Mrs Dahiya

Sailaway Residential Care Home

Inspection report

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20 February 2019
26 February 2019
10 April 2019

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:

Sailaway is a residential care home that provides personal care for up to 18 people aged 65 and over. At the time of inspection 16 people were living at the service including those with Parkinson's disease, diabetes and people living with dementia.

People's experience of using this service:

●The registered provider is the person who is usually in day to day charge of the service. They had been absent from Sailaway for a period of more than 28 days during November and December 2018. On the 20 February we were told by the manager that the provider had been absent since the 10 February and was not due to return until the end of April.

The person left in charge during the manager's absence is referred to in this report as 'the manager'. This person was not registered with the Care Quality Commission and was not legally responsible for how the service is run or for the quality and safety of care provided.

The manager did not demonstrate an understanding of the knowledge and skills required to manage a care home. We observed that they did not have the skills and competencies to meet people's assessed needs and keep them safe. The manager had visited the service up to three times a week. When they were not in the service there was no clear leadership or responsible person in charge.

●People were not always protected from abuse and improper treatment. Systems and processes to protect people from abuse were not operating effectively. The manager and provider had not always reported incidents to the local authority safeguarding team. Staff did not know how to report a safeguarding incident or concern. This placed people at significant risk of harm as allegations and injuries were not being responded to appropriately.
●Incidents were not always recorded or addressed appropriately, risk assessments were not robust and did not always cover relevant risks.
●New staff had not always been recruited safely. Processes were not in place to ensure people were suitable for the job they were applying for or that new staff were of good character.
●The rota did not always ensure that there were medicines trained staff on duty. This meant that some people did not always have access to "As required" medicines for pain relief and other prescribed medicines.
●Advice and recommendations of external healthcare professionals were not always followed.
●People did not always receive person centred care that met their needs and preferences. There was a risk that new or agency staff would not know how to meet people's needs safely or in accordance with their personal wishes and preferences as care records were not always up to date.
●Risks were not always clearly assessed for people. The action staff may need to take to safeguard people

from harm or to provide person centred care was not always detailed in their care records.
●People did not have any meaningful stimulation and occupation. People told us that there was little to do and they spent most days in the lounge with the television on. They did not get an opportunity to go out unless it was with a relative or friend.
●Aspects of leadership and governance of the service were not effective in identifying some significant service shortfalls, such as failing to assess, monitor and mitigate risks relating to the health and safety and welfare of people.
●Some parts of the premises were not secure, clean or properly maintained.
●The provider could not evidence that there was an accessible complaints process and whether complaints were investigated. People were unsure of how to raise a complaint.
●Information about the service was not always in an accessible format for people to understand.
●There was limited information for staff on people's communications needs in accordance with the Accessible Information Standards (AIS).
●People told us that the food was very good and they had enough to eat and drink.

Rating at last inspection:

Good. (The last inspection report was published on 19 April 2017)

Why we inspected:

The inspection took place on the 20 and 26 February 2019 and was unannounced. The inspection was brought forward because of concerns raised to CQC from the local authority. We had been told that there was a long-term absence of the registered owner and lack of effective management oversight by the person left in charge. Staff lacked knowledge and skills to support end of life care and there were not always sufficient numbers of staff on duty.

We visited the service again on the 10 April 2019. This was announced to assess the improvements the provider had made since our visit on the 20 and 26 February 2019.

Enforcement:

This service met the characteristics of Inadequate in three key questions, safe, effective, and well led, and Requires improvement in two key questions; caring and responsive. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded We are taking enforcement action and will report on this when it is completed.

Follow up:

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'special measures' by CQC. We will keep the service under review and, if we do not propose to cancel the registration we will re-inspect within 6 months to check for significant improvements.

The purpose of special measures is to:

●Ensure that providers found to be providing inadequate care significantly improve.
●Provide a framework within which we use our enforcement powers in response to inadequate care and

work with, or signpost to, other organisations in the system to ensure improvements are made.
●Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Sailaway Residential Care Home

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

The inspection team consisted of one inspector on the first day, two inspectors on the second day and one inspector on the third day.

Service and service type:

Sailaway is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sailaway accommodates 18 people in one adapted building. The service has two double rooms currently used for single occupancy. There are bedrooms on the ground and first floors, those on the first floor are served by a stair lift. There is one communal area which is a lounge-diner and leads into a conservatory.

The provider is the manager registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced on the 20 and 26 February and announced on the 10 April.

What we did:

●We looked at the information we held about the service, as well as information received from the service. We reviewed notifications the provider had submitted. A notification is information about important events the provider is required to tell us about by law.
●We did not ask the provider to complete a Provider Information Return (PIR) this is because the inspection was unannounced and we were responding to information shared with us by the local authority. A PIR 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 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 to us.

Before, during and after the inspection we reviewed records and spoke with;

•□Two health and social care professionals who work with the service.
•□Notifications we received from the service.
•□Records of accidents, incidents and complaints.
•□Fifteen people's care records
•□Audits and quality assurance reports
•□Spoke with nine people using the service; four relatives; six staff and the manager.
•□Viewed eleven medication administration records.
•□Reviewed the most recent fire safety inspection report (4 March 2019)

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse.

●Some people did not always feel safe. Three people told us that the behaviour of other people frightened them. We were told that sometimes people shouted, swore and got angry and when this happened "sometimes people get hurt and there is blood". We checked this person's records and saw that the person received medical assistance at the time. CQC referred this incident to the local authority safeguarding team, as the provider had failed to do this. Another person told us about a person who lived at the service who "gets very angry, it's quite scary". They commented, "I don't like it when I see people get hurt, especially the staff".

