Barbara (Aylesbury) Limited

Lakeside Care Centre

Inspection report

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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

This inspection took place on the 9, 10 January and 11 February 2019. The inspection was unannounced.

Lakeside Care Centre 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.

The service provides nursing care for up to 53 older people. At the time of the inspection there were 45 people living at the service. The home is set in beautiful surroundings overlooking a lake. It is made up of three floors with six bedrooms and the communal lounge and dining room on the ground floor. The remaining bedrooms are situated on the first and second floor. The main kitchen, laundry room and offices are situated on the ground floor.

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.

At our previous comprehensive inspection in August 2015 the service was rated as good overall, with a requires improvement rating in the responsive domain. At this inspection we found multiple breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following this inspection, the service has been rated inadequate.

Some people and relatives were happy with the care provided. However, some people raised concerns about the skills of staff and some relatives and professionals were dissatisfied with the way the home was run and managed.

The delivery of high-quality care was not assured by the leadership, governance or culture in the service. People's records and other records such as staff files were not suitably maintained, accessible and accurate. The service was not effectively managed or audited. The service had systems in place to audit the service but the auditing failed to address the issues we found. There was no external auditing carried out which meant the service was not working to best practice in relation to the delivery of care.

Risks to people and people's medicines were not appropriately managed. New staff were not inducted and staff were not suitably trained. Their competencies were not properly assessed for their role and tasks they performed. Most staff told us they felt supported but the records did not support that staff had the one to one supervisions recorded on the supervision matrix.

Systems were in place to safeguard people. However, we saw practices and concerns which should have

been reported to the local authority safeguarding team to safeguard individuals had not been reported.

People were supported to make day to day choices and decisions. However, the service was not working to the Mental Capacity Act 2005 and procedures were carried out which were not agreed as part of a best interest decision.

Staffing levels varied and some people felt the staffing levels were sufficient. Whilst other people and their relatives told us staff were rushed, call bells were not answered in a timely manner and there was a delay in people being supported with their personal care needs such as toileting and meals.

People had care plans in place but they failed to provide the detail around how person centred care was to be delivered and how people's communication needs were to be met in line with the Accessible Information Standard. .

Systems were not in place to comply with the Duty of Candour Regulation and the registered manager failed to notify the Commission of issues that they were required to.

People had access to other health professionals to meet their needs however, the service did not always act on health professional's advice. We have made a recommendation to address this.

Staff were suitably recruited and during the inspection some positive engagements between staff and people were noted. Some people described staff as kind and caring whilst others found staff to be brisk and showed no time for them. We have made a recommendation to monitor staff practice and address.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, Lakeside Care Centre will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not, enough improvement is made within this time frame so that there is still a rating of inadequate for any key question or overall, we will take action 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 this registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. The Care Quality Commission is now considering the appropriate regulatory response to resolve the problems we found during our inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to the concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. .

People's medicines were not appropriately managed.

Risks to people were not mitigated and safe care was not promoted.

People were not safeguarded from abuse.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who were not suitably inducted, trained and supervised in their roles.

People were consulted about their day to day care but the principles of the Mental Capacity Act 2005 were not followed for a person who was assessed as having limited capacity.

People's health and nutrition needs were identified.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people described staff as kind and caring. However, some staff did not always demonstrate those qualities and did promote people's dignity and show respect.

People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive. .

People's care plans were not person centred and their needs were not clearly identified and met.

People were not provided with information suitable to their needs in line with the Accessible Information standard.

People's had access to activities.

Is the service well-led?

Inadequate

The service was not well-led

The service was not appropriately managed and monitored to ensure that safe care was provided.

The registered manager did not make the required notifications to the Commission and did not work in line with the Duty of Candour Regulation.

People's records and other records were not suitably maintained, accessible, accurate and up to date.

Lakeside Care Centre

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 9, 10 January and 11 February 2019. It was unannounced. The inspection was carried out by two inspectors on days one and day two. Three inspectors were involved in the inspection on day three. An expert by experience present on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and dementia care.

Prior to the inspection we reviewed the information we held on the service, such as notifications and safeguarding alerts and concerns. A Provider Information Return (PIR) was already on file and not requested prior to this inspection. The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make.

We spoke with three visiting professionals during the inspection. After the inspection we contacted health care professionals and commissioners involved with the service to obtain their views about the care provided. We have included their feedback received within the report.

During the inspection we walked around the home to review the environment people lived in. We spoke with the registered manager, deputy manager, two registered nurses, two nurse assistants, two team leaders, four care staff, head chef, head of housekeeping, a housekeeper and the activity co-ordinator. Over the course of the three days we spoke with 18 people and 14 relatives during the inspection. We spoke with two relatives by telephone after the inspection.

We looked at a number of records relating to people's care and the running of the home. These included 14 care plans and people's medicine records, staff rotas, seven staff recruitment files and 17 staff training and supervision files. We asked the registered manager to send further documents after the inspection. The registered manager sent us some of the requested documents which we have used as additional evidence.

Other information requested was not provided in a timely manner.

Inadequate

Is the service safe?

Our findings

People were supported by a service that was not safe.

People told us they felt safe. People commented "I am happy that this is the best place for me, it is the safest place for me too. I was falling too often when I was living at home and I feel so much more secure knowing that night care is available at Lakeside" and "Yes, I feel safe, I have a call bell, I keep it handy and I know that I can use it."

Relatives generally felt their family members were safe. A relative commented "Mum kept falling at home but she is fine here and looked after well." Two relatives were not happy with care provided and felt safe care was not consistently provided. They commented" Staffing levels vary," "Staff don't seem to notice when [family members name] condition change," "They are unable to provide explanations for say bruises."

People told us staff administered their medicines. They felt confident they were given the medicines prescribed for them. A person commented "I am a diabetic and I take other medicine; the nurse does my medicine and I trust them."

