a member of the team for one week. They were really supportive."
People had received access to healthcare services and on-going healthcare support. The provider had a link with the local surgery which provided a ward round every fortnight. The staff could contact them in between visits if they required additional advice. A health care professional said, "The staff are very responsive, they contact us if they need advice or if a person requires some attention. For example, the other week a person had removed their bandage, the staff contact us immediately." This action was also supported by comment from relatives. One said, "The staff spotted [Name] had been discharged from hospital with medication they were allergic to, so they took action to rectify this."

We saw that there was a mixed approach to some people's long term health care needs. For example, one person required a specific amount of fluid daily. A family member told us, "[Name] doesn't drink tea or coffee and that's all they serve from the tea trolley. So when they asks for squash they say, 'Ok, we'll fetch one for you', but they forget, because they're busy, and then they doesn't get a drink unless we get it." We saw there was no fluid chart in place for this person. Family told us there had been a recent meeting which had increased the level of fluid the person could have due to concerns about their hydration. There was no record of this increase or measures implemented to ensure the person received the fluids they required.

Other people who required specialist care for their health condition, received a positive approach. A relative told us when [name] came to the home staff had not got the experience to support their person's needs,

however they learn t the skills required. The relative said, "I was pleased with the way the staff had taken this new skill on board. It all seems to be working really well."

Good

Is the service caring?

Our findings

All the people and relatives we spoke with said the care was excellent. One person said, "The staff couldn't be better. They're brilliant and they never stop running around after everyone." Another person said, "I'm comfortable here, ducky. These staff are marvellous, they're very nice. " A relative also supported these comments, they said, "The building is run down, but the care and the service here is marvellous. The staff are fantastic. I don't know where they get their patience from." We saw that staff were knew people. For example, one person enjoyed reading their bible. The staff member located this and also provided the person with a blanket as they had said they felt cold. One staff member said, "I like working with people and talking to them. They always appreciate what you do."

We saw people had the opportunity to celebrate their own events or seasonal occasions. One relative told us, "When it was [name] birthday in the summer and they made her a cake, which was a lovely thought." Christmas celebrations had been held at the weekend, a local choir had entertained people and festive food was provided. A relative had emailed the registered manager thanking them for this event and expressing how much it was enjoyed by all their relative and family members. Relatives told us they felt welcomed to visit the home whenever they wished. Relatives told us they had received information when they had concerns or changes occurred.
People were able to choose when they go to bed and get up. Relatives said, "[Name] can stop in bed if they did not want to get up and have their breakfast whilst there." We saw that one person was enjoying holding a teddy bear that had been given to them by their great grandchildren. Staff spoke with the person about the teddy and ensured, when they put it down it was returned to them.
People said their relative's privacy and dignity was upheld. During the day we saw that residents were well dressed. One person tried to take their shirt off in the lounge; the staff clearing cups away spotted this and responded to encourage them to remain dressed. One staff member said, "It's all about knowing the person and providing that friendly face. Not telling them but asking and taking things at their pace." The registered manager told us in the PIR, 'We have been awarded the dignity award for 2017 and that dignity and kindness is at the centre of everything we do.' We saw this was displayed in the reception.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not up to date and we could not be sure they received the personalised care they required. The registered manager told us in the PIR, 'Every service user that is admitted to the home the manager reviews to ensure that we can fully meet the needs of the service user.' We saw that one person who was at the home for respite had not received an assessment. The person had been to the home previously in July for respite and their information had not been refreshed to reflect any changes. We also saw one person had been in hospital, their care records stated, 'To be reviewed following discharge.' This person had been home from hospital and their care plan had not been reviewed. The records for this person described their support needs as requiring a hoist to enable them to be transfer. We saw and the person confirmed they had made significant improvements and were now able to mobilise or use a wheelchair.

We saw that the care plans had not considered people's individual's communication needs. For example, were people had a hearing or sight impairment. They had also not reflected people's relationship. We saw that a married couple used the home; there was no reference to how they may wish to spend time together or how their relationship could be supported. The PIR said, 'Each resident has a care plan in place which is fully person centred and is reflective of their care and focus on outcomes.' This meant we could not be sure people would receive the care they wished in relation to their needs or preferences.

We saw that there were no care staff present in the lounges in the morning unless they were providing hands on care or serving drinks. In the afternoon care workers were only present if they were writing their notes or providing hands on care. On display in the reception was an initiative called, 'spire-time' which stated, 'At 2.30pm all staff to have 20 minute with the people whilst having a drink.' Residents and family members we spoke with, were not familiar with spire-time and had not noted it ever happening. Staff we spoke with confirmed this event did not happen. One staff member said, "This does not happen, it's a great idea, just not practical." Another staff member said, "I don't feel I can sit and talk to people, how I should. It's their home and we are here to provide them with company as well as care."
The home had an activities coordinator who provided stimulation and activities three days per week. People we spoke with recalled enjoying soft ball games, visits from the local church and some musical entertainers. Picture displays and family members also confirmed activities had taken place and they were noted to be enjoyed by people. However, all of the people and relatives we spoke with said there were not enough activities to keep people occupied and stimulated every day. One relative said, "I've been concerned about the lack of activities for people. I brought a floor game in for all the residents to play and they loved it, but it's been damaged now, so I need to try and find another one." Another relative said, "When I come I get them all talking, because they all like a chat, but the staff don't have time." The activities coordinator was relatively new in post and had placed a book in reception for ideas and comments. We saw these had been read and a proposed date of when they would be achieved placed against the suggestion. This supported the comments in the PIR, 'We listen to resident feedback and incorporate new activities based on this.'
At the time of this inspection the provider was not supporting people with end of life care. However in the PIR, the registered manager told us, 'Our residents and relatives have been fully involved in the planning of end of life care. Their choices and fears including their preferred place for end of life care.' The care plans

