Queensland Care Limited

The Pines Care Home

Inspection report

56-57 Harlow Moor Drive
Harrogate
North Yorkshire
HG2 0LE
Tel: 01423 565633
Website: www.queenslandcare.co.uk

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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

We carried out an inspection of this service over two days on 28 January 2015 and 11 February 2015. The visit on the first day was unannounced.

We last inspected The Pines Care Home on 11 April 2014. At that inspection we found the home was meeting all the regulations that we assessed.

The Pines Care Home provides care and accommodation for up to 30 people, some of whom may have dementia care needs. Accommodation is provided over four floors, which are accessible by passenger lift. There are a range of communal facilities including two lounges, a dining room, conservatory and a garden area. The home is situated close to Harrogate town centre with views over an area of woodland known as the Pinewoods. On the day of our visit there were 25 people using the service.

The home has a registered manager. 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.

Summary of findings

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to care and welfare, staffing levels, staff training, and quality monitoring. You can see what action we told the provider to take at the back of the full version of the report.

We identified that there were not enough staff on duty to meet the care needs of people living with dementia. People were not protected against unsafe or inappropriate care because risks were not identified or acted upon. Staff had not always responded appropriately when serious issues were identified.

We observed most staff were respectful and positive when speaking about the people living at the home. However we found staff lack of knowledge and skills impacted on their ability to recognise and implement measures to de-escalate situations when people were distressed. Not all staff knew how to engage people in conversation or how to respond appropriately to people with mental health care needs.

People were offered a choice of food and they were able to choose where they took their meals. However, we saw that additional staff were needed around mealtimes to make sure people living with dementia were supported to eat in a timely way.

Although the registered manager had measures in place to meet the legal requirements relating to Deprivation of Liberty Safeguards (DoLS) we found that staff knowledge and understanding about mental capacity was limited. Care plans did not always identify people's social history or mental health care needs to enable staff to meet people's care needs. This placed people at risk of receiving care that restricted their rights and freedom.

We found staff followed local safeguarding protocols to keep people safe. Appropriate systems were in place for the safe storage, administration and recording of medicines.

People had access to a range of health care professionals such as GPs. community nurses, dentists and chiropodists who visited the home.

Although we saw some activities taking place these were limited during the evening and at weekends when fewer staff were around.

People told us if they had any concerns they would speak with the registered manager or the deputy manager. We saw one complaint that had been made had been responded to appropriately.

Although management systems were in place to monitor the quality of the service we saw these had failed to identify and respond to the issues we found during our visit.

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 safe. There were not enough staff on duty to meet

people's needs in a timely way. People were not protected against unsafe or inappropriate care because risks were not identified or acted upon. Staff had not always responded appropriately when serious issues were identified.

Staff received safeguarding training. They understood the safeguarding process and knew how to access the local safeguarding protocols.

Appropriate systems were in place for the safe storage, administration and recording of medicines.

Is the service effective?

Requires Improvement

The service was not effective. Although people's physical care needs were met staff were not sufficiently skilled and knowledgeable to meet people's dementia care needs.

The registered manager had appropriate measures in place to meet the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). However, staff knowledge and understanding about mental capacity was limited.

People were offered a choice of food, which looked and smelled appetising. People could choose to eat in one of two dining areas or in their own rooms. This meant that staff support and assistance was not always available to support people and assist them to eat in a timely way.

People had access to a range of health care professionals such as GPs. community nurses, dentists and chiropodists who visited the home.

Is the service caring?

Requires Improvement

The service was not caring. Although we found areas of good practice in relation to 'end of life' care we found that not all staff knew how to communicate effectively with people.

We found limited information was available in people's care plans about their life history, their aspirations and preferences. Not all staff knew how to engage people in conversation and communicate appropriately with people.

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans did not always identify people's social history or mental health care needs to enable staff to meet people's care needs.

Although we saw some activities taking place these were limited during the evening and at weekends when fewer staff were around.

