Four Seasons (Evedale) Limited

Oaklands

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 14 and 15 April 2015 and was unannounced.

At the last inspection in September 2014 we found the provider was meeting all the requirements of the regulations we inspected.

We received whistle-blowing concerns about the service in February 2015 and we shared this information with the local authority who visited the home in March 2015. In April 2015 we received additional whistle blowing concerns so we brought forward our inspection of this service.

Oaklands is a 46 bed nursing home supporting older people some of whom live with dementia. At the time of our inspection 32 people were living there.

At the time of the inspection the manager of the home was not registered, but advised of their intention to apply to become registered. A registered manager is a person

Summary of findings

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. The manager of the service had recently returned to Oaklands after being away at one of the providers other services. Prior to leaving to work at another service they had been the registered manager of Oaklands for seven months.

There was not always enough staff available to meet people's needs. People told us that they felt safe living at the home and staff that we spoke with understood their responsibilities to protect people from harm and abuse. However, we found that people were not always safe from risks related to their needs not being met and not enough staff being available to support them.

The care and treatment people received was not always appropriate, at times the support provided did not meet their needs or reflect their preferences. Staff did not know people's personal preferences and care plans did not always contain sufficient information to enable staff to provide care in line with people's wishes or requirements. The provider was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of this report.

Peoples care was not delivered in a way that promoted their rights and freedom of movement. Staff had a limited understanding of the legal rights of people. Staff had received training to support them in their roles but it was not always evident that staff were working to meet people's needs as they intended. Staff did know how people liked to communicate with them.

Routines and practices observed of staff in the home did not always ensure that people were cared for with respect. Some staff were caring and had some understanding of the needs of the people but this was not consistent amongst the staff group.

Concerns and complaints had not routinely been responded to and had left some people being unclear if people were receiving the care they expected. We found that the provider did not have robust systems in place to ensure that concerns and complaints would be listened to and addressed quickly. The provider was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of this report.

We found that whilst there were some systems in place to monitor the service, they had not been effective. They had failed to address issues identified during the inspection that had impacted on the quality of the care and support provided. Processes in place for assessing the quality of the service were not consistently effective. The provider was not meeting the requirements of the law. You can see what action we 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.

Risks to people were not always acted upon to prevent the risk of harm to people.

People received their prescribed medication but staff did not follow safe practices for the recording and administration of medicines.

Staff were not always available to safely meet peoples needs in a timely manner.

Requires improvement

Is the service effective?
The service was not effective.

The provider had not ensured that peoples care was delivered in a way that promoted their rights and freedom of movement.

Staff had received training and support to carry out their roles effectively however some staff were not clear about what their roles entailed.

Requires improvement

Is the service caring?
The service was not caring.

Staff practice did not consistently ensure people were given choices about the care they received or the daily routines in the service.

People were not always involved in discussions and planning the care they received.

Requires improvement

Is the service responsive?
The service was not responsive.

Care plans did not always contain sufficient information to enable staff to provide care in line with people's wishes or requirements.

People were not supported to engage in hobbies and interests which were personal to them.

The provider did not have an effective system for the handling and responding to complaints.

Requires improvement

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

The providers own systems for monitoring the quality of the service were not effective to ensure people were being supported safely and appropriately.

People told us that the service had improved since the manager had returned.

Requires improvement

Oaklands

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 14 and 15 April 2015 and was unannounced. On the first day the inspection team included two inspectors, a specialist nurse advisor 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 service. On the second day of our inspection the inspection team included three inspectors.

Before the inspection we checked if the provider had sent us any notifications since our last visit. A notification is information about important events which the provider is required to send us by law such as unexpected deaths and injuries occurring to people receiving care. We used this information to plan what areas we were going to focus on during our inspection.

We spoke with the Local Authority who are responsible for monitoring the quality and funding many of the placements at the home and to four health professionals who supported people who used the service.