However, we found safe medicine practices were not promoted. Some staff involved in medicine administration were trained in medicine management but they were not working to best practice in medicine administration. The service had medicines that were prescribed to be administered when required (PRN). There was no protocol and guidance on the use of the "as required" medicine. For example, one person's medicine administration chart (MAR) indicated they were prescribed "as required" medicine for when they were anxious. There was no guidance for staff as to how the anxiety presented to ensure the medicine was given for what it was prescribed for. The service had a number of people who were prescribed medicine patches for pain relief. No records were maintained on where the transdermal patch was applied on the person to ensure staff rotated the patch on each application. People were prescribed creams and lotions. The direction on the MAR chart was to apply as directed but there was no indication in the records where the cream needed to be applied and no body charts were in use to provide this detail.

During the inspection we observed medicines being administered. The staff member administering medicine was wearing a tabard which highlighted they were not to be disturbed. During the inspection we saw they were regularly disturbed by other staff, including the registered manager. We observed a registered nurse had left a tablet to be destroyed on top of the medicine trolley that was left unattended at the time. On another occasion the open trolley was left unattended. A nurse assistant was observed applying cream to a person's arm, in the sitting room and without wearing gloves. The same staff member was about to offer 2 Paracetamol 500mg tablets to a person although their MAR chart stated, 'One to be taken every 4-6 hours up to four times a day'. We pointed this out to the nurse assistant who administered one tablet as prescribed.

We reviewed people's MAR charts. We saw handwritten MAR charts were not always signed by two staff. Some MAR charts had holes punched through them which defaced the medicine administration record.

Other MAR charts had gaps in administration mainly for topical creams.

The medicine administration policy was requested. We were initially provided with a medicine errors reporting guidance as opposed to a policy on medicine management. The policy management policy provided was not reflective of best practice in relation to medicine management. The registered manager told us they were in the process of updating the medicine policy in response to a Clinical Commissioners Group (CCG) pharmacy visit. At the time of the inspection the registered manager told us staff involved in medicine administration had been informed of the changes required to the way medicine was managed but guidance and polices to promote safe medicine administration were still not available. The registered manager told us the meeting minutes to evidence staff were informed of the changes was not available as they had not been typed up.

We asked if staff involved in medicine administration were assessed and deemed competent to carry out the task. The deputy manager told us staff were assessed but there were no records of competency checks maintained. Staff involved in medicine administration spoken with told us they had received medicine training but they had not been assessed in administering medicines. We received a completed competency assessment checklist for two of the nurse assistants after the inspection. This indicated they were assessed and deemed competent in medicine administration but there was no detail provided on the competency assessment as to how they came to that conclusion. The competency assessment and training matrix indicated they had attended medicine administration training and training certificates were provided to confirm this. However, a registered nurse and a nurse assistant undertaking night shifts had no training certificates on file to confirm they had been trained in medicine administration or assessed as competent even though they were involved in medicine administration.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because safe medicine practices were not promoted.

During the inspection we saw thickeners (used in people's drinks to manage the risk of choking) was stored in people's bedroom but not always in a locked cupboard and out of sight. A risk assessment was in place on the storage of thickeners in bedrooms but it lacked detail as to how the risks of this practice were mitigated. In one person's bedroom they had four boxes of thickeners left on top of their bedside table. Three of those were for other people and one belonged to the person. We noted that the product carried a notice 'Do not leave at patient's bedside' on each container. This was immediately fed back to the registered manager to act on and we referred them to the 'Patient safety alert – Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder' (NHS England, February 2015).

People were not always protected from avoidable harm as potential risks posed to them had not been identified or assessed. The risk assessment policy indicated that people's risk assessments would be carried out only by competent staff who have completed risk assessment training with regard to the assessment of potential risks associated with the provision of service user care. The training matrix provided did not include training on risk assessments and management and no competency assessments were on file to show that staff responsible for completing risk assessments were assessed and deemed competent.

People's care plans contained risk assessments in relation to risks associated with falls, pressure areas, use of bed rails, malnutrition and moving and handling. The moving and handling risk assessment was not always completed to include the management plan for managing the risk and the equipment used. At lunch time on day one we observed a person was provided with a soft diet and they had a thickener in their drink, as they were perceived to be at risk of choking, Throughout the meal time the person fed themselves but no staff supervision was provided. Their care plan made no reference to the risk of choking or the level of

supervision required. This was pointed out to staff and the registered manager but no supervision was provided on day two of the inspection either. On day two of the inspection we saw that a risk assessment had been put in place for another person which was dated the day before (day one of our inspection). It indicated the person was at risk of choking and they were to be supervised with their meal. The risk assessment did not outline the level of supervision required. The speech and language therapist meal time information sheet dated 27 September 2018 indicated the person should be supervised at all times when eating. We saw the person was given their meal in their bedroom and no staff supervision was provided throughout.

The service had a person who presented with behaviours that challenged. Their daily records showed a recent escalation in their behaviour, which resulted in staff been physically and verbally abused. The daily records made reference to recording challenging behaviour incidents but there was no risk assessment in place to guide staff on how to manage the risks to them and the individual. We observed that another person who took all of their nutrition via percutaneous enteral gastrostomy (PEG) did not have a risk assessment in place to address the risks of e.g. the feeding tube becoming detached or blocked or risk of infection at the stoma site.

The service had a number of people with medical conditions such as diabetes and epilepsy. There were no risk assessments in place as to how staff would recognise or manage symptoms of hyperglycaemia or hypoglycaemia (high and low blood sugars), or how the epilepsy presented and action to take which could result in serious health issues for those individuals.