Summary of findings

People told us if they had any concerns they would speak with the registered manager or the deputy manager. We saw one complaint that had been made had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well-led. Following changes to the home's registration of the registered manager had prioritised staffing levels and staff recruitment and we identified shortfalls in relation to other management tasks.

Although plans were in place to gain feedback from people living at the home and their relatives we found these were at an early stage of development.

Management systems in place to assess the quality of the service were not working effectively. For example, although audits were being completed we found these had failed to identify issues we found at the inspection.

The Pines Care 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.

We carried out an inspection of this service over two days on 28 January 2015 and 11 February 2015. The visit on the first day was unannounced.

The visit on the first day was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The visit on the second day was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, which included notifications made by the home and information from multi-agency meetings where current issues and investigations were discussed. Before our visit we also contacted the local authority contracts and commissioning team, the safeguarding team and Health Watch to gain their views.

We spoke with four people who lived at the home, three visitors and with two health care professionals. We also spoke with the registered manager, the deputy manager and three members of care staff. 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 speak to us directly about their care. We also observed a further nine people over the lunch period. We looked at all areas of the home including a sample of people's bedrooms, the kitchen, laundry, bathrooms and communal areas.

We looked at a range of records including care plans and medicine records for four people, training and recruitment files for three staff, and quality audits. Following our visit we also reviewed other records relating to the management of the home including staff rotas, the staff training matrix, the medicines policy and the home's Statement of Purpose.

Requires Improvement

Is the service safe?

Our findings

Since the last inspection we had been made aware by the local authority of concerns about the care and welfare of people living at the home. Due to these concerns the local authority looked at safeguarding issues in relation to eight people. Concerns were also raised around staff inexperience, that staff were working very long hours and of a lack of response where serious issues were identified such as pressure area damage.

During our inspection we identified that staff were not always provided in sufficient numbers or appropriately deployed to support people in a timely way and to ensure people's care needs were met.

The provider applied to remove the regulated activity of 'Treatment of Disease, disorder or injury' and 'Diagnostic and screening procedures' from their registration in April 2014, with some staff turnover at that time. Staff reported working excessive hours to cover the home and there had been a heavy reliance on agency staff. The registered manager told us that a recent wage increase had improved staff recruitment and retention. However both people living at the home and care staff we spoke with told us they were short of staff at times. A visitor we spoke with told us they were concerned about the lack of activity and supervision for frail elderly people.

Before our visit the registered manager made us aware of a serious incident concerning one person who needed close monitoring owing to their mental health care needs. During our visit we also observed a person with extensive bruising to one hand. Records indicated the person was experiencing significant distress before their injury and was reported to be shouting, nipping and hitting staff. The deputy manager told us they had witnessed the person trap their hand in a drawer but this was not clear from the person's daily records. This incident had not been included in the monthly accident report, which meant that management systems in place to record and analyse incidents were not being used appropriately.

One person told us they had a safety gate on their door to stop other people entering their room when staff were not about. The registered manager confirmed three people had chosen to have gates put up to keep other people from entering their rooms. Another person told us they were disturbed by someone going into their room at night. We were concerned about this and asked the registered manager to look into the matter and report their findings to CQC. We found that staffing issues were having an adverse impact on staff ability to supervise people properly and to provide consistent, safe care by using gates to restrict people from entering other people's rooms.

During our visit we saw staff worked working diligently to clean the home. However, we identified some issues with cleanliness and there was an unpleasant odour in the lower ground floor area. One chair in this area also had a strong smell of urine and we saw seat cushions were lined with plastic bin liners, which were not comfortable to sit upon. The registered manager explained that care staff were supported by a housekeeper who worked from 8am to 2pm five days a week and kitchen staff from 8am to 2pm seven days a week. Outside these times however care staff also had cleaning, laundry and kitchen duties to meet in addition to their care duties. This meant that whilst undertaking these duties, care staff were not available to meet the care and support needs of people who lived at the home.