We spoke with eight people who lived at the home. We were unable to speak with some people due to their limited verbal communication so we also spent time observing people's care in the communal areas of the home. We also spoke to the relatives of five people who lived in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten staff members including care staff, nurses, domestic staff, chef, manager and deputy manager. We looked at five people's care records and other records that related to people's care to see if they were accurate and up to date. We also looked at medication records, staffing rotas, staff training records, quality assurance audits, complaints and incident and accident records.

Requires improvement

Is the service safe?

Our findings

People who used the service and their relatives told us that they felt that there was not always enough staff to meet people's care needs. One person who used the service told us, "Staff seem to be always busy, they are run ragged." Another person told us, "Staff are over-worked. There should always be someone in the lounge but they can't always do this." Three relatives and two staff we spoke to said that people sometimes experienced delays because two members of staff were not always immediately available to provide personal care. Two members of staff who had worked at the service for several years said that they had intended to read care records in order to find out people's personal interests and life histories but had not had time to do so. During our visit we saw that on several occasions' people had to wait before they were assisted and supported to receive personal care.

The provider had a system for calculating the number of staff required at each shift which was updated each month as people's care needs changed. The provider's rotas for the four weeks preceding our visit showed that the required number of staff identified as necessary to meet people's care needs had attended each shift. However we found evidence that staff were not always deployed efficiently. On two separate occasions when one person requested help to visit the bathroom the response was uncoordinated and disorganised. On one occasion this lack of effective deployment led to the person being supported to go to the bathroom by four members of staff in different inconsistent ways. The persons care plan stated that they needed two people to support them.

The deployment of and numbers of staff available to meet the needs of the people using the service were not adequate. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with said they felt people at the service were safe. One person who used the service told us, "I feel safe, when I ring my buzzer staff arrive in a few minutes." Another person told us, "I feel safe, I am being looked after." The relatives of five people and two health professionals who supported a person at the home also told us they felt that people were safe and that staff provided care in a safe manner.

All staff spoken with knew the different types of abuse people were at risk of. Staff told us that if they had concerns then they would pass this information on to a senior member of staff or the manager. Staff knew the different agencies that they could report concerns to should they feel the provider was not taking the appropriate action to keep people safe. Staff told us they were confident that the manager would respond appropriately to concerns.

We saw that the provider had taken action when they received information of concern. We spoke to the manager and deputy manager about recent safeguarding concerns they had notified us about. The provider was currently investigating these concerns which included interviewing members of staff.

There was information around the home encouraging people to raise concerns if they felt anyone at the service was unsafe this included details of the profiler's safeguarding policies and other external agencies they could share this information with.

The provider conducted assessments of people's care needs and when necessary produced guidance for staff about how to manage the risks associated with people's specific conditions. Relatives of several people we spoke with said they had not been involved in deciding what the risks were to individuals. Therefore it was unclear if these assessments contained all pertinent information staff required to keep people safe.

We saw that people were not always cared for in line with their risk assessments. A person who required support with their mobility had to use another person's walking frame which was not adapted to their specific needs as their own could not be found. People had developed pressure sores while living at the home however assessments to protect people from this risk were not being completed accurately by staff. Four people's pressure relieving mattresses were not at the appropriate settings and some mattresses were different to those identified as necessary in people's care plans. This put people at increased risk of developing pressure sores.

People we spoke with said the service supported them to receive their medicines safely. One person told us, "I am looked after, I am getting my tablets." Another person said, "They give me pills three or four times a day." Staff were able to explain the provider's medicines policy for reporting medication errors and records showed that staff had

Requires improvement

Is the service safe?

received training in how to manage medicines safely. The provider provided evidence of competency assessments they had conducted to ensure staff were able to administer medicines safely.

We saw that some people had medicines prescribed to be taken only when necessary. A nurse on duty was able to tell us how they supported a person to take a medicine which was for use only when they were in pain. We saw that controlled medicines were stored safely and the systems in place ensured that controlled medicines were administered as prescribed.

We audited some of the boxed medicines in the home and found several discrepancies with the balances of the medicines held in the home. Balances held did not cross reference to the amounts that had been received into the home and what had been administered. All the discrepancies showed the balances were higher that they should have been which indicated that some people had not received their medicines as prescribed. The providers own system for checking and monitoring systems and records in the home had failed to identify these auditing issues. Medicine trolleys were kept locked however we found the door to a treatment room could not be locked, although we were told this was in the process of being repaired. A cupboard and fridge in this room that stored medicines were not locked. This meant that people were able to access medicines inappropriately until the repair had been made.