A visitor to the service told us about a disclosure made to them from a person who described being scared at night and another said that they felt bullied by a person living at the service. The visitor had not made the provider aware of this. CQC referred the disclosure to the local authority safeguarding team.

●Systems and processes to protect people from the risk of abuse were not operating effectively, this placed people at risk of harm as allegations and incidents were not being responded to appropriately.

Unexplained bruising for one person was documented on a body map and in the person's daily notes as 'big and black'. A week later this person was noted to have an unexplained skin tear to the same area. These injuries had not been reported as accidents or incidents and no considerations had been made by the provider to identify other possible causes. This meant that the person was at risk of repeated injuries because there was a failure to identify the root cause and enable preventative measures to be taken.

The same person was recorded as having red nail marks and bruises to their hand. They said that this had been caused by someone that they described as being a 'nasty person'. This direct allegation was documented, but had not been responded to. The daily notes showed that there was no consideration given to safeguarding this person, and the manager was unable to demonstrate that the allegation had been considered, or reported to the relevant authority for consideration under safeguarding guidance. This placed the person at further potential risk of harm.

In response to the serious concerns of allegations of abuse, we raised three safeguarding alerts to the local authority, as the provider had failed to act to ensure the people's safety.

People were not always protected from abuse and improper treatment. The provider had failed to respond to allegations and record, report and investigate safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users

from abuse and improper treatment. Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management.

●The provider had not ensured people were protected from environmental risks. Environmental risk assessments were out of date and we observed some poor practice with environmental safety. Two external fire doors were ill fitting and obstructed by rolled up blankets to prevent drafts and rainwater entering the building. In the event of a fire people would be placed at risk as these fire exits were obstructed. We showed this to the manager who immediately removed the obstructions and arranged for a contractor to visit the service later that day to assess what work needed to be carried out to make the doors safe. Subsequent visit to the service showed that work had not been undertaken to make the doors fire safe.

We notified West Sussex Fire Safety of our concerns. They carried out a routine evaluation of the service on 4 March 2019 and believed some people were at risk in case of fire. There were many areas of concerns, some fire doors were not capable of preventing the spread of fire and required proper testing and maintenance and some work was necessary to reduce the risk fire and smoke spreading. The provider has been issued with a schedule of works, which they were required to undertake within the next three months.

●The provider's environmental risk assessment had assessed the following as low risk; people leaving the premises without staff knowledge; people gaining access to the main road; unknown persons entering the building. These risks were reduced by the rear door being kept locked, a key pad on the reception door and alarmed fire exits.

At the inspection we showed the manager that two external doors were unlocked and the security alarms on both doors were disconnected. Staff did not know where the key was for one of the doors or the last time it had been locked. They told us that it was a significant amount of time ago, and we observed that the keyhole contained cobwebs. The other door was reported by staff to have been left unlocked for at least five days as the key was missing. The reception door was closed and two out of the three staff on duty did not know the code for the keypad. As this was also a fire escape route some people would have been prevented from exiting the property in the event of a fire.

Staff told us that the unlocked door at the rear of the property could be opened from the outside. This meant that the premises were not secure. Both unlocked external doors gave unrestricted access to the outside and placed people at risk of potential harm by having direct access to a main road in front of the property. We fed this back to the manager who said that they would arrange for a contractor to attend the service to address the concerns we had raised.

On 10 April 2019 work had not been undertaken to ensure these doors were fire safe or secure. One external door leading directly onto the front garden had remained unlocked as the key was still missing. The alarm had not been repaired to alert when it was opened and its location on the ground floor next to three bedrooms made it easily accessible to people. People were exposed to the potential risk of harm as reasonable steps had not always been taken to assess and mitigate risks.

●Visitors to the service did not always feel that their relatives were safe. Two people told us they had witnessed verbal and physical aggression from people living at the service. They told us that they had spoken to the provider and the manager about this on more than one occasion as they were not assured of staff's ability to manage such situations.

Staff training records showed that three staff had undertaken e-learning for behaviours that challenge. The

rota showed that there was not always someone sufficiently trained to manage actual or potential aggression on duty. Staff and visitors told us that one person had shown aggressive behaviour towards other people on a regular basis. The support plan for this person did not give clear guidance to staff on how to support their behaviour or manage situations where their behaviour was presenting as a risk to others. Staff told us that they did not feel suitably trained of confident to support people who had challenging and aggressive behaviour. This meant that people were at increased risk of harm as staff did not have the right skills to keep people and themselves safe.

The provider had failed to assess, record and do all that is reasonably practicable to mitigate the risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008(regulated Activities) Regulations 2014. Safe care and treatment.

Using medicines safely.

● People did not always have access to their prescribed medicines. There were five occasions in February 2019 when there was no one on duty trained to administer medicines. This had occurred because the manager thought that staff who had completed e-learning were safe to administer medicines, they were unaware that these staff also required a competency assessment. This meant that people who are prescribed medicines to be taken as and when required (PRN) did not have access to this because there was no one to administer it. We spoke to the manager about this.

When we visited on 10 April 2019 we saw that this practice had continued and we identified three more occasions when medicine trained staff were not on duty. This meant that people continued to be at risk of potential harm and discomfort because they did not have access to their prescribed medicines.

The manager gave us their assurance that they would ensure that the rota reflected at least one medicine trained staff was on duty for every shift. They asked the senior support worker to undertake medicine competency assessments for staff who had not undertaken this face to face training.

The provider had failed to ensure that staff were suitably trained and competent to administer medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008(regulated Activities) Regulations 2014. Safe care and treatment.

●Some medicines were not stored safely. Medicines due to be returned to the pharmacy were stored in a cardboard box on top of a filing cabinet in an unsecure office close to some people's bedrooms. The box contained over 500 tablets, that were not secured and were accessible to people. We observed the office door to be unlocked and staff confirmed that this was usual. We informed the manager of our concerns and they arranged for the office door to be locked.