At lunchtime we saw meals were served in one of two dining rooms. People could also take their lunch at their seat in the lounge areas or in their own rooms. We saw people were left unsupervised for periods of time and staff were not on hand to be able to offer timely assistance when it was needed because they were serving lunch elsewhere in the home. This meant that people's needs were not being met because there were insufficient staff to be able to respond in a timely way.

These matters were a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in the PIR that arrangements were in place for the maintenance of the premises and equipment. A fire safety audit was carried out by external contractors and we saw a maintenance log was kept for routine checks such as checks on emergency lighting, wheelchairs and window restrictors. We looked at a sample of maintenance checks and these were all up to date. However, we saw that damage to the furniture in one person's room had not been reported, which meant that the systems in place to identify and respond to areas of routine maintenance were not always working effectively.

Requires Improvement

Is the service safe?

We found recruitment practices were safe and relevant checks were completed before staff worked unsupervised at the home. Relevant recruitment information, such as an application form, written references, identification and interview records were held on file. Criminal record checks had also been carried out with the Disclosure and Barring Scheme (DBS) before people started work. We discussed the application form with the registered manager and recommended this form was reviewed to make sure questions were relevant and met the principles of the Equality Act 2010. We spoke with a new member of staff who confirmed the provider's application and interview procedure had been adhered to. This meant people who lived at the home were protected from staff that had been identified as unsuitable to work in a care home.

We saw in the PIR that staff were trained on how to recognise various forms of abuse and what to do if they suspected this was occurring. Training records indicated 76% of the care staff had received safeguarding training between May and October 2014. The deputy manager told us they were going to undertake advanced training with the local authority that would allow them to deliver safeguarding training to the remaining staff. Rotas showed that a minimum of one member of staff trained in safeguarding was on duty at all times.

Staff we spoke with were able to describe different types of abuse and knew what to do it they had any concerns. They told us they had completed safeguarding training and they said they would speak with the registered manager if they were concerned about anything. They said they were aware they could also raise concerns outside the organisation This showed us staff were aware of the systems in place to protect people and raise concerns.

The registered manager gave us a recent example of when they had made a safeguarding alert in respect of a medication error. This showed us that people were protected by the home's safeguarding procedures because the manager had recognised and responded appropriately to poor practice.

During our visit we looked at the arrangements in place for the safe storage, administration and recording of medicines. There was a medicines policy in place and care staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) guidance on the use of medicines. All staff were assessed on the practical element every six months and following a recent error appropriate arrangements had been made to review people's practice earlier. As the error had not been picked up through the usual audit processes the registered manager had made independent arrangements to have their own practice reassessed. Medicines were stored in lockable trolleys, secured to the wall in the medicines room or in locked cupboards. There were suitable arrangements in place for ordering repeat prescriptions and for obtaining medicines which were prescribed outside the usual 28 day cycle. Any medicines carried over from one month to the next were accounted for to make sure there was an accurate record of the amount of each medicine in stock. Regular monthly audits were completed and we saw that the mental health team supported people's medicine reviews. These arrangements meant that people were protected against risks associated with the unsafe use and management of medicines.

Requires Improvement

Is the service effective?

Our findings

When we visited there were 25 people living at the home, 80% of whom were living with dementia or a mental health condition. We observed staff spoke in a kindly way to people and names were used to gain attention before any activity was undertaken. One person said "I am happy here, although nowhere is like home."

However, we found that staff lacked the necessary knowledge and skills to be able to effectively support people who were living with dementia. Only 30% of the substantive staff team had received dementia awareness training and 40% had received training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), which apply to care homes. None of the staff we spoke with were aware of good practice guidance relating to dementia care such as the National Dementia Strategy and the Prime Minister's Challenge on dementia. The registered manager told us she knew of the guidance but because of staffing issues they had not had sufficient time to be able to look at how to implement it in the home.