A person had an entry in their communication record which detailed that a digital evacuation of their bowel had been carried out. Their elimination care plan made no reference to this been required, justified or agreed with professionals involved in the person's care. The nurse who carried out the procedure had no competency assessment to demonstrate that they were up to date with current guidance and could justify the rationale for this procedure as outlined by the National Institute for Health and Care Excellence (NICE guidance). The registered manager told us the service did not carry out digital evacuations and was unaware that this practice was taking place. The registered manager was asked to make a safeguarding alert in respect of this incident. The Care Quality Commission made a safeguarding alert too in respect of this incident. After the inspection the registered manager completed a notification to us which disputed the entry written in the person's records. They informed us that the registered nurse who had carried out the procedure confirmed they had not carried out a digital evacuation but did not know how to record the action they had taken. The action described on the notification to us was still an invasive procedure that would require evidence of it been justified and agreed with the person and medical staff involved in the person's care.

During the inspection we heard a person calling for help for 20 minutes. There was only a housekeeper on the floor at the time who failed to summon help. The inspector intervened and assisted the person to use their call bell to summon help which was answered by the deputy manager who came onto the unit. This had the potential to put the person at risk.

Accident reports were completed. We noted two people had sustained a number of falls. Whilst these were recorded there was no indication action had been taken to mitigate the risks. The review of the person's fall risk assessment did not show either that equipment such as sensor mats had been considered or tried. We saw in a person's daily entry that a staff member had failed to put the bed sides up in a person's bed to promote their safety. The person subsequently fell out of bed. No injury was reported, although their daily records showed they had complained of pain in their right wrist the following day. We were provided with information after the inspection to show the staff member was spoken with but there was no indication the

incident was appropriately investigated and lessons learnt.

We found evidence staff did not always follow guidance on how to safely support people move position. Where this had occurred, the registered manager failed to act appropriately and investigate the actions taken by staff. A safeguarding alert was not completed either and the staff members training records did not evidence that they had moving and handing training provided before or as a result of this incident. This had the potential to continue to put people at risk.

Two staff were designated moving and handling trainers. There was no certificate on file to indicate they had the required training and skills to deliver this training. One of the staff members told us their training was out of date but could not recall when they had it or when it had expired. The registered manager told us they thought the staff members had done the training in 2016 or 2017 and they thought it was valid for one or two years. This meant staff were being trained by staff who were not suitably trained to facilitate the training. The registered manager told us they had arranged for six staff to be trained as moving and handling trainers but this training was not booked till the 25 March 2019. This meant that people's safety was compromised as none of the staff had up to date moving and handling training.

Prior to the inspection we had received information of concern that the doors between floors were left open and this put people at risk of accessing the stairs and lifts without staff supervision. On our arrival at the home on day three, four of the six doors were open. Throughout the inspection and various times of the day the doors were found to be open. The registered manager and staff gave differing reasons as to why the doors were open. The registered manager told us people were in wheelchairs and therefore unable to access the open doors. Throughout the inspection we saw the home had a number of people who were mobile and therefore, able to access the stairs. One of those people had partial sight. The doors would automatically close in a fire but the practice of leaving the doors between floors open had the potential to compromise fire safety. There was no guidance or risk assessment to support the practice of leaving those doors open and this practice had the potential to put people at risk of injury

We asked to see the environmental risk assessment for the service. None was in place and therefore the environmental risks to people, visitors and staff were not identified and mitigated. Throughout the inspection we observed moving and handling hoists were left in the corridors on each floor. This had the potential to act as a hazard. The service had not considered if this posed a risk to people and the potential risks around their storage had not been considered. After the inspection on day one and two this was fed back to the manager to address. On day three of the inspection hoists were still stored in corridors and no action had been taken to address the potential risk. The home had a contingency plan in place, which was implemented in April 2012 with next review due in June 2019. It did not show that reviews had taken place since the date of implementation of the contingency plan to ensure it was current.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because risks to people were not appropriately managed to promote safe care and treatment.

The local authority guidance on safeguarding adults that was displayed on notice boards was dated 2017 and out of date. This was pointed out to the registered manager and addressed during the inspection. Staff told us they were aware of their responsibilities to report poor practice and that they were trained in safeguarding vulnerable adults. However, the training records viewed did not show that all staff had completed safeguarding training. We saw records which showed poor practice such as using two continence pads for a person at the same time (double padding), one staff member moving a person who required two staff to move and a compliant dated November 2018 with an allegation of neglect was not perceived as potential safeguarding concerns and not reported to the local authority safeguarding team. We asked the

registered manager to make the required safeguarding alerts in retrospect of those incidents. The Care Quality Commission also made an alert in respect of those concerns.

This is breach of Regulation 13 of the Health and Social Care Act 2008. This is because systems, processes and robust procedures were not in place to ensure people were protected.

The registered manager told us two nurses were provided on each shift, including nights. They confirmed a minimum of nine care staff were provided on the morning shift, seven care staff were provided in the afternoon and four care staff were provided at night. The rotas viewed showed generally only one registered nurse was on shift with a nurse assistant. There was usually a minimum of nine care staff on shift in the morning with a minimum of seven care staff on duty in the afternoon. The registered manager was not included on the rota but the deputy manager did a mix of days on shift and supernumerary days and assisted on the floor when required to cover gaps in the rota. The registered manager told us they had no staff vacancies at that time.

During the inspection we noticed there was delay for people sat in the part of the lounge that is adapted as an extension of the dining room in getting their meal. Some people were sat there for 45 minutes. This was because staff were serving the meals in the dining room and supporting people in there who required support with their meal. Staff appeared rushed and at times brisk in their interactions with people. On day three of the inspection, at one point we saw that only one staff member was present in the dining room with fifteen people.

The registered manager told us people had the option to eat their meals in the dining room or in their bedroom. We saw some people choose to eat their meals in their bedrooms, however no staff were available to supervise people on the units who required supervision as staff were on the ground floor assisting with the meal.