At the inspection there were three occasions when medicine keys were left unattended. On two occasions they were left in the locks of the medicine trolley and a medicine cabinet and on another occasion the manager found them unattended and handed them to staff.

A person's medicine box was stored on a shelf in the kitchen. The kitchen door was propped open and had direct access from the lounge. This box had a timer to alert when a person Parkinson medicine was required and contained the medicine the person required for that day. We saw staff dispense medicine from this box and replaced it on the shelf. This meant that people were at risk from accidental ingestion of other people's medicines because requirements for the safe storage of medicines were not being followed.

On 10 April 2019 we observed that this medicine box was stored securely within the medicine trolley which was locked, however staff told us that sometimes they keep the box in their pockets so that they can be alerted to the alarm sounding. This meant that staff were not ensuring that medicines were being stored correctly or safely.

●Procedures had not always identified that people did not have access to prescribed medicines. For example, one person was prescribed additional pain relief to be used when required to alleviate severe back pain. The person's daily notes record that the person is in constant discomfort. The person's medicine record showed that this stronger pain relief medicine was not available to them during January and February 2019 as it had not been requested by the service.

During the inspection the person was complaining of back pain, we asked staff if there was any additional pain relief the person could have and were told, "no, not really". This meant that the person may have experienced avoidable pain and discomfort because prescribed pain relieving medicines had not been available to them. We raised this as a safeguarding concern to the local authority. During further visits to the service action had been taken to address this and the person's prescribed medicine record had been updated to reflect this.

One-person's medicine record showed that their medicine was prescribed at 8pm. Records for the last 12 months showed that staff had been signing to say that it was given at 5pm. This medicine is for a health condition that requires it to be given at very specific times. We saw that there was a discrepancy of administration times between a hospital letter dated March 2017 and the current medicine administration record. The manager had not sought to clarify which time was the correct one as they were unaware that the practice of administering the medicine at a different time to that stated on the person's medicine record was happening.

People were being placed at potential risk of not receiving consistent and safe care and support because the provider had not acted to ensure the proper and safe management of medicines.

The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008(regulated Activities) Regulations 2014. Safe care and treatment.

●We observed medicines being administered to people during a lunch time. Staff checked medicine charts against people's medicines pods before dispensing them and only signed for medicines once they had seen people take them. Staff used a non-touch method when dispensing medicines from individual boxes of medicines. People were asked if they required pain relief and were given time to consider their response.

Staffing and recruitment.

●Staff employed were not always recruited safely. This was because not all the documentation and evidence to make safe recruitment decisions had been obtained. This did not ensure those being employed were suitable to work with people who are in receipt of health care and personal care. For example, where Disclosure and Barring Service (DBS) checks showed a criminal conviction, there was no evidence that the risks associated with the disclosure had been considered. We asked the manager about this and were told that they did not have any processes in place to consider the risks of employing people with criminal convictions. The manager told us that they would take immediate action to address the concerns we had raised. Despite this being fed back to the manager to address during our initial visit, subsequent visits showed that no action had been taken.

● Confirmation of the recruitment documentation relation to the manager was not available for us to view during all our visits. This includes DBS, qualifications and training suitable for the role. Following several requests this was provided. The manager confirmed that some of the information they had provided was not up to date and did not reflect a true account of information held about them. The manager told us what action they were going to take to address this which included renewing DBS checks for all employees of the service to ensure information held was accurate and up to date.
●Where a person's pre- employment check had identified a health disclosure, there were no systems or processes in place to assess their fitness or suitability to the role. The manager told us that they did not have any processes in place to assess risks associated with people's health or consider if work place adjustments might be required. Despite this being fed back to the manager to address during our initial visit, subsequent visits showed that no action had been taken.
● This meant that people may be receiving care and support from people who are not suitable for the position they have been employed into.

Safe recruitment practices were not followed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Fit and proper persons employed.

●The provider did not always assure themselves of people's safety when determining staffing levels. The dependency tool that was in place did not accurately reflect people's level of need as outlined in their support guidance. The information from the dependency tool was used to determine the staffing rota.

During the afternoon, evening and night there were two staff on duty. Some people's support plans said that they required two staff for some aspects of their care and this was not reflected in the dependency tool or rota. This meant that there were periods of time where there were no staff available to other people. For example, the support guidance for a person who had behaviours that challenge outlined the need for 1-1 support from staff to provide reassurance to them when they were is a state of raised anxiety and aggression. The risks to people of not being able to seek assistance when they required it had not been assessed which placed people at risk from not receiving the help they wanted.
●Some relatives told us that they thought that there was enough staff to support people's personal care needs, but there was not enough staff on duty to take people out or provide activities. They also told us that when they visited their relatives there were often long periods of time without staff in the communal areas and on occasions they had to provide support to other people. For example, we were told that shortly after our inspection a visitor witnessed two people being physically assaulted by a person who lived at the service, one person was pushed over and sustained a head injury. The visitor told us that they had to shout for staff assistance to call an ambulance and were left to provide first aid to the injured person whilst this happened. We were also told that the first aid box was empty at the time.

We spoke to staff about this, they told us there were two staff on duty at the time, one was an agency worker. They could not recall where they were at the time of the incident and confirmed that staff were not present. Staff told us it was usual for people to be left alone for long periods of time in the communal areas and did not have a means to summon assistance such as access to call bells. They told us that they had been alerted to the incident by the visitor calling for assistance.

●Care staff prepared and cooked all the meals and we asked how this impacted on responding to people's support needs in a timely manner. Staff told us that they felt the staffing was adequate and as most people received personal care at set times they could manage this around meal preparation.