Although staff provided good physical care we saw that people's emotional wellbeing and the importance of effective communication was not as clearly understood. For example, during our visit we observed staff invited people to 'come upstairs' for lunch. Records indicated a lack of knowledge of caring for people who exhibited anxiety and distressed reactions. We saw in one person's notes they were described as 'violent' and in speaking with staff they used terms like 'confused' and 'wandering' to describe people in their care. This language demonstrated a limited understanding about people with dementia care needs.

These matters were a breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that staffing difficulties had impacted on their ability to operate regular staff meetings and an effective supervision and appraisal system. Staff we spoke with confirmed that staff meetings were not routinely held. This meant that staff were not provided with a regular forum in which they could look at their individual practice and discuss complex cases and best practice with each other.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The DoLS are part of the Mental Capacity Act 2005 and aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw in the PIR that no one was subject to authorisation under the Deprivation of Liberty Safeguards although nine people had care plans that restricted their liberty, rights and choices. The registered manager was knowledgeable about the MCA and DoLS and explained that applications for getting authorisation for deprivation of liberty for people were in process with the local authority.

We found people were not restricted in their movements around the communal areas of the home. However, there was limited signage to help people find their own way to toilets, dining rooms, lounges or their own bedrooms. Although there was a secure courtyard area with attractive seating people could not access this area because the door was kept locked shut. When it came to the dining experience the menu was not well written. It was in pale chalk on a board high up on the wall where most residents would not be able to see it or read it.

We counted only six easy chairs were available in the ground floor lounge and a similar number on the lower ground floor lounge. This meant that if everyone living in the home chose to sit in the lounge they could not be accommodated.

During our inspection we observed the lunch period in both the conservatory and the formal dining room. We also walked around the home and saw people being served with meals in their own rooms. We saw that people were shown two plates of food from which they could choose and all the food looked and smelled appetising. One person said "The food is hot and brought to my room and I'm given the same choice as if I was in the dining room." However, we observed some people were having difficulty eating their meals either because they were eating their meals on low side tables or they were not provided with suitable crockery or cutlery. We observed one person was enjoying their pudding but the 'bread and butter' hadn't been cut up small enough in the dish and so where it had

Requires Improvement

Is the service effective?

crusted on top it was too large and hard to chew. The person was unable to continue with their pudding and pushed their plate to one side. Without appropriate staff support and assistance It did affect that particular person's ability to enjoy their meal, which they had wanted to finish but could not manage without assistance.

In the care plans we saw staff were using the Malnutrition Universal Screening Tool (MUST) to assess if people were at nutritional risk. Staff told us they were aware of the actions they needed to take in order to reduce the risks. For example, they told us about people who needed fortified foods or special diets. We saw that people's weights were monitored to make sure the care plan was effective and people's needs were met.

Although people could retain their own GP if they wished the home had a nominated GP who visited their patients on a regular basis. The registered manager reported they had a good professional working relationship with the GP and the community nurses. This was confirmed by the health care professionals we spoke with. A community nurse confirmed the home had piloted a new pressure sore prevention tool known as 'SSKIN Bundles'. They reported this had been successful in the assessment, prevention and treatment of pressure ulcers and they were hoping to roll this system out into other care homes in the area. People also had access to a local dentist and a chiropodist both of whom were able to make 'home' visits.

Requires Improvement

Is the service caring?

Our findings

People we spoke were very happy with the staff and said they were always respectful to them. We spoke with one person who said "Everyone is lovely." People confirmed they could make decisions for themselves such as when to go to bed and when to get up. One person told us they had enjoyed a lie in but was concerned it affected the staff routine so said they wouldn't be doing it again.

We observed staff approached people with respect and we saw people responded well to them. Staff were polite and they spoke positively about the people living at the home. However, during lunchtime we observed that the member of staff supervising the main dining room did not sit with people or engage them in conversation. People taking their meal in the lower ground floor lounge and in their own rooms were left unsupervised for periods. This included people with dementia care needs who would not be able to call for assistance and who needed prompting to eat their meals.

