Cheriton Care Centre Limited

Maumbury Care and Nursing Home

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

This was the first inspection of Maumbury care and nursing home

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Maumbury care and nursing home provides care and support for up to 37 older people. At the time of the inspection there were 21 people living at the home.

Summary of findings

The leadership within the home needed to be improved. The provider did not have an effective system to check the quality of care people received at the home. Peoples individual care records were not always accurate and there no evidence that the systems in place to evaluate and improve the care being given were being implemented.

The systems and procedures for the safe handling of medicines were not safe and improvements were required. The system in place for the auditing of medication required improvement as it did not identify or plan for areas of improvement.

The risks people faced were not consistently acknowledged in people's care records. When people were at risk of falls these were not acknowledged in their care records. Whilst staff were aware of the risks there was insufficient guidance to meet individual needs consistently. Care records were not always accurate and reliable.

Staff had little time to sit and talk with people or to meet their social and emotional needs. This also had an impact on the staff's ability to meet people's individual needs in a dignified and respectful manner. People could not be confident of receiving care at the time they wished because there was not always enough staff available to meet people's needs. The language, both written and verbalised, that staff used to describe the people they cared for, was not always respectful.

Most staff had received induction training either prior or when they started work at the home. The provider had a plan in place to ensure all staff received the training required for them to meet people's individual needs. We observed a number of care practices that demonstrated staff required more training in order to support people in a dignified and individual way.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the 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?

Requires improvement 

The service was not consistently safe and improvements were required. The medicines administration was not safe at the home. People were put at risk of not receiving medicines as the systems in place to prevent the home running out of stock had failed. Medicines were not stored safely.

People had risk assessments and care plans to keep them safe but some of these records required to be updated. This put some people at risk of harm that could be avoided or minimised.

There were not always sufficient staff on duty to meet peoples social and emotional needs.

Is the service effective?

Requires improvement 

The service was not always effective at meeting people's needs.

People could not be sure that staff had the necessary skills and knowledge to meet their assessed needs, preferences and choices and respect their rights.

Systems in place to prevent people from the risk of malnutrition and dehydration were not effective.

People had access to health and social care professionals when required, staff were proactive in ensuring emerging needs were acknowledged and acted upon

Is the service caring?

Requires improvement 

The service was not consistently caring and improvements were needed.

Staff did not always demonstrate that they treated people with respect and dignity.

Staff were not fully aware of people's daily routines and supported them in a task centred way

Some people could make individual choices about how they spent their time but not all. People were not always treated as individuals and their preferences were not fully recognised.

Is the service responsive?

Requires improvement 

The service was not consistently responsive to people's needs. Care plans were in place but these were poorly collated and sometimes inaccurate.

People were not always encouraged to be actively involved in their care. Activities when provided were not based on people's individual needs and aspirations.

Summary of findings

People knew how to raise concerns. Staff knew how to respond to complaints if they arose.

Is the service well-led?

The service was not consistently well led. The system to ensure the quality of the service was reviewed and improvements made was not effective at driving standards up.

Staff confirmed the registered manager was approachable and they felt listened too.

Requires improvement

Maumbury Care and Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11,13 and 23 of November 2015 and was unannounced. The inspection was completed by one inspector on the 11 and two inspectors on the 13 and 23 November 2015.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about and feedback from relatives. At the time of the inspection a Provider Information Record (PIR) had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In order to gain further information about the service we spoke with seven people living at the home and six visiting relatives. We also spoke with 12 members of staff.

We looked around the home and observed care practices throughout the inspection. We reviewed six people's care records and the care they received. We looked at people's medication administration records, (MAR). We reviewed records relating to the running of the service such as environmental risk assessments, fire officer's reports and quality monitoring audits.

We contacted four health care professionals involved in the care of people living at the home to obtain their views on the service as well as fire officers form Dorset Fire and Rescue Service

Observations, where they took place, were from general observations. We also 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.

Requires improvement

Is the service safe?

Our findings

Medicine management was not safe. On the first day of the inspection we observed that there was a medication on the table. The packaging and medication had no "open or expiry date" on it to indicate when it had been opened or a discard date. The registered manager told us that the medication is discarded after one month when new medication was dispensed. We noted that a person's clinical dressings' were on the floor in an opened box and not stored safely, this was addressed when pointed out.

We looked at the medication trolley that was in use at the time on the first day of the inspection.. We saw that there was some lozenges on top of the trolley which was left unattended whilst the staff dispensed medication in another area. As these lozenges were not secured or supervised, people may have picked them up and taken them, putting them at a possible risk of harm.

