Stoke House Care Home Ltd

Stoke House Care Home

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

Overall summary

This unannounced inspection took place on 27and 28 July and 7 August 2015. Stoke House Care Home is run and managed by Stoke House Care Home Ltd. The service provides accommodation for up to a maximum of 46 older people who require nursing or personal care. On the day of our inspection 27 people were using the service.

The service did not have a registered manager in place at the time of our inspection. 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 and associated Regulations about how the service is run.

Although people told us they felt safe at the service we found that processes were not robust and had not always been followed to protect people from the risk of abuse. We found that the provider was not always identifying risks to people arising from their care needs. When risks

Summary of findings

were identified they were not always being managed correctly to ensure people's safety. There were not enough staff to meet the needs of the people who used the service and medicines were not managed safely.

People were not protected by the Mental Capacity Act 2005. People were not supported to maintain their on going healthcare.

People expressed mixed views on the interaction they had with staff and we observed that not all staff were caring towards the people they were supporting. People were not always routinely involved in decisions about their care.

People felt able to raise concerns but these were not always responded to or acted on. People's preferences were not always taken into account when staff were delivering their care.

Although people and their relatives felt they could approach the manager with ideas and suggestions, the systems in place designed to capture this information on an on-going basis and bring about improvements to the service were not fully effective.

We found a number of 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 report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Systems to protect people from the risk of abuse were not effective. Risks to people were not always identified and acted upon.

Staffing levels were not sufficient to meet the needs of people who used the service and safe medicines management procedures were not being followed.

Staff were recruited by safe recruitment procedures.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were not supported with their ongoing healthcare.

The requirements of the Mental Capacity Act 2005 were not being adhered to which meant that people's rights were not protected.

People told us they enjoyed the food and were supported at mealtimes but people's weight and fluid intake was not being adequately monitored.

Staff received basic induction and training at the service but not all staff received regular supervision.

Is the service caring?

Requires improvement

The service was not consistently caring.

People expressed mixed views on the interaction they had with staff and we observed that not all staff were caring towards the people they were supporting.

There was very little information to show that people had been involved in decisions about their care.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's preferences were not always reflected in care plans or acted upon by staff.

Mixed views were expressed on how complaints were dealt with at the service and we found that complaints had not always been dealt with appropriately.

People told us that they enjoyed the activities on offer, however at other times there was little stimulation for people.

Is the service well-led?

Inadequate

The service was not well led.

Summary of findings

The systems in place to identify and improve the quality of the service were ineffective and had led to a deterioration of the quality of care people were receiving and had placed them at risk of harm.

Although there was a manager in place, they were not registered and people were unclear who was responsible for the running of the service when the manager was absent.

There was a lack of systems in place to ensure people and relatives were involved in the development of the service.

Stoke House Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 27 and 28 July 2015 and 7 August 2015. The inspection team consisted of two inspectors, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with eight people who were living at the service and four people who were visiting their relations. We spoke with two nurses, the manager, the quality assurance manager, four care workers and two laundry staff.

We looked at the care records of 12 people who used the service, three staff files, as well as a range of records relating to the running of the service, which included audits carried out by the manager.

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.

Inadequate

Is the service safe?

Our findings

People could not be assured that incidents would always be responded to appropriately. The majority of staff had received training in protecting people from abuse and the staff we spoke with had good knowledge of how to recognise and respond to allegations, but two out of the four staff members we spoke to were not aware of the need to refer to external agencies. On one of the days of our inspection the person responsible for the day to day running of the service was unsure who to report incidents of abuse to in the absence of the manager.

We saw that there had been incidents within the service which should have been shared with the local authority's safeguarding team and there was no evidence to suggest this had happened. These related to allegations of physical abuse from staff towards people who used the service. As these incidents had not been shared, people could not be assured that they had been properly investigated.