People were unsure or unable to form strong opinions on whether there were sufficient staff on duty at any time to enable everyone to be looked after and cared for appropriately. People commented "Probably they don't have enough carers at times, they could do with a few more sometimes I think," Generally, I think there are just enough girls on duty but there seem to be far more today" and "Enough carers? I'm not sure, they are probably one or two short on occasions but most of the time it is probably okay." Another person told us "Yes, I have a call bell and they all come quickly but this morning, with the bell, I rung it and rung it and they didn't come for ages, that was unusual".

Some relatives felt the staffing levels were not sufficient. A relative told us often only one staff member is left on the unit when staff go on breaks. They commented "Sometimes my [family members name] have to wait to go to the toilet, very degrading and more than one incidence where this has happened." Another relative told us people had to go downstairs even if not well enough to do that, simply because there was not enough staff to supervise people on the units at peak times such as mealtimes. They told us there was a delay in call bells being answered.

Some staff we spoke with thought the staffing was sufficient to meet people's needs. A staff member told us "Yes, I think it is." Other staff told us the staffing levels were not always sufficient. They indicated this was because there had been a number of recent admissions to the home of people with high care needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff were not suitably deployed to meet people's needs.

People told us they felt the home was generally kept clean. A person commented "Yes, my room is always spotlessly clean."

Cleaning and laundry staff were employed and managed by the head of housekeeping. The head housekeeper showed us a weekly cleaning schedule 'domestic cleaning records book' – this was up to date. The service had no designated infection control lead and there was no infection control risk assessment in place to identify and mitigate infection control risks. Staff told us they had completed infection control training. Some staff had evidence of on-line infection control training on their files. Other staff had no evidence to indicate this training had been completed. An infection control audit was carried out in April, June and October 2018. Those audits consistently showed high scores. Gloves, aprons and appropriate bins were provided to prevent the risks of cross infection. However, we saw gloves were not routinely worn when staff were applying prescribed creams to people or when carrying out blood glucose monitoring tests. This has the potential to cause cross infection.

It is recommended that the service works to best practice in relation to infection control to ensure the risk of cross infection is mitigated.

People had individual personal emergency evacuation plan (PEEPs) n place. These outlined how individuals should be supported to evacuate the building in the event of a fire. The building had 'ski pad' evacuation slides for the upper floors. A 'grab bag' for emergency use was available in the reception area. During the inspection we saw the laundry room door was propped open with a wedge, despite the door having an automatic door closure installed. The wedge was removed however, on-going monitoring is required to promote fire safety.

The head of housekeeping was responsible for carrying out health and safety checks and dealing with maintenance issues at the service. The health and safety records viewed showed weekly and monthly fire checks were carried out. A fire risk assessment was in place dated June 2018. This was completed by the registered manager and not by a person deemed competent in this role. The registered manager had arranged for an external company to come in and complete the fire risk assessment. This was carried out and issues identified were being addressed by the head of housekeeping. A legionella risk assessment and water safety check was completed in July 2018. Equipment such as gas, electricity and moving and handling equipment was serviced and suitably maintained.

Staff were suitably recruited. They completed an application form and attended for interview. Pre-employment checks such as references from previous employers to establish the applicants' conduct while in their employment and a disclosure and barring check (DBS) to ensure staff had not committed any offence which would prevent them working with people who used the service were carried out. Some staff had an update service for their DBS. This meant they paid an annual fee to keep their DBS up to date. The registered manager had a copy of some staff member's DBSs relating to previous employment but had not obtained the up to date confirmation of their DBS. They agreed to do this.

Inadequate

Is the service effective?

Our findings

People were supported by a service that was not effective.

Some people told us staff were very good and trained to do their job, However, others told us some staff did not seem to have the right skills, training and attributes for the job. They commented "Some of the carers are fine and skilled but some are not properly trained, they are youngsters after all and I don't think they properly understand my needs," "The carers are alright, they do know what to do, although they vary in their abilities" and "Yes, staff are fine most of the time but some of the younger ones don't know so much though."

The majority of staff we spoke with told us they felt suitably trained to do their job. Some staff members told us they had completed the on-line training but that did not mean they were suitably trained. A staff member told us they had not done any training at the home. They stated, "All my training has expired." They told us they had done "No practical moving and handling training either."

The training policy outlined that each staff member new to Lakeside should complete the staff induction using a 'Red Crier standard pack which was the training package used by the organisation. The registered manager told us new staff were inducted into their roles. However, none of the staff files viewed showed evidence that staff had completed the required induction and the registered manager had no record of which member of staff's induction was completed and signed off. There was no evidence that an in-house induction had been carried out either. A staff member told us that they had been given the Care Certificate (which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care) to complete but "Found it too confusing." They told us they were not supported with it and did not feel suitably inducted.

The organisation's quality audit policy outlined that each staff member will have a professional development plan. The registered manager told us those were completed and filed in staff files. However, none were available in any of the staff files viewed. The registered manager had no system in place which outlined what training was required for each role and therefore they had not satisfied themselves that staff were suitably inducted and trained into their roles.

The service had a training matrix which showed the training that had taken place, however staff files did not include training certificates for all the training recorded on the training matrix. Some staff had on-line training the provider considered mandatory but none of the staff files viewed included certificates to show that any one of those staff members had all the training defined as mandatory by the organisation. No training other than practical moving and handling training was recorded for some new staff in post since November 2018 and the practical moving and handing training was facilitated by staff members who were not trained in the role. A registered nurse on night duty had no training certificates in their file to indicate they had received training in medicine administration and PEG feed training even though they carried out those tasks at night. The registered nurses lacked specialist training in nursing tasks such as catheter care and only four out of 37 staff had training in behaviours that challenged and diabetes. However, there were

no certificates in staff files to confirm that staff who were supposed to have completed challenging behaviour training had that training. No staff had training in epilepsy or Parkinson's Disease even though the service supported people with those medical conditions.