We observed that a large saucepan with vegetables cooking in boiling water was left unattended on a gas

hob in the kitchen for 15 minutes. The door between the kitchen and lounge was wedged open and the boiling liquid and naked flame were left unattended due to there being no staff in any of these areas. Although we did not see anyone enter the kitchen, the situation presented itself as a hazard and staff had failed to consider the potential risks of fire or injury to people when leaving the area unattended. The manager was informed of the risk.

●During all the inspection days there were enough staff to support people's personal care needs and provide appropriate meal time support. However, on each day there were more staff on duty than planned as the manager had asked some staff to stay on duty to support the inspection process. The manager informed us that plans were in place to review staffing levels if more people moved into the service or if people's needs changed significantly.

On 10th April 2019 the manager told us that a new person had recently moved into the service. They told us that they had reassessed their staffing allocation and this did not show that they needed to increase the amount of care staff on duty. However, to enable care staff to be released from cooking the meals, they were in the process of recruiting a chef.

Learning lessons when things go wrong.

●On 10 April 2019 we found that the provider had not taken steps to improve the service to learn lessons from the concerns we had identified on the 20 and 26 February. Further improvements were required to systems and monitoring arrangements for the ongoing quality and safety of the service to ensure people were robustly and consistently protected from the risk of harm and avoidable abuse.

Preventing and controlling infection.

●The carpets in the communal halls and stairs were very dirty and did not present as being cleaned for a significant amount of time. In some bedrooms carpets were heavily stained in places. Staff told us that the service did not have a regular schedule for cleaning carpets and were unable to tell us the last time this happened. The service did not have a schedule for deep cleaning and this is an area that the manager said they would improve.
●Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination.

Inadequate

Is the service effective?

Our findings

Effective – this means people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not achieve good outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Ensuring consent to care and treatment in line with law and guidance

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●Staff were not always obtaining consent before providing care or treatment and we did not observe staff asking people if they could support them with personal care, we saw people being told that it was time for their personal care then being taken to their rooms. MCA were not undertaken prior to people receiving the flu injection and the manager confirmed this. Staff were not familiar with the principles and codes of conduct associated with the MCA (2005) or how to apply those.

Staff said that they were unsure what MCA and DoLS were and did not know how they related to people living at the service and told us that they were confused as to what MCA and DoLS were. Staff that we spoke with were unsure if anyone living at the service had a DoLS in place.

●The inspector requested an overview of the current Deprivation of Liberty Safeguards (DoLS). The manager informed us that there was no process in place for this and said that no one had a DoLS authorised. Records held within the service showed that at least three people had DoLS in place. One person had conditions associated with their DoLS application which were not being met. The manager said that they had not been aware of this. For one person this meant that the manager could not be assured that the person had received a medicine review to ensure that the medicine they were prescribed remained necessary and in their best interests.

●Mental capacity assessments and best interest decision making were not always being undertaken in line with requirements. For example, for one person their MCA assessment did not contain any information as to how the person's capacity had been assessed or how the decision that the person lacked capacity was

made. It did not give information as to those involved in the assessment and document was not dated or signed. This meant that the person's capacity may have been wrongly assessed as the requirements of the MCA had not been correctly applied. The document stated that the decision should be reviewed monthly and there was no evidence that this had happened.

A review of one person's medicine care plan showed a hand-written entry by staff stating that the GP had advised to give medication covertly, without the person knowing. There was no record of a mental capacity assessment or best interest meeting involving health professionals, family members or advocates to agree whether administering medicine covertly was in the persons best interest.

Failing to ensure that staff comply with the principles and codes of conduct associated with the Mental Capacity Care Act (2005 and that they can apply these appropriately is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014. Need for Consent.

Staff support: induction, training, skills and experience.

●Staff were not always able to demonstrate the required level of competence and skills in areas they had undertaken training in. Processes were not in place to check that staff had the competencies, skills and experience required for the role. Training records were not monitored and there was no evaluation of the outcome of staff training.

The training records for eight staff showed that two had not completed safeguarding training and training records for staff who were administering medication showed that three staff had not undertaken face to face competency assessment. Staff told us that they did not receive supervision or appraisals which meant the provider could not be assured of staff knowledge and competence following training.

One staff who had undertaken safeguarding training told us that "bruises should be reported to the manager because if someone else sees them I might get the blame", another told us that if they witnessed abuse they would talk to the member of staff and ask why they did it and then they would phone the manager. Neither staff considered the impact of abuse for the person or the persons immediate safety and wellbeing.

● Medicine practice did not always show that staff understood practices in the administration of medicines. For example, staff went to a person's room at 11.30am to give them a drink. Staff were observed picking up a tablet that was on the person's table tray and giving it to them to take. This tablet was not checked against the person's medication record and was assumed to be one the person had not taken in the morning.

A person had recently been admitted to hospital after being given another person's medicine and this was confirmed in the hospital discharge letter. This placed the people at potential risk of harm from receiving the incorrect medicine as staff failed to follow safe practices. We were notified of this at the time by the provider who also referred to the incident to the local authorities safeguarding team.

●The provider did not have a robust induction programme for staff to prepare them for their role. Staff who were new to care had not undertaken the care certificate. This is an agreed set of 15 standards that sets out the knowledge, skills and behaviour expected of people working in health and social care. There was no record of induction for this person and the manager was unable to confirm what induction they had undertaken.

●Staff told us that they completed several shadow shifts before working on the rota and were given access

to e-learning which they accessed independently on the computer. There was no record of supervision and staff said that they were not aware if their performance was being monitored. The manager confirmed that there were no formal processes in place to ensure staff were supported, skilled and assessed as competent to carry out their roles.