We made a total of seven safeguarding referrals to the local authority as we identified concerns during our inspection.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A visitor to the home raised concerns about the safety of people using bed rails. We found that some people who used bed rails at night had detailed risk assessments in place to determine whether their use was appropriate. However, we saw that one person had bed rails in place and although this was recorded in their care records, there was not a robust risk assessment in place which had considered all the factors to determine whether the use of bed rails was safe and appropriate. Records confirmed that the person was checked regularly throughout the night to reduce the risk of harm, but the person had recently sustained an injury from hitting their arm on the bed rails. There was no record to show that alternative options for keeping the person safe had been explored or consideration given as to whether bed rails remained appropriate.

Although some people's care records contained risk assessments to assess the risks to people in relation to areas such as falls and pressure ulcers, these were not always in place or reviewed regularly. One person's falls risk assessment had not been reviewed since October 2014 when they had been assessed as being at high risk of falls. Their skin integrity risk assessment had not been reviewed since October 2014 despite them having skin damage. Another person who had skin damage had not had their skin integrity risk assessment reviewed for five months. This meant that the risk assessment process was not effective as risks were not regularly assessed and actions to minimise the risk reviewed. A member of staff told us, "There has been an increase in wounds [to people]."

We saw that another person was at risk of falls and had fallen more than 30 times over a few months. We witnessed that the person was in a communal area of the service for at least an hour without the constant presence of staff. Two of the staff we spoke with were not aware that the person's care plan stated that they should be observed at all times. The person's care plan did not contain any additional information on how to reduce the risk of falls. This meant the person was being placed at risk of sustaining injury through further falls.

We found that information contained within care records about the management of risks to people was not always sufficient to ensure their safety and was at times contradictory. We saw from the care records of one person who had a health condition that there were two different documents which held differing advice about the risks around this person's condition. Staff told us they would not follow the guidance in one of these documents as they did not believe it would be safe. This meant the person was at risk of harm as staff did not have appropriate guidance.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who used the service felt there were sufficient staff to meet their needs. However, one person told us they had to wait sometimes to get out of bed until 11am, which happened on one of the days of our inspection. Relatives were concerned that there were not enough staff at the service to meet people's needs and keep them safe. One relative told us that they had heard people calling out for staff and that on occasions they had seen people wait up to 45 minutes for someone to attend to them. Another relative stated, "[There are] not enough staff, sometimes there are plenty of staff and other times not enough." Visitors to the home told us that it was sometimes difficult to find staff to talk to about their relative. One visitor told us, "Staff look after so many people, when you come into the home, no staff approach and say how [person] is."

Inadequate

Is the service safe?

Staff told us that staffing levels were low within the service. One staff member told us that staffing levels were, "Consistently poor." Another staff member said, "Staffing levels are appalling. It's impossible to do everything. Paperwork and care plans are not being done." We viewed records which confirmed that the amount of care staff on shift regularly fell below the amount of staff identified as required by the provider.

Staff told us that they did not think that people were being assisted to use the toilet or repositioned as frequently as they should be. Staff also told us they didn't feel that people always received thorough personal care. Records we saw were not completed to verify people had received the care they required. One member of staff told us they felt a person who used the service was at risk from injury due to falling because there were insufficient staff to supervise them appropriately.

Prior to our inspection we received information from a visitor to the service that staff had been telling people to go to the toilet in their incontinence pads as they did not have time to take them to the toilet. We were told this had happened during our visit. People did not receive support they needed in good time. We observed people waited between five and 15 minutes for staff to become available to support them to use the toilet. Three people told us that they sometimes had to wait half an hour for staff to support them to use the toilet.