Systems were not in place to ensure that staff were assessed and deemed competent to carry out tasks as part of their role. A registered nurse had carried out an invasive procedure on a person without being deemed competent to do that task. We saw in a carer's meeting minutes that staff had brought up issues about a registered nurse's practice in relation to the use of the suction and the BiPap machines. (If you have trouble breathing, a BiPap machine can help push air into your lungs.) This was discussed at a subsequent registered nurses' staff meeting. The registered manager provided us with a file note to say that concerns around using the BiPap machine were raised directly with the registered nurse and they were subsequently dismissed. There is no reference to a discussion around their knowledge on the use of the suction machine. Despite this being raised as an issue, the registered manager then failed to put systems in place to assess nurse's competencies in the use of those machines to satisfy themselves that they were competent in using them.

One of the nurse assistants was trained to do medicine administration and other aspects of a nursing role such as syringe driver, taking bloods and PEG feeds. Training certificates were provided to show they were trained in those areas. A competency tick list was in place but no detail around the competency assessments were provided. The other nurse assistant had completed no aspects of additional training except medicine administration training for the role but was included on shift in the role of nurse assistant. The nurse assistant on night shift had no competency assessments carried out on them and had no training specific to that role. We saw they administered medicines even though there was no indication in their training file they had completed medicine administration training. The nurse assistant job description outlined it was required for staff in those roles to have a National Vocational Qualification level 3 and to hold a medication certificate. The nursing assistant files viewed did not evidence that they had those required qualifications and skills to enable them to fulfil the role.

A visiting professional told us the nurse assistant role was not clear and it gave the impression that staff in those roles were registered nurses. They went on to say that "The nurses do not always seem to know how to manage situations and I question is this because they lack the training and experience in the role."

Staff told us they felt supported and had regular one to one supervision sessions. A supervision matrix was in place where the dates of supervision were recorded. However, some of the dates of supervisions recorded on the supervision matrix did not correspond with them or the staff member who had carried out the supervision having been on duty. The registered manager told us this was because staff would have come in on their day off but had not recorded it. The organisation's policy on supervision outlined that staff would have six formal supervision sessions per year. Seven of the seventeen staff files viewed had no supervision record included for 2018, four staff had one supervision recorded, three staff had two supervisions recorded and three staff had three supervision sessions recorded. The matrix indicated staff had annual appraisals but only appraisals for 2015 were filed in some of the staff files viewed. The registered manager was unable to explain the lack of supervision records in staff files. They told us they signed them off prior to them been added to the supervision matrix.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff were not suitably skilled, trained and supported in their roles.

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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw an example of a decision specific mental capacity assessment. However, this did not provide detail on how the person's capacity to understand, retain, weigh and communicate particular decisions was determined. The decision for which we saw mental capacity assessment was 'Day to day assessment of mental capacity'. The form was blank, apart from the person's details and date of assessment. It simply stated, '[Person's name] had fluctuating capacity', without detail to support how this conclusion was determined. In another person's file it was recorded they had 'limited capacity' but the mental capacity assessment referred to the person needing support with 'complex decisions' Their mental capacity assessment was incomplete so it was not established how staff had concluded the person had limited capacity or what areas they needed support with. A registered nurse had carried out an invasive procedure on this person without any regard as to whether they could consent to and understand the procedure being carried out or whether the procedure was in their best interest. The outcome of the mental capacity assessment also questions the person's understanding of the risk assessment for storage of the thickener in their bedroom, which if eaten could lead to choking. The person's medicine administration record indicated that one of their medicines was to be crushed and given in yogurt. There was no indication that the service had considered was the person able to consent to this or was it being administered covertly which means it was hidden from them. If given covertly there was no best interest decision to support the practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff were not working in line with the Mental Capacity Act 2005.

The registered manager told us most people currently residing at the home could consent to their care. Staff we spoke with showed an understanding of consent and offered choices. Records showed people who required bed rails were consulted with about their use on and gave their consent. In a care plan, we saw that a person who received nutrition and hydration via PEG did not comply with their PEG feeding regime. The person's refusal to follow the regime had been recorded in the care plan, in daily notes of care, and the GP and dietitian were aware of the situation. A meeting was being arranged to further review the situation.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had no DoLS applications pending or approved. Staff spoken with confirmed they had completed on-line MCA and DoLS training. The staff files did not evidence that all staff had this training. Staff demonstrated a good understanding of the Act and their responsibilities. Some staff members could cite the key principles of the MCA 2005. A staff member cited key principles including "assuming capacity" and acting in the person's "best interests" should they lack the capacity to make a decision.

The registered manager informed us some people had a nominated Power of Attorney for their health and welfare and property and financial affairs. Records relating to Lasting Power of Attorney's for a sample of people were requested and viewed. A person told us it was "For everything, I've got no worries. It was the best thing."

Care plans included an initial assessment but this was brief. The registered nurses told us they completed their assessment on admission and relied on referrers to give them the detail as to people's needs. The nurses advised the registered manager or deputy manager carried out assessments of people admitted from home.

A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Professionals included the GP and physiotherapist (both visited during our inspection) district nurse, palliative care nurses, occupational therapist and speech and language therapist (SALT). People who lived locally could keep their regular GP. Access to routine dental and optician appointments were promoted. The GP's sent a summary of their visit to the home by email and this was printed off and included in people's files. The service had no system in place to ensure that people and their medicines were reviewed by their GP's at least annually.

We spoke with a GP who told us "The staff are brilliant" and they "Call us when they need us". They "Look after patients well". We also spoke with a physiotherapist who told us they worked specifically with people admitted for up to two weeks under the 'discharge to assess' scheme. We observed that the physiotherapist visited the home on both days of our inspection. They told us "If staff are worried, I will come and see them immediately." This meant that people's mobility was assessed promptly.