Staff were not trained to meet the needs of people who had specific health and support requirements. Some services users had Parkinson's disease and some people were living with dementia. There were people who were known to have behaviours that could be challenging to others. The provider's on-line training gave staff access to e-learning training in these areas. Training records showed that some staff had accessed training in specific topics such as epilepsy, dementia, challenging behaviour and Parkinson's diseases, however this was not consistent through the staff team and the provider had not taken measures to address this.

The effectiveness of staff training and the competency of staff was not monitored to ensure that they had the skills and knowledge to fulfil the requirements of their role.

Failure to ensure that staff were supported to undertake training, learning and development to enable them to fulfil the requirements of their role is a breach of regulation 18 of the Health and Social Care Act (Regulated activities) Regulations 2014. Staffing.

Supporting people to eat and drink enough to maintain a balanced diet

●People were at risk of potential weight loss as their nutritional needs were not always being met. For example, one person's nutritional care plan stated that due to weight loss the nutritionist recommends adding cream to porridge to add calories. Care staff cook the meals and those on duty were unaware of the requirement to fortify this person's meals. This person was continuing to lose weight. For another person, their weight was not being monitored weekly as advised in the care plan. This was fed back to the manager who said that they would take immediate action to address this.

Until it was highlighted to the manager and appropriate food supplements had been obtained, some people were at risk of weight loss. This was because they were not receiving nutritional supplements in line with their assessed needs. The medicine records for a person showed that they had been prescribed a supplement to increase calorific intake. Their medicine assessment record (MAR) for January and February 2019 state that none was in stock. It was not apparent what had been done about this even though this person had been losing weight.

We discussed our observations with the manager who told us that they were not concerned as people's food records shows that they are eating all their meals. There was no consideration of the impact for this person of having a low body weight or why they are continuing to lose weight even though they are eating all their meals.

Failing to mitigate the risks to a person's health by not ensuring that medicines, including prescribed food supplements are administered accurately and in accordance with the prescriber's instructions is a breach of Regulation 12 of the Health and Social Care Act (Regulated activities) regulations 2014. Safe care and treatment.

●People had constant access to drinks. Hot drinks were given at set times of the day and people had glasses of water and juice which the staff always kept topped up. We saw people requesting a hot drink and this was made for them.

●Meals were prepared and cooked by the care staff. Although people told us that they did not know in advance what the meal was, they told us that the food was very good and that they were always given a choice of two things once the meal was ready. One person said, "I love the porridge although some staff make it better than others it's always good" Another told us that the meals were always good, they had so much food they were putting on weight", another described the meals as wonderful and plentiful. We saw meals being presented in an appetising way and served hot.
●On 26 February the manager ordered a fish and chip supper for everyone. People were very excited about this, one person said that this was very unusual to have a takeaway but "it smelt good and tasted fabulous".

Staff working with other agencies to provide consistent, effective, timely care.

●Feedback from visiting professional reflected a lack of clear processes in place for example, care plans were not in regular use as they could not be located and staff did not seem to know where records were kept. The culture of the service was described as task focused and engagement between staff and people was observed to be poor. One health care professional told us that they had visited on a regular basis and had never seen a manager.
●The provider did not always seek the support and advice of health care professionals available to them, for example local authority resources and training to support staff care for people with dementia and Parkinson's disease. The manager told us that this was an area they planned to improve and were looking to utilise the local authorities' training opportunities to enhance staff skills and knowledge.
●One healthcare professional said that the staff had worked closely with their team to follow a rehabilitation plan to discharge someone from hospital. This had been very successful and had a positive outcome for the person involved.

Adapting service, design, decoration to meet people's needs.

●The decoration, furniture and fittings in the service were tired, and in some places in a very poor state of repair. We discussed this with the manager on our initial visit and they told us that they would get a contractor in to address the concerns we had raised.

In one person's bedroom large areas of the wall where the plaster had blown and was flaking, leaving several piles of plaster dust on the floor. This had been caused by damp and the bedroom was noted to be very cold.

Another person's bedroom had a smashed window that had been boarded up, this was approximately one meter by one meter in size. The material used to board over the window had evidence of paint on it that suggested that it had been in place for some time. The manager could not remember how long this had been like this but stated that it had happened "a long time ago". In other bedrooms we saw holes in plaster board, stained carpets and some were frayed. One person's bedroom floor was uneven and had a noticeable slope towards the window which could impact on the mobility of the person. Another person's divan bed base was visible and heavily stained and some bedrooms smelt heavily of urine. Several bedrooms on the ground floor were very cold. The manager confirmed that they felt very cold and commented that they had recently had the radiator in one of the rooms repaired.

●Some outside doors remained ill-fitting and daylight could be seen between the frame and the door. Some other parts of the building were also in a state of disrepair.
●The manager told us that they had met with a contractor who was going to undertake remedial work in the service. They were unable to give a date for this work to start as it had not been arranged.

The provider had not ensured that the premises were secure, clean and properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act (Regulated activities) Regulations 2014. Premises and equipment.

●For people living with dementia the provider had not ensured that the environment met national good practice guidance. There was a lack of signage to help people orientate themselves and the majority of décor was in neutral colours. For some people living with dementia the neutral colours mean that they may not have been able to distinguish the difference between doors, sanitary fittings and walls. We discussed this with the manager who told us that they would look to guidance on how to address this whilst taking into consideration the needs of others and maintaining a homely environment.
●There was stair lift for people who had bedrooms on the first floor and were unable to use the stairs. Some people who were assessed as being at risk from falls had sensor mats in their bedrooms to alert staff if the person had fallen or was moving around their room. We saw staff responding to the alarms for these mats and outside doors being opened in a timely manner.
●Bedrooms reflected people's personal preferences and belongings and there was art work in some of the communal areas that had been prepared by people living at the service.