We looked at the Medication Administration Records (MAR) in use at the time which showed that medicines were administered as prescribed. The registered manager gave us small sample of the contents of MAR to look through. These MAR evidenced that two different people had not received their pain reliving medication for two days as they had 'run out of stock'. We looked at the auditing of medicines management for the period of time in question. The providers system was to look at 10 peoples MAR each month for auditing purposes. The medication management audit did not reference the out of stock pain reliving medication, the action taken to address this or indicate a plan of how to prevent this in the future. We spoke with the registered manager of our concerns over this issue. They did not tell us what they had done to ensure people were not in pain. They told us that they had problems with the pharmacy dispensing the medication but there was no recorded evidence to support this. The systems in place for the management of medicines were not safe and put people at risk of unnecessary pain. The above illustrates a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control practices were not consistently safe. On the first day of the inspection at 8.45 am we observed that in one person's toilet area there was personal care equipment, towels and used gloves discarded on the floor as well as soiled pants, in the sink a towel was soaking in water. We spoke with staff on duty about our observation who made arrangements to clear the area. In another person's room a soiled nightdress was on the floor at the end of the bed, the person laid in bed naked. Again we informed staff of our observations, they removed the nightdress and ensured the person was appropriately clothed. We spoke with the registered manager who acknowledged our observations. They told us the nightdress may have been removed by the person themselves which staff confirmed. However the person' care records did not evidence this behaviour nor was there guidance to staff on how to effectively clean the area where the soiled nightdress was in order to ensure the person's room was clean of any spillage's .

We spoke with staff about infection control within the home. They told us about the procedures they used to prevent cross contamination such as using disposable gloves and aprons. Some of the staff identified the registered manager as the infection control lead but not all which meant they were not clear as to who to go for guidance and support. We noted that there was a letter to all staff stating the homes uniform policy regarding the wearing of jewellery and how to wear their hair, it asked all staff to comply with this. We noted that not all staff were adhering to this policy including the registered manager. As jewellery and wrist bands hinder the effective washing of hands to not comply with there dress code undermined the providers' infection control policy.

People told us that they felt safe in the company of the staff. One person told us "there is nothing to worry about here". Most of the risks people took were evidenced in their care records but some lacked the detail to inform staff of how to keep people safe. For example, staff told us that one person was unsteady, on their feet required a degree of supervision and were at risk of falling. We looked at the persons care records that did not contain a risk assessment in relation to falls. We spoke with the registered manager about this person. They told us the person had never fallen and they did not consider it was necessary.

We looked at the systems in place to ensure those that were at risk of skin damage had their risks minimised. In three peoples care records we noted guidance to staff in relation to repositioning people whilst in bed. In two of these people's care records the frequency of the repositioning was not consistently recorded. For example, in one part of the records it stated to reposition every three

to four hours whilst there was also instructions to reposition every two hours. Health care professional's had also raised concerns over this issue. We looked at the records made by staff to evidence the repositioning of individual people. We noted that these were not always completed, one persons' repositioning was overdue. We pointed this out to staff who made arrangements to address this. We spoke with the registered manager about our concerns that people were not being repositioned. They told us people were repositioned but staff were not recording their interventions and reassured us this would be addressed.

We noted that these three people were laid on a pressure relieving air mattress. We looked in people's care records to establish what setting the air mattress should be set at.(if pressure relieving mattress are incorrectly set they can cause further skin damage. The pressure setting is set according to weight.) These people had not been weighed although their care plans stated they should be. The last time one of the people had been weighed was on 19 August 2015. This meant that people were at risk of harm as the system used to set the equipment up safely was not being used. The above illustrates a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The building was not safe in all areas as the provider had not fully complied with the requirements of the Regulatory Reform (Fire Safety) Order 2005). A fire officer from Dorset Fire and Rescue had carried out an inspection of the property in November 2015. They raised concerns that the provider had not made suitable arrangements for a fire safety risk assessment to be carried out by a competent person. As such a number of actions were needed to be taken to address the issues identified. This meant that people may be at risk of harm as the fire risk assessment was not sufficient to protect people from the potential risk of fire.

People told us there were enough staff to meet their needs. One person told us "there is always someone about to help me". We spoke with one person who was dressed and in their bedroom at 8.55 am. They told us they were waiting for a member of staff to help them to breakfast. We asked them how long they had been waiting, they told us " I am not sure but it seems a long time". Some staff confirmed that there was always enough staff on duty to support people but not all. One member of staff told us that in their at times they were short staffed. Prior to the inspection a relative had raised concerns that there was not always sufficient staff to meet people's needs.