Two health professionals told us people's conditions were not routinely monitored in that their vital observations were not done and recorded. They told us constipation medicines were requested for individuals but no records regarding bowel movement and/or weight were recorded. They advised requests for blood tests were not being done when asked which impacted on people's medication reviews. This meant the care was not effective.

It is recommended the registered manager ensures people's health needs are effectively monitored to promote their health and well-being.

People were happy with the meals provided. People commented "I seem to like it here, the food is very good, no complaints at all really". "I lost a lot of weight when I was in hospital before coming here, the food is good. There are choices and I think the menu is on a rota, I've certainly put on weight now". "They have their own chefs here and the chef comes in to see us sometimes and asks us what we think of something new he has cooked". "The food it is good, there is often too much. I was a good cook and I appreciate the food here, although often just the soup and the pudding would be enough."

Meals were prepared from fresh ingredients. People were offered a choice of main meals and alternatives such as omelettes, salads or jacket potatoes were available. A weekly 'winter menu' was in use which provided variety and balance. There was a fork mashable version of regular menu. The chef told us there was "generally a soft option" Some people required high calorie diets and these were provided. Foods were fortified and high calorie foods were provided e.g. mashed potato fortified with butter or cream, fortified milkshakes. We observed people were provided with drinks regularly throughout the day and people who required it were provided with thickeners in their drink and equipment to enable them to eat independently and safely.

Areas of the home had been updated. New lifts had been installed and the communal bathrooms had been updated. However, other areas of the home were beginning to reflect its age with the décor a little tired and paintwork often chipped and in need of renewal. The owner who was present on day two of the inspection told us they were looking to update the home. A redecoration programme was requested but not provided. On day three of the inspection the registered manager told us they were getting quotes for work to be done but there was no written refurbishment plan in place to outline the schedule of works planned.

Some people and their relatives described the home as "shabby" and a relative told us the chair provided in their relative's room was not fit for purpose. We reviewed this and saw that the shower chair was damaged. The arm rests were split with foam coming out of it and this allowed the water to soak in. This was fed back

to the registered manager to address prior to a new person moving into that bedroom.

Requires Improvement

Is the service caring?

Our findings

Some people and their relatives told us staff were kind and caring. A person told us "I've done wonderful" since coming to the home. They told us there were "lovely staff". Another person told us "It's all right. It's much better than when I was living on my own." A third person told us "here everything is okay". They added they received "all the help that I ask for". A person pointed to a staff member and told us "This lady is the best of all." "They do all that they can for me here." "Yes, staff are as good as good as gold, they shower me, dress me and help me in so many other ways".

Some people found some staff less caring. They commented "Well the carers do say hello to you but you get the impression that most of them are just here to do a job," "You can't explain to some of them how to do it because they haven't been listening," "Sometimes when two staff are using the hoist to move me they talk to each other over the bed, they often talk over you and to themselves" and "The majority of staff are okay but a few can't seem to speak to you in a civilized manner, if I talk to them politely then some of them don't even answer."

Another person described staff as "pretty good." However, they told us "there is the odd one who can be a bit 'knocky' with me." We asked the person what they meant and they commented "For the very first time I wasn't happy with them this morning; I have a rail at the side of my bed, to stop me falling out, but they didn't come to get me up until 11 o'clock this morning". "They never answered me back when I kept on asking for the rail to be let down but I could hear them helping other people to go to the toilet, but they told me I must wait. ""I know they have lots to do but being forced to stay in bed until 11 has got me down this morning, I was cross."

A relative told us "Staff are lovely. A lot of the staff speak the (person's native) language." Another relative told us "We have nothing but positive comments" about the home which they described as "utterly fabulous". Staff were "kind and caring towards Mum". A staff member told us "This is more like a family run home." A health professional commented "Staff nurses and the carers do seem caring but the issue is having time to care."

Throughout the inspection we observed positive and negative interactions. Some staff were kind and caring in their engagement with people. They spoke to people calmly and offered good eye contact and appropriate touch. Other staff were rushed, serious faced, displaying furrowed brows and made no time to stop and engage, however briefly, with people. At lunchtime a person was sat at the dining room and told us they had asked the nurse assistant to take them to the toilet before lunch but the staff member proceeded to carry on doing what they were doing. After 10 minutes the person asked another staff member who supported them.

During lunchtime a person started to be sick at the table. There was a staff member sat at the same table supporting another person with their meal. However, they failed to notice that the person was being sick. The staff were alerted to it by another person sat at another table. This was fed back to the manager to address. On day three of the inspection we checked the staff member's file to see if this had been addressed

with them. There was no evidence on their file to suggest it had.

During the inspection, whilst a member of the inspection team was in a person's bedroom a staff member entered to deliver something. The staff member did not stop and engage with the person. The person proceeded to talk to the staff member and asked her a question. The staff member did not respond to the question and left the room without explanation or stopping to listen. This did not promote the person's dignity.

During discussion with a registered nurse they referred to two people as "falling for attention." When asked if this was documented, they commented "I must have got mixed up with someone else." This was fed back to the registered manager to address.

Whilst the registered nurses and deputy manager worked on the floor there was no evidence to suggest that staff practice was being monitored and poor practice addressed.

It is recommended that systems are put in place to monitor staff practice to ensure that staff work in line with best practice to promote people's dignity.

People had their own bedrooms with an en-suite shower. The bedrooms viewed were personalised. Staff were observed to knock on people's bedrooms doors, prior to entering. People who required it were provided with napkins at meals times to protect their clothing. People were suitably dressed clean and tidy. People told us staff knocked on their bedroom doors. A person commented "They always knock on my door even if they are just coming to check if I am alright".