There were not suitable systems in place to ensure there were sufficient staff on duty to meet people's needs. Concerns about staffing levels were raised with the manager following the first day of our inspection, and we received assurances that staffing levels would be increased. On the third day of our inspection we saw that improved staffing levels had not been maintained.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people may not be receiving their medicines at their most effective. The temperature of the room used to store medicines was not recorded, although on the day of inspection the temperature was within the recommended temperatures. The temperature of the refrigerator used to store medicines had also not been recorded regularly. Medicines should be stored at safe recommended temperatures and the provider could not be assured this was the case as the medicines temperatures were not taken. We found that there was no date on opening of liquid medicines or external creams so that staff could ensure the medicine was being used within the correct time period. There was no record made of where medicine patches were applied so staff would rotate their application to ensure they were applied to a new area of skin to increase their effectiveness.

There were risks people may not receive their medicines as prescribed. Medicines were administered by nurses at the service. We saw the required safe practices in administering controlled medicines were not followed. We observed two staff checked a controlled medicine but the second staff member did not check the medicine was administered to the person it was prescribed for. Additionally there was no guidance for staff about when to administer medicines that had been prescribed to be given when required (known as PRN).

Recommended safe practices to ensure people received their correct medicines were not followed. We saw that some people's medicines were hand written on the medicine administration records (MAR) and these had not been signed to ensure they had been checked against the prescription to ensure they had been written correctly. We found that some MAR sheets did not have a photo of the person on the front sheet and there was no alert for staff of two people with very similar names to ensure staff were aware of the risk of misidentification. We witnessed two occasions when the staff administering medicines briefly left the keys in the medicine trolley unobserved which meant that unauthorised people could have accessed medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe. One person told us, "I feel safe yes, because we are all closed in, there is no one to grab you from the outside, the staff are great." Another person said that they felt safe because, "You have everything you need here and [staff] are here at hand."

Staff told us that they felt people were safe and that the manager would act upon any concerns raised. One staff member told us about an example of when the manager had acted appropriately in response to an incident involving a person who used the service, to protect them from the risk of harm.

Inadequate

Is the service safe?

Staff were recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. The files contained all relevant information and appropriate checks had been carried out before a staff member started work.

We saw there were plans for emergency situations such as an outbreak of fire. An emergency continuity plan was in place in the event of emergency and personal emergency evacuation plans (PEEPs) were in place for people who used the service.

Requires improvement

Is the service effective?

Our findings

Although people told us they had access to external healthcare if they needed it, we found that people's on going health needs were not managed effectively. We accessed records which suggested a long delay in making a referral to the falls prevention team for a person who fell regularly.

We looked at the recording of people's weight records. We found that the system was not effective in ensuring that changes in people's weight would be picked up by staff. One person's care plan stated that they should be weighed weekly and we did not see evidence of this taking place. Their nutritional risk assessment had not been reviewed monthly despite them having a very low weight and assessed to be at nutritional risk. Another person had not had their nutritional needs risk assessed since entering the home. A staff member told us that people were not being weighed regularly. There was a risk that people could lose more weight without this being recognised by staff in a timely manner to prevent deterioration in health.

Staff did not act upon the advice of healthcare professionals in areas such as wound care and pressure area relief. We looked at the care records for people assessed to be at risk of skin damage. Records showed that people were not receiving positional care in line with care plans. Staff told us that they were not confident that people were receiving positional care as required. One staff member told us, "Repositional turns are not done." The records we saw confirmed this. This left people's skin integrity at risk, including the development of a pressure ulcer. Specialist mattresses to reduce the risk of skin damage were not always checked at the required intervals as stated in care records to ensure that they were at the correct setting. This put people at risk of harm.

Some people in the service had diabetes and it was unclear from care records how their condition should be monitored. Staff did not know whose blood sugars should be monitored. This meant that there was a greater risk that staff would not effectively monitor the health of people with diabetes in order to promptly identify changes which may affect their health.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views on whether staff asked for their consent before carrying out care interventions and whether they were able to make their own decisions. One person told us, "Oh yes they do [ask for consent], they always come up to you and say what for and how." Another person told us, "They say we are going to your room, the facts, but no, not generally [ask for consent]."