We looked at the staffing rotas for the preceding two weeks and talked with staff about the usual staff allocation at the home. Staff told us that normally there were four care staff working from 8am-8pm supported by a member of management or a clinically trained member of staff, the rotas confirmed this but not always due to unplanned sickness. The registered manager told us that the staffing levels at the home were in line with company policy.

Prior to the inspection a relative had raised with us concerns that staff did not appear to have time to carryout basic care tasks, they told us about their concerns that people did not get the support they required at meal times. We observed the support that people received during the communal meal on the first day of the inspection. There were 12 people supported by four staff, two staff supported people to eat, two served the meals. People commented to each other that there seemed to be a lot of staff today. One of these staff told us they had come in on their day off.

Staff told us two care staff were required to assist eight people out of bed. Whilst they were assisting this meant that there were two care staff to support all of the other people over two floors. This meant in the morning it involved supporting with personal care tasks, getting and serving food for breakfast, supporting them with their breakfasts and ensuring people were repositioned if required. The numbers of staff on duty meant that people received support in a task centred way as staff did not to have time to sit and talk and engage people about things that interested them. Following the inspection and production of the draft report the provider told us that there was only two people living at the home that required staff support using manual handling equipment.

We spoke with staff about their knowledge and understanding of safeguarding people in their care. Most of the staff we spoke with could tell us the provider's policy on reporting suspected abuse and what statutory agencies could be contacted if necessary. Most staff could also explain the provider's whistle blowing policy and told us about the circumstances when this might be used and

Requires improvement

Is the service safe?

agencies they would contact if they had cause for concern. We looked at the staff training records which confirmed that all but three staff had received training with regards to safeguarding people.

Requires improvement

Is the service effective?

Our findings

We spoke with people about the food and drink on offer at the home. One person told us, "the food here is good, another person told us that at times they get fed up with only having sandwiches for tea". Another person told us that food is available by way of snacks and biscuits at regular times throughout the day. One person told us "if you want a drink you just ask, staff will get it for you". We looked at the menus for the two weeks prior to the inspection. These evidenced that a choice was offered and when required further alternatives had been made available but only to those who could verbalise their choice.

We spoke with staff about how choice is offered at meal times. They told us that about mid-morning a staff member will go around and ask people want they would like at lunch time. When the meal was served this could be changed if required. We asked staff how people with special diets, such as pureed diets, were offered a choice. The staff told us the kitchen staff knew about the requirements of soft or purred diets. Whilst the kitchen staff were aware of any special instructions or diets there was no system in place to offer people a choice of what the puree consisted of. This meant that not all people were provided with a choice at mealtimes. The above illustrates a breach of regulation 9(1)(c). of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have an effective system to ensure people who were at risk of dehydration or malnutrition were safe. We spoke with staff about people's nutritional needs. They told us that currently some people were at risk of unplanned weight loss. They told us about the systems that they had in place to monitor people's weight through weight monitoring. We looked at the weight monitoring of one person who was at risk of unplanned weight loss. The care records showed that they had not weighed the person as required, staff told us this was because the person did not get out of bed. Although management were aware of other systems to establish people's weight other than weighing, these were not being used. The registered manager told us the person's GP was aware of the weight loss and that they were not being weighed, although this was not recorded in the care record. The person's plan of care was to still to weigh the person weekly. The person was not receiving the care as described in their care records.

A number of people needed to have the amount they drank recorded to ensure they had enough. These records were not accurately completed and therefore staff were unable to assess whether people were receiving enough drinks. . An example of this was we looked at one person's fluid monitoring chart at 8.30am it was recorded they had received some fluids at this time. We looked again at the person's fluid monitoring chart at 12.30, it had no further entries from 8.30am. We discussed this with the registered manager who told us that staff were not recording when they support people. A staff member later told us that they do not think the fluid monitoring records were accurate and gave an example of a person who they felt was extremely difficult to support with fluids. They told us the person only took a few sips at a time; however the records showed that the person was drinking near to the required amount for the day. The staff member commented they were not confident the person's fluid chart was being completed accurately.

We looked at the records relating to three peoples fluid intake on the first day of the inspection. These records did not inform the staff of the expected amount each individual needed in the day to avoid dehydration, we pointed this out to staff. On the third day of the inspection we looked again at these records that did evidence the expected amounts that individuals needs however the totals that people had received were inaccurately totalled up.