Requires improvement

Is the service effective?

Our findings

Most people we spoke with said the service was meeting their needs. One person told us, "They support me as I want to be supported." A relative said, "Everything seems fine."

People who used the service told us that staff did not always have the skills and knowledge they needed to meet people's specific needs. A relative said that staff did not always understand what a person's behaviour meant or knew how to communicate with the person. They told us, "Some staff are good [at communicating], some staff are not good at all." Two health care professionals who visited the service told us that staff they spoke with did not always know the current care needs of people who lived at the home and the health care professionals said they would often have to approach the manager for further information about people's latest care needs and conditions.

Staff told us they had regular training in the skills they needed to meet the needs of people at the service. Staff we spoke with could demonstrate what people's specific gestures and movements meant and we observed staff demonstrate a variety of communication styles depending on the specific needs of the person they were communicating with. There were two members of staff who were responsible for ensuring that staff had knowledge of the correct use of hoists However during our visit we noted that staff did not hoist people in line with recognised good practice. We raised this with the manager and they took action during our visit to update their hoisting guidance for staff.

The Mental Capacity Act 2005 (MCA) including the Deprivation of Liberties Safeguardings (DoLS) sets out what must be done to protect the human rights of people who may lack mental capacity to make decisions to consent or refuse care. Staff told us they had completed MCA training and could explain people's differing levels of capacity.

People who used the service and relatives told us that staff would approach them for their permission to provide personal care. However we observed that this was not always done and that the wishes or agreement of people using the service was not always obtained before staff provided care or made everyday decisions on their behalf. Throughout our visit we observed staff regularly change television channels without asking if this is what people wanted. We saw a relative instruct staff to take a person to the hairdresser who was present in the home but the staff did not approach the person to ask if this was what they wanted to do.

The manager was knowledgeable about their responsibilities under the MCA. Records confirmed that best interest assessments and meetings had been carried out when a person was thought to lack capacity and included, where appropriate, people's relatives in the decision making process. This supported decisions to be made in line with people's known wishes and values. The manager could identify those people supported by others who had lasting power of attorney to make decisions on their behalf and also explained the plans they had in place to support people to vote in a forthcoming general election.

The provider had made DoLS applications to the local authority when a person was under constant supervision. However there was a lack of knowledge amongst the staff we spoke to about other practices which could compromise a person's liberty. We noted one person was sat in the lounge but they were unable to leave their chair because staff had left their walking frame in their bedroom. Staff we spoke with were unaware that his could be a restriction of the person's liberty. We saw that the provider had not always obtained authority to covertly administer a medication to a person without their knowledge.

Everybody we spoke with said they enjoyed the food. One person told us, "The food is well cooked, we do get some choices." However, some people told us they felt the portions were too big which made them less appetising. We noted that a lot of food was left on plates when people had finished eating. People were given appropriate adapted crockery and cutlery when necessary to help them eat their meals however staff did not always ensure that plates were well positioned to ensure that people could easily eat their food.

Staff were able to tell us what people liked to eat and how they needed their food to be prepared, although we saw that when some people were served food that they could not manage staff did not intervene, offer support to cut up food or to provide an alternative meal that the person could manage. The food served to some people became cold as they took a long time to eat and no offer was made by staff to reheat the meal or provide an alternative. Whilst

Requires improvement

Is the service effective?

most people ate their meals in the dining room some people were supported with their meals in their bedrooms, and we observed that staff provided individual one to one support and encouragement to ensure that people received adequate food and drink to meet their needs.

People's weight was monitored to ensure they were receiving adequate nutrition and care records contained guidance for staff about how to support people to receive the nutrition they required to stay well. We noted however that a person who was at risk of choking was not served a pureed meal in line with their care plan. The deputy manager told us that the person did not require pureed meals however the guidance for staff had not been updated. We spoke to the chef who told us that they were regularly kept up to date with people's dietary requirements and explained how they would prepare meals throughout the day according to people's preferences. There were drinks available in the lounges for people to help themselves to and also dedicated drink services at set times to support people who were unable to help themselves to drinks.