Staff told us that they had received training in areas such as the Mental Capacity Act 2005 (MCA) and could tell us about the use of Deprivation of Liberty Safeguards (DoLS). The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. The manager told us that no applications for a DoLS had been made for anyone at the service.

People who did not have the capacity to make certain decisions were not protected under the Mental Capacity Act 2005 (MCA). We found that the requirements of legislation to protect people in making decisions were not applied in the service. A general checklist was completed in respect of people's capacity, but this was not specific to any one decision as the legislation requires.

Mental capacity assessments had not been completed to determine if two people could make a decision whether they wished to have bedrails fitted. Additionally there was no record to show if the decision to use bedrails had been made in each person's best interest.

People had restrictions placed upon them without the required authority. One person told us very clearly that they did not wish to reside at the service but we found no evidence that an assessment of the person's capacity to make a decision about where they live had been carried out. It was recorded in the person's care records that they were unable to leave the service, "due to DoLS" but there was no evidence that an application had been made in respect of the person. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005.

We looked at the care records for three people who had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms in place. We looked at an additional care plan which had a handwritten note in the front of care documentation which read "DNR" (Do not resuscitate which is an abbreviation of DNACPR) but we did not see a DNACPR

Requires improvement

Is the service effective?

form within their care record. Another DNACPR form which had been completed by the person's doctor did not detail how the person or their relatives had been involved in this decision or how their views were incorporated into the decision. Although it is the responsibility of the person's doctor to complete this form, there was no evidence that the staff liaised with the doctor concerned to ensure they were delivering care which reflected the person's rights and choices. There was also a risk that this person's end of life wishes and needs may not have been fully considered and acted upon in the event of a cardiac arrest.

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

People felt they received care from sufficiently skilled and competent staff, although they felt that this was only true for regular staff at the service. One person told us, "Yes definitely, because the staff get on with it straight away, they do things, there and then." Another person told us, "The regular staff are very good."

We saw evidence that staff undertook an induction when they began working at the service however, some staff felt that the induction process did not provide them with all the information and training they required to undertake their role. One staff member described the training that they had received as, "Very basic." We were told by two staff members that there was no opportunity to shadow more experienced colleagues when they started work as new staff were included in the staffing numbers.

Staff told us they were supplied with on going training and we saw records to support this. Most staff were up to date with training in a variety of areas such as moving and handling, dignity and dementia. There were mixed views from staff on the quality of the training that was provided. Although the majority of staff received regular supervision, one staff member told us they had not received any supervision. The manager told us that no appraisals of staff had taken place but they would be started shortly. This meant that staff members' performance over the whole year was not being considered and developmental aims for the next year were not being identified.

People told us that they enjoyed the meals at the service and one person told us that they were offered a choice of dish at mealtimes. They said, "A mixture of everything, it's a matter of what you like and what you don't like, there is usually a menu sheet and you can mark down what you like." Another person said, "You can have anything special if you ask them."

Visitors to the service told us that they were concerned about people not receiving enough to drink throughout the day as some people who used the service were unable to request drinks and required prompting to drink. One relative said, "During the day I come down and get glasses of water for [relation] and other residents, some residents are bedridden, some have water but not everyone has fluids and water during the day."

We observed people being provided with drinks during our visits. We saw occasional prompting from staff; at other times there were no staff in the communal areas of the home to prompt people to drink. Records of people's food and fluid intake did not evidence that they were eating and drinking enough throughout the day. From our observations and the records we looked at, we could not be assured that people were receiving enough fluids throughout the day to maintain their wellbeing.

We observed mealtimes in two communal areas of the service and checked on people staying in their bedrooms at lunchtime. We found that where people needed assistance to eat this was provided on a one to one basis in an unrushed manner. We found that where people had been assessed as needing special diets, for example soft or pureed food, these were recorded in people's care plans and catered for. We saw that people were served with a meal and offered an alternative if they asked or indicated they did not want it.

Requires improvement

Is the service caring?