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place. The care plans viewed outlined the support required with aspects of their care but did not provide specific detail to promote continuity of care. For example, a person's care plan on promoting skin integrity indicated the person had an air flow mattress in place and was to be turned regularly. There was no detail on what constituted regular turns and the turn chart records showed variance in the frequency of the turns. Other care plans indicated people needed support with their personal care, food and fluid and dressing but did not provide the detail on the level of support required.

The service supported a number of people with a diagnosis of diabetes. Their care plan made brief reference to the person's diabetes but it did not outline how staff would recognise a hypo or hyper glycaemic coma and the emergency action to take. Other people had medical conditions such as epilepsy and Parkinson's Disease. Their care plans made no reference to these conditions or the level of support and intervention required, including any emergency action following a seizure. A person living at the service had been displaying behaviours that challenged. Their daily reports showed they had been physically and verbally aggressive to staff. The person's care plan made no reference to it and no behavioural care plan was in place to provide consistent guidance on how the person was to be supported.

The service had people on end of life care. A care plan for a person who was receiving this support was reviewed. It did not provide any details on the person's wishes and simply stated "The family are involved in this." People had care plans around their prescribed medicines. However, the care plans failed to make reference to the use of anticoagulant medicines for individuals and any potential risks that staff needed to be aware of and respond to. Care plans were reviewed monthly but the reviews failed to pick up that the detail within the care plan was not sufficient to enable staff to provide person centred care to people. The service was in the process of changing over to electronic care plans but there was no timescale in place as to when this would be actioned.

A keyworker is a named staff member who supports a person to coordinate their care. There was a list in the office of keyworkers for individuals. However, people and their relatives were not aware they had a keyworker or who it was. This was fed back to the registered manager to ensure people and relatives were informed.

People's care plan outlined how they communicated their needs although the detail around how to promote their communication was brief and not very specific. The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had no policy or guidance on how they would meet the AIS. Information on complaints, menus and activities was not person centred or provided in a user-friendly format. Therefore, information was not accessible to everyone in line with the AIS.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because person centred care was not promoted.

We saw for one person whose first language was not English staff used an iPad to promote their communication. People's day to day choices on what they wanted to eat, drink and do were promoted. A person commented "They usually take me to bed at 8pm, which is exactly when I want to go to bed". Another person said "Yes, I stay up quite late at night, in my room and they respect that. My room is a big long room and I am hoping that they will let me bring in (my knitting machine) eventually."

The service had an activity coordinator in post, however throughout the inspection we saw they regularly assisted people with their care. The service had a monthly calendar of events which included mainly in-house activities such as dominoes, bingo, crosswords, quizzes and games. Throughout the inspection at various times of the day an activity took place. They had an external entertainer that came in once a month and the activity coordinator had set up visits to the service from a local children's day nursery.

We received mixed feedback on the current activities provided. People were very positive about the activities organised over the Christmas period. Some people told us they were happy with the activities provided, whilst others felt more activities out of the home could be included. People said, "I do sit in on some of the puzzle game sessions and enjoy them" and "The music and the quizzes we have here all help me". Others said, "I would like to get out, just occasionally, and they did push me on a few walks around the lake in the summer but otherwise I am in here all of the time," "Yes, I do miss having the chance to go out at all, just to the pub would be lovely, I do miss that,"" Well I don't feel I get enough exercise, it will be good when we can go around the Lake again," "A singer comes in, but most of the residents are half asleep when he sings," "I have to say it is always very quiet at the weekends, people tend to sleep a lot," "I'm not aware of there being any one to one activities, especially for people in their bedrooms" and "I would like a Church person to come sometimes but it seems nobody does now- a Korean Father used to come and give Holy Communion, he did not stay very long but he does not come now."

Relatives spoken with were happy with the activities provided. Relatives commented "They had functions in the summer, the Fete was good… it boosts everyone's morale if nothing else," "My relative had been reluctant to attend any activities, but they had recently joined in the bingo session" and "On occasions some…Young people come along to visit and it is a delight to see how some of the residents enjoy that."

The service had a complaints policy in place. It indicated complaints would be investigated and responded to within 28 days. The service had a log of complaints. Three complaints were logged for 2018 and several compliments were on file. One of those complaints dated 15 November 2018 was still open and being addressed. People told us they felt able to raise issues with staff. One person felt their complaints were not acted on. They commented "It is no good complaining to the manager. They come in and tell me all the staff are complaining about me as opposed to wanting to hear my complaints".

Some people had a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) order completed and on file. They had been completed by a consultant or a GP and discussed with the person or their family.

Inadequate

Is the service well-led?

Our findings

People were supported by a service that was not routinely and consistently well-led.

There is a legal requirement for providers to be open and transparent. We call this duty of candour (DOC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation. The registered manager had an awareness of what the duty of candour meant. They told us they would speak to the person and their relative affected. However, there was no duty of candour policy in place and evidence to support that people were provided with a written record of the incident as is required under Regulation 20.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the duty of candour Regulation was not complied with.

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when an allegation of abuse had been made. The registered manager had some awareness of what needed reporting to the Commission. However, we saw the required safeguarding alerts were not made and the Commission was not informed of incidents that required notification to us such as poor practice in relation to moving and handling, double padding and allegations of neglect.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is because the registered person failed to notify the Commission without delay of incidents which impacted on people's care and well-being.