The above illustrates a breach of regulation 17(1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about the training they had undertaken and how they accessed training. They told us the training that was available was a mixture of distance learning materials and face to face training. Some staff told us they had received training in areas such as dementia care, control of substances hazardous to health, health and safety and moving and handling during the induction period. Staff told us they had received a three day induction into their work. We spoke with the registered manager who told us all staff had enrolled to carry out the care certificate. However not all staff were aware of the skills for care 'certificate in care,' only one confirmed they had enrolled on this industry

Requires improvement

Is the service effective?

standard course. Staff employed with a clinical responsibility had yet to receive role specific training but told us there was a plan was in place to address this. One member of staff told us "I think moving and handling training could be improved, I don't think that all staff have the necessary skills to meet people's needs".

We looked at the training records. These evidenced that most staff had received a three day induction into the work they will do covering areas such as 'duty of care, equality and diversity, safeguarding, dementia awareness and moving and handling. The induction mirrored the expectation of the expectation of the care certificate. The training records evidenced that of the 17 staff, 11 staff had received their induction prior to starting work at the home, three had carried out the induction on the day they started and one within four weeks. Two staff had started work and were still awaiting their induction four to seven weeks after their start date. All staff had received a 'local home induction' on the day they started work, most had a competency assessment carried out within the first few weeks of them starting. No staff were recorded as having completed the Skills for Care workbook. We were given the providers 'on going training programme' that listed the training needed in the first year of operation.

Mental capacity assessments were meeting the requirements of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager had made arrangements for people's capacity to make decisions to be assessed when there were concerns identified. Applications to deprive people of their liberty had been made to the relevant authorities to ensure people were not at risk of not having their liberty restricted unlawfully.

People told us that if they needed to see a doctor or specialist the staff made arrangements on their behalf. We looked at people's care records which evidenced that when a person's needs had changed a range of services had been considered. The home had an arrangement with the local GP to provide a service to the people who lived at the home. The staff told us that the "GP's visit the home at the request of the staff". They also provide emergency call out cover if required. People who were paying for a residential service received clinical support from district nursing services to support their needs; those paying for a nursing service received the support of clinically trained staff employed by the provider.

Requires improvement

Is the service caring?

Our findings

People were not consistently well cared for. Health care professionals had told us about concerns they had when visiting people at the home. They explained that two of the people they wanted to see were in bed at 14.30 and 15.30 respectively with the curtains drawn. The health care professionals were told that in one case the person was being nursed in bed, in the other staff had apologised to the health care professionals that this should not have happened.

People were not always treated with dignity and respect. We observed one staff member support a person to eat but they did not interact with them and spent time talking with other staff. After a few minutes the staff member left the person they were supporting, before the meal was completed and never returned. No other staff member offered the person support or encouragement. The person attempted to eat their food using their fingers but gave up after a few minutes. The actions of staff failed to ensure the person was supported in a caring manner which undermined the person's dignity.

We looked in people's rooms and noted that in four of the room's peoples continence aids were on display, on beside tables and dressing tables. We looked again later in the day and found that they were still in the same place indicating that this is where they normally were kept. We spoke with staff and found that some of the language they used to describe people lacked respect. Examples of this was talking about people as tasks "that person is a double up (meaning they require two members of staff to support them with their needs) or they need "feeding" (meaning the person needed support to eat their meals). People's daily records did not consistently demonstrate that people were treated with dignity, for example with entries such as 'repositioned and changed and washed and dressed this morning, med's food and fluid given.' We spoke with the registered manager about our observations regarding respect. They told us that just the way they (staff) speak, it's not how I would describe the work that we do". This meant that to a degree there was an acceptance of the language used and no consideration was given to improve this. The above illustrates a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not consistently receive care based on their individual needs. We asked staff how they were allocated the work they have to do. One member of staff explained, "the work we do each day is organised by the senior staff on duty. We are told what we need to do and who needs support". The staff member told us about the tasks that were needed to be completed but little about people's social and emotional needs. Another staff member told us about the tasks that are required throughout the day such as assistance with personal care, repositioning people where required and supporting people to eat and drink.