Our findings

People gave mixed feedback about the approach of the staff and our observations supported this. One person told us, "Yes [staff are] very [kind], they are never nasty or anything." However, other people told us that the staff could be "sharp" at times. One person said, "Yes I think on the whole they are kind, they can be a little sharp, you have to wait to go to the toilet."

We saw some staff chatted to people as they assisted them to move around the service in a kind tone of voice and used effective communication skills such as establishing eye contact with people before speaking with them. For example one person was waiting to visit the hairdresser and a member of staff said, "I will tell her [the hairdresser] for you. She has a long queue so you may have to wait for a bit." We saw another person being assisted by two staff to use equipment to transfer them onto a chair; staff explained what they planned to do, took their time and were supportive of the person who expressed their fear in using the equipment. However we also observed other staff raise their voices unnecessarily when talking to people or responded to a person's need with little interaction.

People were not always supported to be involved in planning their care. Not all of the people we spoke with had seen their care plans and it was not clear how people were involved in the planning of their care. One person told us that their relative had looked at care plans on their behalf. We did not see that there were systems in place to involve people in the planning of their care package such as monthly or annual reviews. Therefore it could not be assured that care and support was delivered in line with people's individual requirements or in a way that ensured their diverse needs were met.

Staff told us that they got to know people's preferences through what they were told by relatives or by getting to know the person when supporting them.

Advocacy information was available for people if they required support or advice from an independent person.

People were given support with their independence and to maintain contact with their friends and relatives. One person told us that they were encouraged to be independent and we observed that people were supported to be independent at mealtimes. People told us that their relatives were able to visit regularly and we observed people meeting with relatives in communal areas of the service and in their bedrooms. One person had visitors over a mealtime and sat with their relations, enjoying conversation over lunch.

People told us that staff respected their privacy and dignity and gave examples of staff knocking on their bedroom doors before entering. Some people told us that they had the ability to lock their bedroom door if they wished. One person told us, "Yes very much [staff treat them with dignity and respect] and they always explain what they are going to do." People told us that staff used screens around people when providing support to prevent this being seen by other people.

The staff we spoke with were knowledgeable about the principles of privacy and dignity. One staff member told us, "It's being aware that some female residents don't like male carers, making sure before providing personal care that doors and curtains are shut. We tell people what we are about to do and encourage people to make choices."

Requires improvement

Is the service responsive?

Our findings

Effective systems were not in place for people to be able to raise a complaint. One person told us that they did not know how to make a complaint about the service. Visitors to the service said that it had been very difficult to make an appointment to have a meeting with the manager. One visitor said that they had made an appointment to see the manager but the manager did not attend on the day of the meeting. Visitors told us that they had not been given the opportunity to discuss any concerns or complaints with the management at the service and raised issues with us during the inspection.

Complaints were not acted on appropriately. We saw that two complaints had not been responded to correctly. Both were in relation to staff conduct and in both cases there were no records to show the complaints had been investigated, acted on and an outcome given to the people making the complaints. However, a third person told us they had made a complaint and it had been resolved to their satisfaction, but there were no records made of this.

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

Most staff felt confident that, should a concern be raised with them, they could discuss it with the management team. They also felt complaints would be responded to appropriately and taken seriously. One member of staff told us, "I would take any concerns raised with me to the nurse in charge, they would be acted upon." Another staff member told us they had passed complaints to the management team but they had received no feedback on any outcomes.

Staff we spoke with were knowledgeable about the needs of the people they supported and felt that they gained knowledge from their experience of working with people and from information that relatives provided. Staff told us that they did not have time to read care plans but they were told about people's needs when they moved into the service. Not all staff were aware of information that was contained in care plans.

People could not be assured they would receive care as described within their care plans. We observed that the time people were assisted to get up did not always reflect their preferences. This meant people's wishes were not taken into account when providing care. Some care records contained a life history which gave information on the person's background and activities they enjoyed. Other care records showed little detail of the person's life history, and the interests they had enjoyed which would help staff support people in a more person centred way.