Supporting people to live healthier lives, access healthcare services and support.

●People had access to healthcare services. One person told us that they had had a headache for a few days and staff had ensured that they had seen a doctor. During the inspection there was a visit from a community healthcare professional and records showed that people also had access to chiropody. Staff sought medical assistance when they were concerned about people and there was evidence of hospital admissions and visits by the emergency services.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence.

●Some people were not always treated with dignity or respect. One person had been sitting in the conservatory for most of the morning. At lunch time they were supported to walk to the table for lunch. This person was noted to have been heavily incontinent which had soaked through their clothing. The staff supporting this person was made aware of this by one of the inspectors but did not support the person to change. A plastic-coated pressure cushion was instead placed on a dining chair and the person was supported to sit down. The person remained in this clothing whilst they ate their lunch.
●For one person their daily routine record outlines their preference to eat at the dining room table with other people. It also stated that it is important to them to know what is for dinner and with staff support they can make a choice of what they would like to eat. We observed that the person was asleep in the lounge. Staff attempted to put a large "bib" over the person, but as they were asleep it was placed over their head and left to rest over their arms and hands. Once everyone was eating their pudding staff woke this person up stating, "I have your lunch, its pork casserole". The person was very sleepy, and staff began to feed them large mouthfuls of food stating, "You like, it, don't you?". Food was placed in their mouth whilst they were still finishing the previous mouthful. After the main meal the person was almost asleep, but was fed banana custard, without being told what it was. This meant that the person did not receive a positive meal time experience that was in line with their preferences.
●The provider did not always maintain people's privacy in respect of unauthorised access to confidential data by ensuring that that personal information was stored securely. In an unlocked room next door to bedrooms, personal documents belonging to people were left in a pile on an unused desk. These documents were from 20017-2018 and contained personal data, such as financial information. This meant that people could not be assured that their personal and sensitive data was being protected and handled in line with General Data Protection Regulations (GDPR).

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity.

●Systems and process were not in place to enable people to make decisions about their care. Records did not always contain enough personal details to enable staff to know how to support a person to express their views or make decisions and choices about the care they receive. We spoke to the manager about this and they told us that they were planning to implement a key working system to address this. They said that staff will receive training and guidance to enable them to undertake the requirements associated with key

working responsibilities.

● Staff communication with people when they were not supporting people with direct care was poor. After lunch we observed staff sitting at the dining room table talking to each other. Staff were not making any attempt to talk to people who were sitting close by. We asked one staff why people were not being offered activities and we were told that "afternoons were boring" and "personal care is done, people are best left to sleep after their lunch". Staff did not demonstrate an understanding of the benefits of positive communication for people who have care needs or who are living with dementia.

●On10 April, we saw that this had improved. We saw some very positive interactions and people were being included in conversations and activities. People were more engaged and alert and the atmosphere in the lounge was very sociable. People were observed to be chatting with each other, there was lots of laughter, staff were initiating conversations and very few people sleeping.

●People told us that staff were kind to them and that they did not feel rushed when they were being supported. One person said, "The staff are nice and helpful". Another told us that the care team were very good, but sometimes they wished that there were more of them.

●We saw that when staff did engage with people they showed compassion and were caring.

●People were supported to receive visitors at the service. One person told us that they enjoyed visiting their relative, they were made to feel welcome and could pop in at any time.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

End of life care and support.

●We had been notified by the local authority that they were concerned that staff were not adequately trained to support end of life care and had recently raised a safeguarding regarding a delay in a person receiving end of life medicines.
●Prior to the inspection and in response to concerns raised to us by the local authority we asked the manager if anyone at the service was currently receiving end of life care. They told us that one person was. The following day we inspected the service and were informed that this information was incorrect and no one was currently receiving end of life care.
●We spoke to staff about how they would support a person with end of life care. They told us that they had supported someone recently with end of life care but had not been trained at the time. Some staff told us that they had received training for this following the safeguarding raised by the local authority and others told us that the manager was going to arrange training for them. The manager told us that some staff had undertaken e-learning and that they were planning to have face to face training provided by the local hospice in May although this had not yet been booked.
●Staff said that they were not confident in how to support a person through the final stages of their life, but all demonstrated the need for compassion, acknowledging that would be a difficult time for the person's family and friends.
●Staff told us that they did not feel adequately supported to discuss end of life care issues with people or their relatives. They told us they were pleased the provider was arranging training for them.

Failing to ensure that staff have the skills and knowledge to support people with end of life care is a breach of Regulation 18 of the Health and Social Care Act (Regulated activities) Regulations 2014. Staffing.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

●People did not always receive a person-centred approach to having their needs met. Assessments and risks assessments lacked important details, which impacted on the care plans developed for them and meant that staff had limited care direction.
●People did not always receive support in a timely way or receive a person-centred approach to having their needs met. For example, we observed that following lunch staff went around the lounge in a clockwise rotation telling people "it's time for you to go to the toilet". This process continued after lunch until everyone had been supported to the toilet. There was no consideration for the individual continence needs of people.
●One person asked three staff over the course of 45 minutes if their skirt could be changed because it was wet. They were told that it was not their turn and that they would have to wait as other people were being 'changed'. When staff did come to support the person, they came with a wheelchair. The person questioned

why they were being asked to go in a wheelchair and asked for their walking frame, which staff fetched.

● Records contained personalised information about people's preferences, social backgrounds and things that were important to them. However, this information was not transferred into people's individual care plans or reflected in the day to day support that they received. Staff did not use this information to support people in a personalised way. For example, one person it was important for the them to listen to classical music and that they enjoy people reading to them. During all of our visits we did not see this person having access to any of these things.