People had access to a range of health care professionals to ensure their needs were being met. A person told us, "I've been helped when I needed to go to appointments at hospital." During our visit people were supported to meet with a GP and a social worker who were visiting the service to review people's care needs. We looked at the records of people who were at risk of tissue damage. We saw that they had received regular visits from a specific health care professional who had left instructions for staff about the care each person required. We noted however that staff had not always recorded if they had provided care in accordance with these instructions and we saw that a health care professional had recently raised concerns that a person's skin integrity had deteriorated because staff had not followed their instructions. We spoke with three health care professionals as part of the inspection and all said that although they had concerns about the quality of care people received they felt it was improving due to the efforts of the new manager to ensure that specific instructions were carried out and records made.

Requires improvement

Is the service caring?

Our findings

People who were able to tell us said that they were mainly happy with their care and that staff were kind. A relative told us, “Staff seem polite and helpful.” Three members of staff we spoke with told said they had developed caring relationships with the people at the home and spoke fondly about the people they supported. A member of staff commenting on how they liked to provide care told us, “The best thing about working here is the people.”

We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw that staff were respectful and spoke with people kindly however we noted that the vast majority of conversations were to discuss people’s specific care needs and not to engage in person centred conversation which promoted peoples’ wellbeing and social inclusion.

A member of staff explained how they had supported a person to knit when they found out this had been a hobby they enjoyed. But four other members of staff we spoke with were unable to tell us people’s life stories and what occupations or interests they engaged in before joining the service, although this information was available in people’s records. Not all staff were able to demonstrate a person centred approach when delivering care to people.

The service had several systems to support people to express their views about the service. Care plans contained evidence that people were supported to comment about the quality of care they received and how they wanted their care to be delivered. A relative told us that they were expecting a person to receive a specific treatment when they arrived at the home however this had not happened. They had not been given an explanation why this was or involved in making decisions about the person’s care plan.

People were not always actively involved in making decisions about the care they received throughout the day. We noticed that on several occasions staff did not always attempt to find out people’s personal preferences before providing care. We saw several examples of people receiving personal care and grooming without staff first asking if this is what they wanted. . We observed staff members switch television and radio channels without seeking the views of the people who were watching and listening to the programmes. People were not consulted if they wanted to take part when a religious service was held in the lounge and the provider had not given people the choice to worship in private had they wished.

Staff were aware of the need to protect people’s privacy and dignity. We observed staff refer to people by their preferred names and adjust people’s clothing in order to maintain their dignity. Staff told us that they received regular training in this aspect and records confirmed this. We observed staff close curtains and doors when providing personal care. Peoples clothing and personal belongings were managing well by processes and systems in the home.

We noted that during meal times people were not always supported by routines and staff practice. One person who had sat waiting at a dining table for lunch, was moved from the table so that they could receive some planned treatment from a nurse. There was no explanation provided to the person as to why they had been moved from the table when waiting for lunch or when they could expect to receive their lunch. We saw that the person was served their lunch 45 minutes after first being seated at the table before they were moved away. No regard had been afforded to the impact this had on the persons enjoyment of their meal.

Requires improvement

Is the service responsive?

Our findings

During our visit we saw that staff responded promptly to people's request for help. People who used the service told us that staff were generally responsive when they required support however we observed that staff were sometimes unaware of how people wanted to be supported.

Visiting health care professionals told us that they had recently complained that staff had not always responded to their instruction in order to ensure people received the appropriate care as their needs changed. One care professional told us that this had resulted in it taking longer for a person to recover from a specific condition. Staff were unable to tell us at what firmness people's pressure relieving mattresses should be set at. We found that four out of five pressure relieving mattresses we looked at were not at the settings identified as necessary in their care plans. This meant that staff were not responding to professional instruction provided or following systems to support people whose pressure areas were at risk of from deteriorating. The complaints made had not been acted on.