People's care plans, risk assessments and medicine records were not suitably maintained. They lacked detail, were inaccurate and were not routinely signed and dated. Some sections of the assessment documentation and mental capacity assessments were not completed. After the inspection the registered manager sent us a notification which disputed an entry in a person's file. They indicated the entry was not an accurate record of the procedure and action that the registered nurse had taken. They told us this was because the registered nurse did not know how to record the action they had taken. On day two of the inspection staff training certificates were not available to us during the inspection. This was because the registered manager told us they did not have the key to access them. The staff training and supervision matrices were not accurate. They did not reflect the training and supervision staff had. Dates on some staff competency records and supervision records did not correspond with those staff being on duty and the rota was not reflective of them coming in for supervision and training. The registered manager told us they carried out staff return to work interviews and dealt with disciplinary issues. However, records were not always available on staff files to indicate any action had been taken in response to poor practice.

The registered manager carried out quarterly quality audit checks of health and safety, infection control, laundry and catering. The audits completed on each of those areas showed a high score to indicate they

were very few issues identified. Where issues were identified e.g. in the kitchen audit an action plan was completed and repeated on each of the audits except for the kitchen audit dated 7 October 2018 where there was no reference to the previous actions and no indication if it had been rectified. The registered manager told us they audited staff files. They had a matrix to enable them to audit when staff supervision had been carried out. However, the audit was ineffective as the supervision records viewed did not match the date entered on the matrix and supervision of staff was not taking place in line with the provider's policy. The training records showed gaps in training and inductions which had not been picked up and addressed either. Systems were in place to record the number of accidents, incidents, complaints and staff sickness each month. The accident records showed a high number of accidents were reported in June, July and August 2018. We reviewed those records and saw two people had recurrent falls and there were trends around the days and times of these accidents. There was no indication this had been picked up as part of the auditing of accidents and incidents and addressed.

The registered manager told us that the deputy manager and registered nurses carried out audits of medicines and care plans. Medicine audits were scheduled to take place in February, May, August and November each year. The medicine audits for February and May 2018 were available but the audits for August and November 2018 were unable to be located. The registered manager was sure these had been done but did not know where they were. The medicine audits for February and May 2018 showed 100% pass and no issues were identified which is not in line with our findings or the Clinical Commissioners Group (CCG's) findings in relation to medicine management. We asked the deputy manager for copies of the audits of care plans. They told us "We do audits but we do not record it." The care plans viewed did not evidence auditing was taking place which could have enabled the issues we found in people's care plans to be highlighted.

There was no system in place to monitor staff practices and address poor practice. Despite concerns been raised in staff meeting minutes about poor practices at night, no night time checks were recorded as having taken place. The registered manager told us they carried out night checks but did not record them. Therefore, there was no way of verifying that those checks had taken place.

There was a lack of provider engagement and oversight of the service. The provider had no systems in place to monitor the service and relied on the registered manager to do this and report back to them. Therefore, there was no external scrutiny of the home and practices. As a result, shortfalls in care and practices that we have found at this inspection were not identified by the provider or the registered manager.

The findings of this inspection and the breaches of Regulations of the Health and Social Care Act 2008 demonstrate that the service was not been effectively managed or monitored to provide safe care to people. The registered manager had been the registered manager at the home since October 2011. They told us they felt supported by the provider and had formal meetings with the owner on a regular basis. However, no records were maintained of those meetings. They told us they liaised with other registered managers, attended provider meetings and kept themselves up to date through reading journals and attending relevant training. The training matrix provided showed the registered manager had training the provider considered mandatory such as fire safety, infection control, health and safety and safeguarding vulnerable adults. They had completed a work book on medicine management but had no other training recorded relevant to their role as a registered manager. Despite the recent medicine training the service was not working to best practice in relation to medicine management. The registered manager told us they were unaware of the National Institute for Health and Care Excellence guidance (NICE) on medicine management in care homes which was originally published in March 2014 and therefore had failed to keep themselves up to date. The registered manager was not clear of the vision and values for the service. Their intention was to continue to run the service as it was but they acknowledged they needed to make improvements to

medicines following a recent CCG pharmacy visit.

The organisation's quality audit policy suggested staff and relative meetings would be held three monthly. It was not specific as to the frequency for each staff role or night staff and there was no schedule in place to outline when meetings should take place. No relative meetings had taken place. The registered manager told us they had no uptake in relative's meetings, hence why they were not taking place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because records were not suitably maintained, accurate or complete. Systems and processes were not established and operated effectively to promote good governance and effective management of the service.

Some people and their relatives were happy with the way the service was managed. They told us they could approach the manager and a person commented "[Managers Name], she is alright". Other people and their relatives did not find the registered manager or deputy manager approachable or accessible. People commented "It would do [Manager's name] good if she came around the bedrooms sometimes to see how the carers do their jobs, to see how it was". "[Manager's name] only comes up to see me if I have made a complaint". Some relatives described the management team as "Rude, brash, confrontational, and argumentative." A relative commented "The [managers name] is not very warm, she doesn't speak to us and fails to respond to our emails."

Some professionals were positive about the way the service was run and managed. However, two other health professionals described the leadership style as "bullying" with one of those health professionals telling us they had been bullied. The local CCG involved with the service provided us with feedback on their visit and findings. They made us aware of the registered manager's initial unwillingness to engage with them, accept and follow their advice to bring about improvements to the service. Staff told us they felt the home was well managed. They confirmed the registered manager and deputy manager were approachable and accessible. They said the deputy manager assisted on shift when required.

Staff and resident meetings took place. Four resident meetings took place over the year and were facilitated by the activity coordinator. These included discussions on forthcoming activities as well as getting feedback on people's care and any suggestions for improvements. Registered nurses' meetings had taken place in January, April and October 2018, carers meetings had taken place in May and October 2018 and night time carers had one team meeting in January 2018 to specifically address concerns they had. Relatives were invited to give formal feedback through the homes surveys. The quality audit policy indicated surveys were completed annually. The last relative, resident and professional survey was completed in 2017. No issues were raised and only positive feedback was received. The registered manager confirmed a survey was not completed in 2018 and they were in the process of sending out the surveys for 2019.