We saw in the PIR that care plans included information about people's life history wherever possible to allow them to care for people in a kind and compassionate way. However when we looked at the care plan for a person who was newly admitted we saw it contained little information about their history. It was recorded that the person 'could not remember' when asked about their past. Information from the person's previous placement indicated they had a close relationship with one relative so this person could have been approached to be included in the pre admission assessment and provide information. This was important because by identifying people's preferences and aspirations this would help staff to put each person's needs and choices at the heart of their care.

We observed the majority of staff were respectful when speaking with people living at the home and with each other. However, when one person asked what the time was we heard a staff member say "Oh, I don't know, what time do you think it is." This was disrespectful and we intervened to tell the person the correct time. We observed the same person asked different staff members for assistance to find a glass for their bedside table. On each occasion staff responded that they would find one later. We saw in the person's records that they had also asked night staff for a glass. The deputy manager responded to the person and said they would fetch one.

Overall, we observed the atmosphere was relaxed and staff were friendly and welcoming. People confirmed their visitors could visit at any time. During our visit we saw staff knocked on doors before they entered people's rooms and one person we spoke with confirmed staff always knocked before coming into their room.

During our visit we spent time in the lower ground floor conservatory and observed staff interactions with people. We saw staff spend time with people and offered people the opportunity to play board games with them.

The registered manager told us that people's wishes regarding their end of life care were known as well as their decisions about resuscitation. We saw that people who required do not attempt resuscitation orders (DNAR) had these on file and we confirmed these were reviewed by GPs and senior staff. We spoke with a visitor who told us care staff had provided their relative with excellent care and support during their recent illness. They said their relative was well cared for and the staff had been very sensitive to the family. The visitor commented that they had even put reclining chairs in the person's room so that the visitors could rest when spending a long time at the home. The visitor said the registered manager couldn't have done any more to make them feel welcome. The registered manager told us they felt training in end of life care was very important and all staff were going to receive NVQ level2 training in end of life care within the next 12 months.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained assessments relating to people's physical health and wellbeing, skin assessment, nutrition, continence, mobility and falls risks. We saw that care plans contained some good information about people's preferences and choices regarding their personal hygiene and food preferences. Files all contained information about people's mobility and the risk assessments relating to people's physical care needs were well documented.

However, we found that care planning around people's dementia needs was not developed. This meant that people were at risk of receiving unsafe or inappropriate care. We found that the pre admission information being gathered focused mainly on people's physical health. This was of significance because in the past year there had been 20 new admissions and most people now living in the home had dementia care needs. Without the appropriate assessment staff could not be confident that they could meet people's care needs before they moved into the home.

We saw in one person's care file that the mental health team had provided detailed information to enable staff to provide person centred care. However, staff were not applying this guidance in practice. The person was reported to enjoy their daily routines and it was suggested small items including cotton wool, make up and small tubs of cream should be made available on their dressing table. We checked their room and saw it was in some disarray with personal possessions and clothing hidden under their bed. The television was playing to an empty room, items of furniture were broken and there was an unpleasant odour in the room and on the person's bedding. We did not see any of the items that were mentioned in their care plan on their dressing table. Information that we gained from our observations and from the person's care records showed us this person was experiencing periods of anxiety and distress. We saw from their daily notes that they had sustained bruising in two separate incidents in December 2014 and again during the week we visited. It was evident that further intervention and support was needed to make sure this person received safe, appropriate care.

These matters were a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a visiting health care professional who told us that staff had worked well with them to provide coordinated care for one person. They said staff acted on advice they gave them. They reported the registered manager had worked well with their team to provide support for one person who had recently moved into a supported living arrangement.