People had mixed views about the quality of activities people were supported to engage in. A relative told us, "When the activity worker is here, she spends time and does things with some of the residents." They also told us that no activities took place when the activities coordinator was away, as care staff were not available to support people at these times. One relative told us, "They [people in the lounge] never move out of their chairs." Another person told us that their relative, "Sits in the chair all day long." During our visit we never saw any person being supported or prompted to go out into the garden and enjoy the warm weather.

A member of staff said they had supported a person to pursue a specific hobby but we observed that people were offered few activities to engage in during our visit and people were left to entertain themselves by viewing television or listening to the radio. There was a dedicated activities coordinator working at the service who had just returned after several months' absence. People who used the service and relatives told us that the provider had not ensured that planned activities were delivered consistently during the person's absence. The manager confirmed this.

During our visit we observed that the activities coordinator spent much of their time providing personal care such as supporting people to eat and drink and was not able to get engaged in responding to people's expressed interests.

A person who used the service and the relatives of two other people said that the provider did not always support them with their preference to go shopping in the community. One member of staff said they could not always take people out when approached because this would result in other people at the service being left without support. We observed several group activities taking place during our visit however people were not approached for their view on whether they wanted to participate or not. We saw that a person who was visiting the service conducted a religious service in the lounge without seeking consent from people. Whilst some people were seen to be joining in and enjoying the occasion some people who did not want to take part in the service were unable to continue to pursue their chosen interest or were unable to leave the lounge without support. The provider did not always seek out or respond to people's preferences to ensure the support they received was in line with their wishes.

There was information about the provider's complaint's process around the home and people told us that they felt they could raise concerns. However relatives we spoke to said they felt the provider did not always take their concerns seriously. One person told us, "We have raised several concerns and are still waiting to hear what's happening." A member of staff told us, "Relatives are fed up of going into the office. Some of them now call the regional manager direct." A few weeks prior to our visit we received information from the relatives of two people who used the service. One relative told us that they were frustrated because the provider had not responded to their concerns and another person confirmed they had contacted the area manager because they were frustrated with the lack of response from a senior member of the home staff.

The provider did not have an adequate system to record and review comments and complaints about the service. We spoke to the manager and deputy manager about concerns several people said they had brought to the manager's attention however there was no record of these issues being raised or discussed with the manager. The provider did not keep records of concerns people had raised or if they had been resolved. The provider's system

Requires improvement

Is the service responsive?

to learn from concerns and complaints to prevent incidents from reoccurring was not robust. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Investigations into concerns were not thorough. Prior to the inspection we had received information from the provider about an investigation into an incident which resulted in a person who used the service suffering a serious injury. The provider had investigated the concerns however they failed to follow up on the potential seriousness of the person's injury or identify how to prevent similar incidences from occurring. We also identified that some complaints had been allocated to staff for investigation, and the staff member who had been delegated to investigate had been implicated in the complaint. This meant that there was a risk the investigation would not be impartial. The providers own system to investigate complaints was ineffective.

Requires improvement

Is the service well-led?

Our findings

The manager of the service had recently returned to Oaklands after being away at one of the providers other services. Prior to leaving to work at another service they had been the registered manager of Oaklands for seven months. Whilst they were not the registered manager at the time of the inspection they advised of their intention to apply to once again become the registered manager.

Staff we spoke with said that the manager and deputy manager were approachable and welcomed their opinions on the quality of the service. However people who used the service and relatives had mixed views about the accessibility of the manager. One relative told us, "The manager seems to be getting things done, however they never introduced themselves to us." Some relatives we spoke with said they regularly visited the home and were welcomed by the deputy manager but were not approached for their views. The relatives of two people told us that they had seen the manager but had not spoken to them. During a period when there had been no manager in the home the deputy manager told us that they had been unable to fully manage the service because they were also responsible for working most of their shifts as a nurse at the service.

Some people who used the service told us that they regularly saw the manager conducting audits and challenging incidences of poor practice and felt the monitoring of the quality of the service had increased since she had returned.

