The Grange Care Providers Limited

The Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 19 and 25 May 2016. The first day was unannounced and the second day was announced.

The service was last inspected on 22 April 2016 where we gave it an overall rating of good. The service required improvement in responsive. The provider was asked to consider improving the range of activities available in the service. At this inspection we were not able to see improvement in the activities provided.

The Grange is a residential care home for older people. It is registered to provide accommodation and personal care for a maximum of 24 people. There were 20 people living at the service on the days of our inspection. Some of the people were living with dementia.

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.

The provider and registered manager were not proactive in identifying and managing risks to the people who lived there. Risk assessments for people living at the service were not individualised and staff didn't always know how to effectively support people safely.

People were place at risk of harm because the provider had failed to maintain the building in a safe manner. Some fire doors were unsafe and not fit for purpose. There were worn carpets and loose floorboards which compromised the safety of people who lived at the service.

Accidents and incidents were not thoroughly investigated or audited. The provider missed opportunities to learn lessons from these incidents as a result.

People's ability to consent to their treatment was not always respected. People were not actively involved in decisions about their care and treatment. People's care records lacked detail about their individual care needs and preferred interests and hobbies. Complaints were not managed well and people could not be assured that their concerns would be listened to and acted upon.

The registered manager lacked confidence in dealing with difficult issues, such as safeguarding concerns or staff management. Investigations were not carried out thoroughly to find out the cause of concerns and opportunities to improve practice were not taken.

People were cared for by sufficient numbers of staff during the day. However, we were concerned about the numbers of staff providing care during the night.

People received kind and caring support from staff. People's dignity and privacy wasn't always respected by the staff as they provided care and support.

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

During the inspection we found breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people's health and safety were not identified, managed, reviewed or updated to ensure people's safety.

There were no systems in place to identify themes with accidents or to learn how to prevent further accidents.

The provider did not have systems in place to check equipment in the service on a regular basis.

The provider had not maintained the building safely to protect people from avoidable harm.

Is the service effective?

Requires Improvement

The service was not effective.

People were cared for by staff who did not receive the required training to be able to care for people safely. There was no system in place to identify when training was due to expire.

The senior staff team did not fully understand the requirements of the Mental Capacity Act 2005 and did not have processes in place to protect people's rights.

People were supported to eat and drink enough and to have a balanced diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always respected by staff.

People were cared for by kind and caring staff.

People did not receive a consistently caring service because of a lack of involvement in their personal care planning.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always provided with care and support which was individual and personal to them.

People were not supported to take part in activities or pastimes on a regular basis.

Complaints were not always dealt with to the satisfaction of the person complaining.

Is the service well-led?

Inadequate

The service was not well led.

The was a lack of effective leadership.

Effective systems were not in place to assess and monitor the quality of the service provided.

Action was not taken where shortfalls in the service were known.

The provider's systems did not always identify when premises were unsafe. Where they had been identified, there were delays in making the premises safe.

The Grange

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 19 May and 25 May 2016. The first day was unannounced and the second day was announced.

The inspection team consisted of two inspectors.

We carried out this inspection in response to concerns we had received and information that was shared with us from the local adult safeguarding team. We completed a comprehensive inspection and looked at all five key questions.

As part of our planning we reviewed the information we held about the service and the provider. This included statutory notification's received from the provider about deaths, accidents and safeguarding alerts. A statutory notification is information about important events which the provider is required to send us by law. We asked the provider to complete a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used this information to help plan our inspection. We also spoke with the GP who attends people in the service and the local safeguarding team.

During the inspection we spoke with seven people who lived at the service and two relatives. We spoke with five staff which included care staff, the cook and the deputy manager. We also spoke with the registered manager and the registered provider. We reviewed four care records which related to assessment of risk and people's needs, including mental capacity assessments. We also viewed other records relating to staff training and management communication.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people's care and support in

the communal areas of the home and how staff interacted with people.

Inadequate

Is the service safe?