●For some people who had support needs specific to their health, care plans were not in place to enable staff to support them in line with their assessed needs. For example, a person living with diabetes did not have a care plan in place that provided guidance on how to support them to manage their health and diet. There was no guidance to recognise when the person's blood sugar was unstable or what actions might be required. This meant that staff who were new to the service and did not know people well, would not have sufficient information to look after the person effectively.

●Another person was sleeping on an electronic pressure mattress without any formal assessment to see if this was suitable for them. This person had a diagnosed spinal condition and a history of back pain. The mattress was not plugged in which meant the person was sleeping on an non-functioning air mattress that they had not been assessed as requiring. This meant that the person's spinal condition had the potential to be aggravated by having an inappropriate mattress on their bed. CQC raised a safeguarding concern to the local authority regarding this.

We discussed this with the manager who told us that the mattress was on the bed when the person moved in and they had not considered if it was appropriate for them. They told us that they would arrange for the person to be assessed by a health care professional to identify a suitable mattress for their diagnosed health condition.

During subsequent visits to the service this had not yet happened and we observed that the person was still using the air mattress and an assessment had not been arranged. When we entered the person's bedroom the person was lying on their bed and the air mattress was not switched on.

Failing to ensure that people receive person centred care and treatment that is appropriate to their needs and reflects their personal preferences is a breach of Regulation 9 of the Health and Social Care act (Regulated Activities) regulations 2014. Person centred care.

●There was a lack of activities for people to support people's wellbeing and provide meaningful stimulation and occupation. Visitors and staff told us that people often spent most of the day in the lounge sitting in the same chair. For people living with dementia there was a lack of stimulating activities that gave purpose and pleasure. Staff were unaware of the positive benefits for a people being engaged in suitable meaningful occupation to improve their quality of life.

●We observed the television remained on the same channel. One staff told us that this was because one person gets upset if the television channels get changed so staff keep the remote control. We observed a person asking for the television to be changed as they wanted to watch a quiz programme. After three requests they went to their room as the channel was not changed, no one appeared to be watching the television and most people in the lounge were asleep.

●There was an activity programme for one activity each morning and afternoon. On the days we inspected the scheduled activities were not taking place and arrangements had not been made to replace them. Activities seen on three days of inspection was watching television, jigsaw puzzles and colouring books.

●Relatives told us that people did not go out unless they had a relative to take them. This was confirmed by staff. One relative told us that once a month a person comes into do art with people and that's popular, we

could see evidence of this around the home. Another relative told us that most of the time its relatives that initiate bingo or puzzles as there is very little to do.

● Over the course of the inspection gradual improvements were made to activities. People told us that they would like activities such as singing and gentle exercise. The manager had started to arrange for a person so come into the service and engage people in a range of activities. People told us that they were enjoying this, one person told us that they had been singing which was good fun. We also saw that the television was being used for a music channel and we saw that people were enjoying this and one or two were singing to some of the songs they recognised. These positive improvements were not yet embedded and sustained and this is an area of practice that needs to improve.

Improving care quality in response to complaints or concerns

●There was no record of complaints of concerns at the service. It was unclear if complaints were being appropriately addressed due to the lack of recording. The manager told us there had been no complaints and put this down to everybody being satisfied with the service they were receiving.

●We asked people if they knew how to make a complaint and people were unsure. One person told us that they would tell the provider, another said that they would tell their relative, other told us that they did think that they could complain.

●There was a complaints policy in place however there were no accessible complaints process available to support peoples understanding of the process.

●Relatives told us that they would complain to the provider or manager. One person told us that they had raised concerns in the past but had never received an outcome. We spoke with the manager about this who told us that they were unaware of the concerns this person had raised and had been unable to find any record of them.

●From 1 August 2016, all providers of NHS and publicly funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social care act 2012. Services must identify, record, flag and meet people's information and communication needs. Information about the service was not in an accessible format for people to understand. Peoples care plans did not include information about people communication needs. We recommend that the provider obtains information, sources training and implements policies and procedures in relation to compliance with AIS.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means the service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

●The service was not well-led. The manager told us that the registered provider had been absent from the service for period more than 28 days during November and December 2018. When we inspected on 20 February 2019, the manager told us that the registered provider had been out of the country for two weeks. On 10 April 2019 the provider was still absent from 10 February 2019 and we were told that they would be absent for at least three more weeks.

The registered provider did not notify CQC of either absence lasting 28 days or more. This is a breach of Regulation 14 Care Quality Commission (Registration) 2009. Notice of absence.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support.

●There has been a lack of supervision and oversight by the provider of the manager left in charge during their absence. The manager was unable to demonstrate that they understood the knowledge, skills and competencies required to meet service users' assessed needs and keep people safe.
●The manager has not been providing day to day management oversight in the service. They told us that they visited the service up to three times a week and lived an hour away by car. When they were not in the service, there was no clear leadership or responsibility for each shift.
● There was concern that the provider had not taken ownership or fulfilled their obligations and responsibilities. They had not ensured effective oversight and monitoring of the quality of services and the safety of people. For example, they had not monitored or supervised staff to ensure that people were receiving a safe and effective service and that systems and processes were being adhered to.
● Staff told us that that they did not receive supervision, another told us that their last supervision session was over two years ago. The manager was unable to provide any confirmation or records of staff supervision and told us that this was an area they planned to improve.
●Process were not in place to monitor the effectiveness of staff training or evaluating training records. The provider had not ensured a process for assessing staff's learning, areas for development or if further additional training or support was required. For example, the advice given by the e-learning training provider for medication safety states that "The completion of this e-learning module does not provide your competence to administer medication. You must undergo additional face to face training to enable you to administer medication to individuals."