The provider attempted to promote a culture which valued the views of people who used the service. The provider had sought the views of people who used the service and their relatives to identify how the quality of the service could be improved. People told us that they were encouraged to express their views at meetings but a member of staff said that it was difficult to support some people to express their views because communication aids had not been used. However there was no evidence about how the views of people had been used to improve the service. The provider had organised relatives meetings but these were poorly attended. The manager said they had advertised the meetings and held them at different times in order to engage with people's relatives but this had been unsuccessful.

The provider had systems in place for daily exchanges between staff of information about peoples care and support needs but not all staff said that these meetings were effective. Two members of staff said that handover meetings were not always effective at identifying or alerting staff when people's conditions changed. One member of staff spoke about how they were unaware that a person had suffered bruising because they were away when it had been discussed, they told us, "If I am not on duty I don't know what was said at recent handover meetings and I have to ask other staff." Another member of staff said, "The information [at handover] is not always up to date, however I can discuss it with the nurse on duty." Nursing staff told us they regularly met with the deputy manager to review the quality of the service.

Systems in place for auditing the quality of the service and for ensuring the accuracy of records of care and treatment provided to people using the service were not effective. Nursing staff told us that they regularly reviewed people's care notes for accuracy and to ensure that people were supported in line with their care plans. We looked at five care plans and saw that they were some incomplete records. It was not possible to review if people had received the care they needed to maintain their health or if the care provided was in line with their wishes. Some care plans contained unclear guidance for staff putting people at risk of receiving inconsistent support. The provider's audits of the records had not highlighted the omissions or unclear directions. An audit of medication records was conducted during the inspection by senior staff in the home. The audit did not identify any concerns with how people's medications had been managed, however we identified several errors with how people's medicines were recorded that the providers own audit had failed to identify. We saw that an assessment of one person's mental capacity had not been fully completed so there was no clear guidance for staff if the person concerned had capacity. The providers system for checking that records were accurate and complete had not identified these issues.

We found that the provider had conducted several audits to review the quality of the environment and equipment used in the home, however, many records had not been completed for several months. There was no assurance that checks of hot water temperatures were safe and appropriate or that hoists had been maintained and checked providing assurance that they were safe to use. The checks on the maintenance of the property and

Requires improvement

Is the service well-led?

equipment did not ensure that people would be protected from the risk of harm. Floor coverings and wall surfaces were generally worn and in some places presented a potential trip hazard. We saw that the protective coatings on some furnishings and equipment were also worn and these issues had not been identified in the providers audits. We also found that the systems in place to take action to reduce identified risks were not effective. During the first day of our visit we observed that staff had identified a wheelchair was not safe to use, however it was not withdrawn from use until the following day.

Policies and guidance provided for staff to ensure that they delivered consistent and safe care to people were not always available or up to date. Guidance related to the administration of "as required" (PRN) medications were inconsistent and on occasions lacked sufficient detail about how much medication had been given, placing people at risk of not getting medication they needed. Staffs were unable to confirm if the medication policy available in the home was the latest guidance available.

The providers system to ensure that staff were skilled and trained to carry out their duties and responsibilities was not effective. Some individual members of staff who were appointed to lead and train other staff in specific tasks told us they did not have the knowledge they needed to training people properly. No assessment of the staff competency had been carried out. We also found that an infection control lead member of staff had not been appointed to. An infection control lead member of staff has a key role in ensuring that safe care and treatment is provided by staff who are aware of their own role in the prevention and control of infections.

The provider's processes for assessing, monitoring and improving the safety and quality of the home were not consistently effective. There were no effective systems in place related to the supervision of staff, maintenance of records and management of risk assurance systems so that the provider could evaluate and improve practice in the home. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home management were supported by the provider's regional staff. The regional manager who was present in the home one the first day of the inspection, was newly appointed and at the time of the inspection had not been involved in audits and monitoring of the home.

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 Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not operate an effective system for identifying, receiving, recording, handling and responding to complaints. regulation 16(2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have robust systems in place to ensure were able to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 4 to 20A). Regulation 17(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People who use services and others were not protected against the risks associated with unsafe or unsuitable care because the provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (1)**