Our findings

Staff members we spoke with told us that they knew what abuse was and that they would not condone it if they saw it.. Two staff members said that they would report it to the manager or deputy manager initially, and would contact the Care Quality Commission (CQC) or the local authority if they were worried about someone. The registered manager was able to confirm to us that they understood their responsibilities with regard to the reporting and monitoring of safeguarding concerns within the service. However, they could not assure us they would take appropriate action when concerns were identified. For example, we were notified of a concern about a person who used the service sustaining an unwitnessed injury. The registered manager had not sufficiently investigated the cause or reported it to the appropriate people. They were unable to identify if the accident could have been avoided or how to prevent reoccurrence.

We found further examples of accidents and incidents that were not thoroughly investigated or audited. The registered manager did not have methods in place to identify themes or learn how to prevent reoccurrence. This placed people at risk of further harm or injury. For example, one person had fallen five times in three months and was high risk of further falls. The person fell for a sixth time and was taken to hospital with a serious injury. There was no evidence that the registered manager had sought guidance and support from healthcare professionals in order to reduce the person's risk of falling. The registered manager told us this person had always fallen and did not believe it was necessary to contact other professionals for further guidance.

Premises and equipment were not maintained and well managed to keep people safe. There were areas of the premises which were hazardous and compromised the safety of the people living at the service, staff and visitors. For example, there were areas of worn carpets and loose floorboards under carpets which formed a trip hazard. One healthcare professional had tripped on one area and was injured. This area was repaired as a response to this incident, but other areas remained unsafe. The registered manager stated that they had informed the registered provider of these concerns. Records we looked at showed the provider was aware of this potential hazard in March 2016 but had taken no action to reduce the risk to people by repairing damaged floorboards at the time of our inspection.

We looked at how the provider and registered manager managed risk at the service. We found that people were not involved in the process and risk assessments did not reflect their individual needs. The registered manager told us they did not have any processes in place to identify and monitor changes in the levels of risk for each person. The risk assessments we looked at were the same for everyone using the service. Therefore staff could not rely on the guidance given to keep people safe. This was because they were not person centred. Staff we spoke with told us they read the care plans, but did not understand how to keep people safe from the information in the plans. One staff member said that, where possible they found out from people themselves about what support they needed. Where people had difficulty communicating their needs, care was seen to be provided in a kind way but people were not included in deciding how the care was provided.

We saw wheelchairs were not properly maintained and placed people at risk of injury when they used them. The registered manager told us there was no current system in place to make regular safety checks on equipment used in the service were carried out. They were not able to tell us when they thought a wheelchair may be unsafe to use. A staff member and the registered manager showed us how people using the lift needed to use the wheelchairs with footplates folded back and this caused their feet to drag on the floor placing them at risk of injury. We asked the provider and registered manager to take action to repair equipment that could have caused injury to people.

We saw that fire doors were propped open with chairs or wedges. Other fire doors did not close properly or had holes in them. We also found one door handle in one person's bedroom was missing and could have affected their ability to leave the service in an emergency. Personal Emergency Evacuation Plans (PEEP) were not in place. These plans showed how each individual's evacuation needs had been assessed in the event of fire or other emergencies. This information would be used to assist staff and emergency services in the safe and rapid evacuation of people living at the service. The registered manager was not aware of the requirement for PEEPs, and was not able to tell us what would need to be considered in preparing a PEEP. The provider had not taken sufficient action to keep people safe in their planning of fire prevention and event of fire breaking out. We referred our concerns directly to the local fire safety officer. We were advised after the fire officer visited, the provider needed to take further action to fully meet fire safety requirements.

This is a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the staffing levels were sufficient to provide the required level of care for people living at the service. They could not tell us how they determined the number of staff they needed on duty to meet the people's needs. There was no system in place to help them do this.

We saw that the staff were able to provide support for people in a timely way during the day. However, at night there were two staff on duty. The provider had recently notified us of four serious injuries people had sustained. Three of the injuries occurred during the night when there was reduced staffing numbers. Staff told us that some people needed two staff to help them move safely or to be supported with personal care. When staff were doing this there was no other staff available to support other people in the home. The service also had five people in independent living bungalows across the car park from the main building. The registered manager told us that people living there were checked every hour by a member of the night staff. This would mean that there were times during the night where there would only be one member of staff in the main building. This raised concerns that one staff member would not be able to provide safe care for the people living in the main building as some of them required the support of two staff members.