We spoke with staff about people's individual social and emotional needs. Whilst staff could tell us about the task they performed to support people they were less clear about people's individualised routines and interests. Where people had individualised ways of communication such as picture cards and reference to their use in people's care records the staff did not tell us about these when asked. We did not see any individual picture cards in the rooms of people who required them but the manager was able to show us a set that were kept in one persons room. This meant that whilst peoples individual methods of communication were recorded staff did tell us about their use. However the registered manager told us they used them.

We asked relatives if their views had been sought about the provision of care. One relative told us they had not been consulted and had to ask for information. Another person confirmed they had been consulted. We looked at the care records that did not consistently evidence that people had been consulted about their care. Whilst care records described the tasks that people required help with there was little guidance about people's individual routines and how they wished to be supported in an individual manner. Some staff were able to tell us what time people got up but they were not able to tell us this was the person choice. The above illustrates a breach of regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were well cared for at the home. One person told us "I moved here from another home, this is much better there are people around to talk with". We spoke with visiting relatives and asked them their opinions

Requires improvement

Is the service caring?

of the service on offer. One relative told us “it seems ok but it’s too early to judge”. Another relative told us “it’s a nice environment but the staff seem to be very busy and don’t seem to sit and talk with people”.

Requires improvement

Is the service responsive?

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Requires improvement

Is the service well-led?

Our findings

The service was not consistently well led and improvements were needed. A registered manager was in post since the opening of the home. Although there were systems in place to ensure good quality care, such as quality audits tools, these were not being consistently or effectively used to drive standards up at the home. We spoke with the registered manager about the systems in place to audit the service's performance and ensure ongoing improvements were implemented. They told us that as the home had only been open since July 2015 a full audit of the home had yet to be commenced but one was due. On the first day of the inspection, 11 December 2015 we asked to see the infection control audit following concerns with some practices at the home. We did not see one on that day but were given the infection control audit carried out on 12 November 2015 on the second day of the inspection which did not identify any issues.

Nutritional audits had been carried out in September 2015 and again in October. In the September Audit it was established that a tape measure was needed, to assist with the measuring of peoples mid upper arm circumference in order to calculate individuals Body Mass Index, so that staff could assess the individuals risk of malnutrition. Again this was required in the October audit as well as ensuring the expected amounts of fluid individuals need must be recorded. It also commented that pictorial menus were needed. We did not see any pictorial menus being used to offer people choice, staff did not mention them when asked.

During of the inspection we noted that where people could not be weighed no other systems were being used to assess people's weight in relation to malnutrition. People did not have recorded the expected amounts of fluid they required. Other visiting professionals also told us of their concerns that identified individuals were at risk of low weight as no system was in place to establish the risks of malnutrition. This meant that whilst audits had taken place these were not effective at driving the standards up and put people at risk of harm. We asked to see an audit of the care plans which would inform us how the provider ensured that people's needs were being met and that staff were delivering care as planned. This audit was not made available to us during the inspection.

People's care records were not well organised and the management had difficulty in providing the information we requested when asked. For example, we asked to see one person's daily recording charts. The care records themselves stated that staff must record certain information throughout the day. The staff could not find these records when asked, informing us they should be kept in the person's room, they were later produced. This meant that the records that staff required to record information were not available as required. We looked at the care records for a person who had recently taken up residency. The care records were not organised and had been put in a folder uncollected. This meant that staff would find difficulty in finding information important to them in delivering a service. Therefore there was no evidence that care records had been audited which would have identified that staff did not have sufficient guidance to support people in the way they wished. The above evidenced a breach of regulation 17(1) (2(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a management structure in place at the home. The register manager was supported by a head of residential care and a senior clinical member of staff. Staff were aware of the roles of the management team and they told us the registered manager was approachable and available to discuss issues most of the time.

Records showed that staff had recorded accidents and incidents. Where people had been involved in an incident or an accident, for example a fall, the staff recorded the cause, the injuries and the actions or treatment that had been delivered. These accident / incident records were checked by the registered manager, who assessed whether an investigation was required and who needed to be notified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) (2) (g) Medicines administration records were not accurate putting people at risk of harm. The storage of medicines was not safe. 12 (1) (2) (a) (b) The acknowledged risks people faced were not consistently managed or action taken to minimise these risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9 (1)(c) – People were not provided with a choice at meal times. 9 (1)(a)(b)(c)- Care was not designed to provide care with a view to meeting peoples preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 . People were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) (2) (c) Care records were not accurate putting people at risk of receiving inappropriate care .

This section is primarily information for the provider

Action we have told the provider to take

17(1) (2) (c)(f) The systems in place to improve and evaluate the care practices were not being fully used.