We spoke to the manager about face to face medicine competency assessments and they were unaware of this requirement. The manager's lack of knowledge and understanding of this and their lack of oversight of

the rota had led to five occasions in February 2019 when there was no one on duty trained to administer medicines. This meant that people did not always have access to the medicines they needed when they needed them.

●The systems for assessing, monitoring and improving safety and quality of the service were not always effective and had not identified the serious shortfalls found during inspection. The manager told us that there were not currently any audits in place to monitor standards of care in the service.

We spoke with the manager about our concerns regarding, failing to follow safeguarding guidance, unsafe management of medicines, lack of process to monitor accidents and incidents, environmental safety, failure to follow safe recruitment practices and the lack of up to date information and guidance within care plans. Subsequent visits to the service conformed that no improvements had been made by the manager to address these.

●The provider did not have oversight of medicines and had failed to implement a process to audit and monitor these to ensure people were receiving their medicines as prescribed by a medical practitioner.
● Systems were not in place to enable the provider to oversee accidents, incidents and allegations or to identify safeguarding concerns, themes and trends and to try and prevent a reoccurrence. The manager told us that they were unaware of some of the safeguarding allegations that had been identified during our inspection, including allegations noted within the service's own records. This was because the way incidents were being recorded made it difficult for the provider to retrieve essential information for them to be able to do this.
●Governance systems to monitor and review care plans were not robust and failed to ensure that care plans provided clear and accurate guidance for staff. Care plans were reviewed by the same person each month. The process did not involve people, their family or other staff and did not have management oversight.
● The lack of management oversight of documents meant that the provider had failed to identify that support was not always being given in line with health professional guidance or that some people were not receiving care in line with their support plan requirements.
● There were multiple examples where care records lacked sufficient detail or were not being completed accurately in relation to the care provided. For example, at 3pm on20 February everyone's activity record had already been completed for that evening.
●For another person their care plan records them as being at high risk from falling and needing two staff to support full personal care and mobility. The overview page on the outside of their file, designed to give new staff and agency staff, a brief over view of the person, stated that the person's "mobility is generally good and they can cover large distances independently". This meant that the person was at risk of not receiving the correct support as the provider did not have a robust system to ensure people were receiving the care they needed and that records were accurate.
●Systems were not in place to ensure staff had up to date information and that policies were reviewed and up to date. The provider's safeguarding adult's policy was last reviewed in 2013 and did not include the most up to date information on the local authorities' safeguarding adult's guidance, or how to report a concern including contact numbers.
●The Fire risk assessment was due to be reviewed in March 2018, but there was not record that this had happened. The manager could not locate the last fire inspection report and did not have a system in place to ensure oversight of fire safety.
●A review of the environment and fire safety records showed that the provider was not ensuring safety checks were being carried out appropriately. For example, records showed that on the 18 February 2019 the fire escape routes were checked and recorded as "all areas checked and in good working order". However, our observations were that two external fire doors were being obstructed and two fire doors were ill-fitting.

●Processes were not in place to audit safety requirements. Guidance was not available for staff to follow when a safety check showed that action was required and staff did not know who to call in an emergency in the absence of the manager. For example, the manager was unaware that one person's electro-magnetic fire door opener had been bleeping for three days prior to the inspection because staff told us they were waiting for the manager to change the batteries.

This lack of guidance meant that for the person whose bedroom this was and for those in bedrooms located nearby they had had to endure the sound of the fire door bleeping whilst they were sleeping. People were also placed at risk in the event of a fire as this door was being propped open with a wooden door wedge and piece of cloth. In the event of the fire alarm system being activated this door would not have automatically closed to prevent the spread of fire or smoke.

There was not an adequate process for assessing and monitoring the quality of services provided and that all records were accurate and complete. This was a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated activities) Regulations 2014. Good governance.

●Service that provide health and social care to people are required to inform CQC of important events that happen in the service. The provider had not always informed CQC of significant events in a timely way. This included two incidents identified in the service records that should have been identified as a safeguarding concern. This meant we could not check that appropriate action had been taken. A new system had recently introduced to monitor accidents and incidents and support the provider to have oversight. This contained one record and needs times to imbed its self for the provider to be assured of its effectiveness.

The provider had failed to notify CQC of relevant incidents that affect the health and safety and welfare of people using the service. This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care.

●People were not engaged in the running of the service. For example, they were not consulted in decisions about everyday living such as menu planning and activities. People had to rely on their relatives and friends to support them to uphold their religious beliefs and records showed that consideration had not been given to people having equality or protected characteristics. The manager told us that there were no systems and processes in place that would support this currently but it is something that they are considering for the future.
●There was not an established or structured approach to continually evaluate and improve the service or act on feedback from people and stakeholders. The provider had signed up to an online portal for receiving feedback about the service but this was not being monitored on a regular basis. There was also a suggestion box in the main reception. The manager told us that the suggestion box is rarely used and they had not logged into the online portal for over a year.
●The manager told us that the provider did not have a process in place to monitor and act upon feedback and that they used the opportunity of the Christmas tea to speak with individual families and gain feedback on the service their relative was receiving.
●This meant that the provider had failed to ensure that processes were effective in monitoring, assessing and improving the quality and safety of the service provided.

Working in partnership with others.

●The provider did not have any links with local organisations or external bodies for the development of the service. The manager told us that they did not attend local provider meetings arranged by the local authority but this was something they were considering for the future.
●The manager told us that people did not have the opportunity to engage in activities and events in the local community unless they were going out with a relative or friend. There was little evidence of people coming in to the service to provide social and recreational activities. On 10 April we saw that this is an area that had improved.