We discussed the recruitment and induction processes with the manager and deputy manager. We saw that staff members did not start working at the service until the manager had received two references and a Disclosure and Barring Service (DBS) check. The DBS checks the background of staff to be sure they are fit to care for people.

We looked at how people were supported to take their medicines. We saw that the staff member gave their medicines according to national guidelines. They spent time with each person, explained what the medicines were for. They ensured each person had a drink to help to swallow the medicines. One person told us that they received their painkillers when they need them. A staff member told us that staff do not give medicines unless they have received training. This staff member took overall responsibility for the ordering and storage of medicines. We noted that their medication training was last undertaken in 2008. They were unable to tell us how they updated their knowledge to reflect new practices and guidance. The provider did

not have systems in place to check the competency of staff members dispensing medicines. This placed people at risk of having medicines given by staff who did not have sufficient knowledge about their medicines to be able to safely support them with their medicines.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed.
Staff members we spoke with confirmed that they were aware of the MCA and DoLS. One staff member said, "It is important that we don't deprive people of choice and their rights." Another staff member told us, "If a person lacks capacity then we need to make decisions in the best interests of that person. We can look at the best time to help them because it may be different times when they will do things." There was no system in place to show how the registered manager assessed people's capacity to make specific decisions about their care and treatment. For example, we talked with a staff member about a person who occasionally wanted to go outside. We were told that the person would not be supported to leave the home because it was not safe. The staff member told us that when this happened, they would try and distract them to do something else and report it to the manager. We checked this person's care records and we found no mental capacity assessment had been completed with the person. We looked at another person's mental capacity assessment, the registered manager told us, "Because of [Person's name] communication and cognitive problems, the family/friends will also be involved in any decision involving [Person's name] care." The registered manager confirmed that this was decided because staff had difficulty in understanding the person and not because the person lacked the mental capacity to make their own decisions about their care and treatment. The registered manager also confirmed that neither the person nor family and friends had been involved in any decision making.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to received care and treatment when this is in their best interests and legally authorised under the MCA. The application for this is called the Deprivation of Liberty Safeguards (DoLS) and the Care Quality Commission monitors the operation of DoLS in care homes.

On the day of our inspection we saw that the registered manager had made four DoLS applications. We spoke with the registered manager who could not tell us why they had made these applications to deprive people of their liberty but they added people would be in danger if they went out alone. There was no system in place to assess people's mental capacity, no information about acting in the person's best interests. The registered manager was not able to say how they had included this person in the decision making or how they had considered other least restrictive options prior to these applications being made.

We asked the registered manager how they enabled staff to learn and keep up with current best practice. They told us that much of the staff training had been cancelled because of staff shortages but said that some staff had recently completed their fire safety training. We heard mixed views on staff's knowledge of how to support people with dementia. Two staff members told us that they had received training which had improved their understanding and confidence in supporting people living with dementia. One staff member told us, "I have developed empathy and understanding in how to help people." However, there was a lack of

understanding about how to identify and alleviate episodes of ill-being for people with dementia. For example, we talked about a person who frequently cried out. A staff member told us that this was because of the person's condition and that the staff team just accepted that. The registered manager was not able to tell us what support or actions had been taken to support the staff team to understand or alleviate the reason for this person's crying out. There was no information in the care file to assist staff to support this person when upset.

We received mixed responses to our question about staff supervision. The registered manager told us that staff received supervisions. However, the deputy manager told us that the supervisions did not always happen because the staff did not show up. One staff member said that they received supervisions every three months and they found them helpful as it was an opportunity to discuss their progress. One staff member confirmed that they were provided with sufficient induction to assist them to get to know the people living at the service.