We spoke with a visitor who was concerned at the lack of activities on offer. They said they felt there was little organised activity particularly during the evening and at weekends when fewer staff were around. They said they did not know if the home had any relatives meetings but would be happy to attend to put forward their views if asked. The registered manager explained that staffing difficulties had affected their ability to provide regular activities. They told us they had tried holding meetings in the past but these had been poorly attended. However, they said they were in the process of employing an activities organiser to improve activities on offer. They told us they planned to send out invitations to another relatives meeting and hoped to encourage better attendance by making it a social event. They also aimed to recruit volunteers to come into the home a few hours a week to provide one to one time with people, reading newspapers and painting nails.

During our inspection we observed an independent entertainer who visited one afternoon engaged people effectively in conversation. People were animated and laughing and appeared to enjoy the activity very much. Some people we spoke with told us they preferred to follow their own interests and pursuits. We met several people who told us they preferred to say in their own rooms reading and watching television. When we visited some people in the conservatory were involved in a board game.

We saw the complaints procedure was on display in the hallway. During our visit staff said they felt that the registered manager and the deputy manager were approachable and they would go to them if they had any concerns. The registered manager told us complaints were taken seriously, and if at all possible they were resolved at the time they were raised. They said they had an open door policy, and the manager and deputy were available to

Requires Improvement

Is the service responsive?

listen to any concerns that may arise. In the past three months the registered manager had dealt with a complaint about unpleasant odours in the home. They had concluded this was an isolated problem and had reminded staff to be vigilant. They had not investigated any other complaints.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. During our visit people spoke positively about the registered manager and the staff team. However, owing to staffing shortfalls the registered manager told us they had needed to prioritise staff recruitment and supporting the staffing levels over their other management tasks.

The provider told us in the PIR that they planned to enrol staff on 'champion pathways' so that they could cascade their knowledge to the rest of the care team. The registered manager and the deputy manager told us about their plans to improve attendance at relatives meetings and to send out satisfaction surveys for people using the service and their families to complete. However, these plans were at an early stage and management systems to encourage feedback about the service were not fully established.

These matters were a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in the PIR that the registered manager and deputy manager carried out internal audits and a quarterly senior management visit was used to identify any shortfalls thus enabling the service to continually improve. However we saw that the routine audits had failed to identify the issues we found during our inspection. During our visit we identified shortfalls in relation to staff training and supervision. We also identified shortfalls in staff knowledge and skills in relation to meeting people's dementia care needs effectively.

There was a system in place to analyse accidents and incidents and during our visit the registered manager showed us the online system used to analyse and keep track of accidents and incidents, which highlighted any patterns or times of accidents and incidents. However, we identified that staff had failed to record every incident using this system. This meant that trends around incidents might not be identified so that action could be taken to prevent their reoccurrence.

The registered manager confirmed in the PIR that they operated an open door policy and that the registered manager and deputy manager were always available. They told us that both staff residents and visitors were encouraged to speak openly and honestly about anything, which promoted a positive culture within the home. However, before we visited a visitor contacted us to raise concerns about the lack of management cover particularly during the evenings and at weekends. We confirmed this was the case from checking staff rotas and from feedback from safeguarding investigations.

In the past year the local authority investigated historical allegations of abuse relating to eight people. All of these were found to be not substantiated. The provider co-operated with the investigations and they produced an action plan, which was shared with CQC. The provider told us they had reminded staff about internal procedures around media and mobile phone policies in response to breaches in confidentiality, data protection, and dignity and respect. During our visit we confirmed with staff that they were aware of policies and procedures relating to their practice in the home and signed copies of memos relating to the use of social media sites, cameras and mobile telephones had been placed on each person's file.

We spoke with a healthcare professional who reported that the registered manager and staff were keen to learn and responded well to advice they were given.

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 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were not provided in sufficient numbers to adequately support people and ensure people's care needs were met. Staff had not received appropriate training and supervision and appraisal.Regulation 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were at risk of receiving unsafe or inappropriate care because care was not always planned to meet people's individual care needs. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to monitor the quality of service delivery. Regulation 17