had a section which referenced people's preferences and any wishes; however these were not details and provided generic statements. A family member told us about their relative's wishes and said, "The staff know all about it." When we checked the care plan there was no mention of these special wishes. For some people a do not attempt cardiopulmonary resuscitation (DNACPR) was in place. A DNACPR is a document which instructs health care providers not to undertake cardiopulmonary resuscitation (CPR) if a person's s breathing stops or if the person's heart stops beating. The DNACPR is created, before an emergency occurs. However guidance states that the original copy of the DNACPR form with the original signature must stay with the person and follow the person when they change care settings for the DNACPR in order for it to remain active. We saw the home had a photocopy of the DNACPR, which meant the person's wishes cannot be legally followed and a photocopy would not be accepted by other health professionals if the person had to be transferred to a different locations, for example, the hospital.

This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People we spoke with understood how to make a complaint and we saw the complaints procedure was displayed in the reception of the home. However some relatives felt they did not wish to make a complaint and they did not want to, 'rock the boat.' We saw when complaints had been received, they had been addressed. However there had been no follow up taken to see if the action taken had resulted in the complaint being resolved. This meant we could not be sure people and relatives felt confident that their concerns were investigated fully.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection found whilst the provider was not in breach of any regulations there were aspects of care the provider had not always been pro-active in determining service improvements for people's care. We reported on these in our last report. During this inspection we found that these improvements had not been made.

There was a registered manager at Bank Close Care Home, and they had completed audits in relation to accidents and incidents. However, the analysis of these did not reflect any trends and they had not been reviewed month on month to consider any on-going risks to individuals. For example, the October 2017 audits showed that there had been six falls during the evening and night-time. The analysis stated there was no pattern, however we identified they were all at night time and all un-witnessed. There was no recorded outcome to identify, if the risk had been assessed or what action had been taken to reduce the risk of the person's falling again. The PIR said, 'All accidents and incidents are given to the manger to process and review. Audits have an action plan to drive improvement. All accidents, incidents, are recorded so we can monitor and analyse trends and ensure lessons have been learnt.' We saw there was no annual analysis of the accidents and incidents to consider long term trends. This meant we could not be sure that the audits were being used effectively to consider continuous learning and improvements.

There was a mixed view on the support from the registered manager. Some staff and relatives felt able to approach them and felt they were supportive. Other staff and relatives felt they were not, and told us they felt the registered manager did not always act or listen. All the relatives thought the deputy manager was approachable. One relative said, "The deputy manager is great because she used to be a carer and they seem to be the only one able to get [name] to have a regular shower."

We saw that the registered manager and provider had not always protected staffs rights and wellbeing. For example, staff told us and we saw they did not have an opportunity to take a break. Staff said they were not paid for half an hour on each shift; however they never had the opportunity to take a break. We saw staff took a piece of toast or sandwich whilst they worked. One staff member said, "You have to take your chance when you get it here. If you don't eat on the go you might not get anything to eat. And you might not even get a break when it's busy."
This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
The provider told us they aimed to have regular meetings with the registered managers at all their locations. This had happened in the past, however recently it was left to the regional manager who has since left the company. The provider said, "I want to review things in more detail and give them a chance to discuss things good and bad. They can share their knowledge."
The provider had asked for feedback from the people who use the service and relatives. We saw the results from the 2016 survey were available in the reception. The survey reflected mainly positive comments. The registered manager told us they planned to send out another survey soon to as this was an annual events to seek people's feedback.

The registered manager understood their responsibility of registration with us and notified us of important events that occurred at the service; this meant we could check appropriate action had been taken. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating and offered the rating on their website

We saw that the registered manager worked in partnership with other agencies. For example, the health service, the local church and school. The school had arranged a lunch and bingo and several people had agreed to attend this event. They plan to use the activities coordinator to consider other local links which could be made in the area, to support people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured the care was personalised to meet the person's needs. People had not been consulted about their care and preferences. The provider had not provided details in relation to people preferences and relationships. There wishes for end of life had not been considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The Provider had not ensured peoples safety through risk assessments. People had been supported to move incorrectly and not in relation to guidance or training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had been requires improvement in this domain at the last inspection. the improvements had not been made. Audits had been completed; however they had not always been used to consider trends and to drive improvements. the support available was not always consistent to support the staff so their rights and wellbeing was protected.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people.