People who had difficulty swallowing had been assessed by the Speech and Language Team (SaLT). One person living at the service had swallowing difficulties and was given a cup of tea which had been thickened. The tea was too thick and did not move in the cup. This meant that the person was not able to drink it. We asked the staff member to provide another cup of tea. We asked this staff member if they knew how much thickener should be used for this person's drinks. We checked the person's care plan and what staff told us mirrored what was in their records and showed us that staff knew what the person's needs were in relation their drinking. However, the initial cup of tea had not been made according to the instructions provided. The SaLT assessment involved the specialist looking at the best consistency for drinks to be taken safely and reduce the risk of choking. By not following this instruction, the person was placed at a higher risk of choking.
We spoke with four people who agreed that the food was very good and that they could have a different choice if they did not want the main meal. We saw staff supporting people to eat in a discreet and dignified manner. The softer meals were presented in an appetising way. Clothing protectors were offered and removed straight away after the meal. The cook told us on the first day that they offer good, wholesome food. Staff were seen to take time to talk with people and encouraged them to take their drinks. Snacks were offered in a way which helped people who struggled to make a choice. For example, a staff member reduced the options to two biscuits which the person liked and held them up for the person to make a choice. This was done at the pace of the person's ability to decide.

People living at the service were able to access healthcare services when required. We saw that people had been supported by the SaLT and the district nurses. However, we spoke with a doctor who was recently asked to visit a person using the service out of hours. When they arrived at the service, the staff who had requested the visit had gone home and the staff on duty were not aware that the visit had been asked for. This was because this key information had not been shared during the handover between day and night shifts. As a result the doctor was unable to get an accurate picture of how the person had been through the day and the reason for being called out. The person themselves was in the lounge and did not know why the doctor had been asked to see them.

Requires Improvement

Is the service caring?

Our findings

We received a complaint from a doctor that people's dignity and privacy was being compromised when they visited as they were expected to review people in the lounges. We discussed this with the registered manager and deputy manager. They said that this had improved and people were now usually seen in their rooms. However we were told that people were no longer seen in the communal areas but now they were taken to other people's bedrooms for their consultation. We also spoke with a relative who was sitting in the dining room with their family member. This relative told us that they were not able to have privacy when spending time with their family member. They said that this was because they could not get their relative upstairs to their room and there was nowhere else to go but the dining room. When asked how they felt about [Family member's] care. They responded, "[Person's name] is fed, watered and washed. The care is OK. I have no specific worries."

We saw that the staff team supported people to be involved in their care provision as it happened. However, this approach was instigated by the staff themselves as opposed to following care planning which had been agreed with the involvement of the people. We saw that people's views were not always respected by staff. For example, we saw one person was given a mug of coffee with sugar. They told the person sitting next to them, "I have got sugar in it again. I hate sugar, I haven't had sugar for years." We asked the person if they would like their drink changing. They said, "No, it is too much trouble". The staff member then came back and asked what was wrong. When the person told the staff member that she hated sugar in their drink the staff member responded, "Oh [Person's name] you always have sugar."

We saw that people's dignity and privacy was respected by the staff as they provided care and support. For example, one person required a change of clothing. The staff members supported the person in a very discreet manner, talking gently with them as they assisted them to use the stand aid hoist. They then took the person to the bathroom to assist them to change. When they returned with clean clothes on, they were smiling and happy as they chatted with the staff. There were people living with dementia who had some difficulties expressing themselves verbally. We observed staff interactions in one lounge. We saw kind and unrushed staff interactions. For example, one person started to call out for help. This was responded to quickly and reassurance given. The staff member took time to sit and chat with the person who appeared calmer. Staff recognised when people felt discomfort. One staff member was seen to go to a person and ask, "Are you comfortable? Do you need a cushion?" Staff were aware of people moving around their home and offered assistance and reassurance as required. For example, one person needed assistance to walk to the toilet. The assistance was offered in a discreet and kind manner which helped to maintain the dignity of the person being assisted.

We spoke with four people in one lounge who chatted as a group. These people told us that they felt safe and happy at the service. One person said, "The staff know what they are doing." Another person told us, "I am very happy here. The staff are lovely and I like living here." Three other people in the lounge were not able to join in the conversation verbally but were engaged in the discussion with us. We saw by their smiling facial expression and open body language that they appeared content. In the second lounge we observed staff interactions with people and saw that they provided care and support in a kind and thoughtful way.

One person needed to be transferred using a hoist. The staff waited until the person had finished their biscuit before beginning the process. Throughout the transfer they spoke kindly, explaining what needed to happen and reassured the person which reduced any anxiety about the transfer.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 22 April 2015, the provider needed to make improvements to the way they supported people in maintaining their hobbies and interests. There was limited opportunity for people to take part in activities. At this inspection we found that no further action had been taken by the provider. Staff members still worked to provide some activities. For example, we saw one staff member help a person to set up a jigsaw as they knew the person liked to do them. The conversation heard between the two about how to begin the puzzle was kind and supportive. On both inspection days the main activity was watching television. One person told us, "I do get bored sometimes." People were still not being offered the opportunity to keep active. One staff member told us, " We do try and do things with people but we do not always have the time."

We also looked at how the provider involved people in the planning of their own care and treatment. We saw in people's care records information which was disjointed, did not reflect people's choices or their individuality. There was no evidence to show how people, or those that mattered to them, had been consulted about the care staff had planned. We discussed the care needs of a person living at the service that we had spent some time with. The deputy manager told us that the person had Parkinson's disease but they did not. The person had a condition which needed specific care and support.

Care plans did not have enough information to assist staff in deciding the best way to support people. For example, one person had cognitive difficulties which caused them to cry out frequently. The care plan did not reflect this person's needs with regard to their condition. We saw another care plan where the person's needs had changed significantly but the plans had not been reviewed to reflect this. For example one person's physical health had deteriorated and they had become more anxious and this had affected their mobility. The person's care records had not been reviewed to show this change and as a result the staff team were not provided with advice as to how they could support this person. Shortly after these changes were seen, this person fell and was admitted to hospital with a serious injury.

Five people using the service lived separately from the main house. The registered manager and provider told us they were independent living units. However, we found that the people were not supported to be independent. They were still dependent upon staff to provide food and drinks to them. They were not involved in activities and were at risk of being socially isolated as a result. One staff member told us that some of the people were living with dementia and needed a lot of support. However, the provider stated that the people needed minimal care and support. The provider told us that they had not given these people the means to make hot drinks or snacks because they would not like to risk them having a kettle in their room. There were no risk assessments in place to verify the reason for this decision.

We had received complaints about the service from a number of sources which had been shared with the registered manager. The registered manager felt that these concerns had been resolved but was not able to show us any evidence of how they reached that conclusion. The service had a complaints procedure which was given to people on admission. It was also on the notice board in reception. We reviewed the complaints received with the registered manager. They had a complaints book in which complaints had been

handwritten. The content of the handwritten notes was very sparse and did not show evidence of any investigations of complaints or outcomes, including whether the complainant was happy with the outcome. There were no copies of letters sent to people and the registered manager was unable to tell us if people were happy with the outcomes.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the provider sent out quality surveys yearly. They told us that the information was used to improve the service provided. They were not able to show us any evidence of processes in place to ensure that this happened. The last one was in March 2016 but had limited responses. We were shown a summary of the survey where eight people who used the service and five relatives had responded. One person requested that their room was upgraded. The registered manager told us that this work would be completed as part of the overall improvement plan for the premises.

Inadequate

Is the service well-led?

Our findings

The registered manager informed us on the first day of our inspection that they had resigned their post and were due to leave on 26 May 2016. A new manager had been appointed and the deputy manager would be the interim manager until the new manager took up their post. This was confirmed by the provider who confirmed that they would visit the service weekly to support them.

People we spoke with who were able to tell us said that they knew who the manager was. One person said, "[Manager] is a nice person and comes and sees us." Staff members we spoke with felt that the provider and manager supported them. One staff member said, "I have confidence in the manager and deputy to deal with concerns." Another said, "The manager is open to suggestions or concerns." We were told by one staff member that they felt the provider listened to them.

We found that the service lacked effective leadership. The registered manager and deputy manager told us that they did not undertake staff management such as disciplinary processes with staff members whose work attitude, values and behaviour was below the expected standard. They said that their reasons for not doing this was because they did not have the confidence to take action. The deputy manager told us that, on occasions, staff did not turn up for work but no action was taken to ensure these staff faced consequences for their actions. This lack of action meant that they had not taken steps to protect the people living at the service from avoidable staff shortages.

There were no systems in place to ensure staff received the required training to be able to care for people living at the service. Training was cancelled by the registered manager at short notice because of staff shortages. These sessions were rearranged but there was a large delay in the getting them in place. The registered manager was not able to tell us what training had been completed and by whom. The only way the registered manager could find the information was to look through staff files to find the certificates. Because the provider did not have a robust system in place, they could not guarantee that the staff at the service provided care which was up to date and reflected best practice.

The provider did not have a system in place to assess the dependency of the people living at the service, and to increase staffing levels if people's needs increased. This lack of oversight placed people at risk of harm and neglect due to the high level of care and support needed by people during the night.

Accidents and incidents in the service were documented and looked at by the provider. However, the registered manager could not tell us how the information was used to learn from mistakes and influence positive changes in how care and support was provided. The registered manager had not undertaken robust investigations of accidents or incidents in the service when required. They told us that they did not feel confident to undertake investigations but confirmed that they had not sought support or training in this area to enable them to develop these skills.

We found a lack of provider oversight with regard to people's care plans. The plans were seen to be generic in nature and had very little individual content. In some plans the names of other people appeared within

the documents. We saw that the plans in place were not reviewed as people's needs changed. The provider did not have an auditing system in place to check that the care planning records were person-centred and relevant to each person's needs. Key decisions with regard to the care and support of people was made without the inclusion of the person or their family members. These decisions included assessments of mental capacity and any requirement for the provision of Deprivation of Liberty Safeguards.

We found that the systems in place to monitor the quality and safety of the service were inadequate. The provider had failed to make sure quality assurance systems were in place to ensure that risk had been thoroughly assessed to protect people from harm and ensure their safety. We found areas of the service where people's safety could have been compromised. The registered manager told us that they had brought their concerns to the attention of the provider. Once made aware of the problems, the provider had not taken action to reduce risk in the service. Records we looked at showed that the provider had identified the risk of unsafe flooring and floorboards throughout the premises in March 2016, but had not put in place any measures to reduce the risks or to repair the areas noted at the time of our inspection. Control measures to reduce the risk of injury for people who used the service were not in place. In addition the provider told us that they were unaware that fire doors in the service were not effective and in disrepair.

There was a lack of process for the checking of equipment to ensure they were fit to use. Wheelchairs with trip and injury hazards were in use in the service on our first inspection day. We brought this to the attention of the registered manager, deputy manager and provider at the time. When we returned one week later, these wheelchairs were still in use and had not been repaired.

We found that relationships between the service and the local doctor's practice were difficult. The practice had reported a lack of confidence in the knowledge and ability of the senior staff team to recognise when to seek their support.

The registered manager did send to CQC statutory notifications of incidents as required. However, the content was not always clear and did not give the required information about the incident being reported.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a whistleblowing policy in place and the staff we spoke with were aware of what to do if they had a concern.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have systems in place to work in accordance with the requirements of the Mental Capacity Act 2005, and did not have processes in place to protect people's rights and gain consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not identified, managed, reviewed or updated to ensure people's safety. The provider did not have systems in place to identify themes with accidents or to learn how to prevent further accidents. The provider had not maintained the building safely to protect people from avoidable harm. The provider did not have systems in place to check equipment in the service on a regular basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have systems in place to identify, record and respond to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to take action where shortfalls in the service were known. Effective systems were not in place to assess and monitor the quality of the service provided. The provider's systems did not always identify when premises were unsafe. Where they had been identified, there were delays in making the premises safe.