Where people's preferences were included within their care plans these was not always updated. For example, one person's preferences had changed about how they spent their time, but records had not been updated to reflect this. However, we found that staff were aware that the person's preferences had changed and acted accordingly.

An activities co-ordinator worked at the service for four days a week (Monday to Thursday.) Most people we spoke with enjoyed the activities on offer at the service. One person told us, "We do exercises, moving your body, it's very good. The lady that does exercises comes in and we do different types of exercise, she's very very good." Another person told us that activities were "brilliant".

Staff told us that the activities provided for people were very good but one staff member thought that people would benefit from newspapers or magazines being brought in for people to read. We observed people in communal areas of the home during the morning of our inspection and found that there was little stimulation or interaction with staff during this time. We asked about the activities for people who remained in their bedrooms during the day and were told that the activity co-ordinator spends time on an individual basis with people, talking to them and engaging in activities such as nail care.

The activities co-ordinator provided activities and individual support to people in the afternoon and early evening. We saw that a range of activities were offered to people such as physical exercise, quizzes and bingo. The provider also invited entertainers into the service every couple of months and provided a summer show and panto for people on an annual basis. We saw that people's feedback was sought on the activities on offer and people were invited to make suggestions for future activities which they may enjoy.

Inadequate

Is the service well-led?

Our findings

We found there was a lack of culture in shaping the service around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulations and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

There was a lack of effective systems in place to monitor how incidents, allegations and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not safe.

We saw there had been audits completed in the service but where issues had been identified action had not been taken to improve the quality of the service and this had led to people receiving care which was inconsistent and had not met their needs. The audits had not picked up issues that have been identified in this report in areas such as the lack of safeguarding referrals and referrals to the falls prevention team being made, poor practice resulting from inadequate levels of staff deployed in the service and people not having their needs met. This showed the systems in place were ineffective in identifying where improvements were needed. Had effective systems been in place these issues which placed people at risk of harm could have been identified and acted on prior to us visiting.

We saw an audit had been carried out in June 2015 and this identified shortfalls in the safe management of medicines and issues with staffing levels. The manager had highlighted that staff were struggling in the morning to meet the needs of people and stated that extra staffing would be looked at to address the issue. Neither of these issues had been resolved by the time of our inspection. This showed the audits to be ineffective in bringing about improvements when issues were identified. We received assurances that staffing levels would be increased over the course of this inspection but found that these had not been maintained consistently.

Although staff we spoke with told us that they felt confident that the manager would respond to issues raised with them, staff had raised issues about the low levels of staff both with the manager and the provider and this had not been addressed. Staff raised the same concerns with us during our inspection. Despite these concerns being raised and the issue being identified in the manager's audit, systems had not been put in place by the provider to address staffing levels and assess how many staff were needed to meet the needs of the people who used the service.

There was a manager at the service who was not registered with the Care Quality Commission, however an application to register had been received.

Records we looked at showed that the manager sent us notifications for certain events in the service but had failed to notify us of allegations of abuse. Providers have a legal obligation to notify us of such incidents.

We saw there had been a survey given to people and their relatives in 2014. The results of the survey were on display at the service and recorded positive feedback. However, one relative told us their relation had been at the service for a number of years but they had only had the chance to participate in a survey once.

Although most people told us they felt confident to approach the manager with any comments or complaints, people who used the service were not aware of any organised meetings where they could raise any comments, complaints or suggestions. Relatives told us it was difficult to make appointments to discuss any issues with the manager. One relative told us that they had made a number of requests to meet with the manager which had not been facilitated. One service user told us that they had raised concerns in the past and things had not been addressed.

Therefore the system was not fully effective in ensuring information was being captured on an on-going basis to enable the provider to assess, monitor and improve the service based upon the quality of people's experiences.

All of the above information constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users must be protected from abuse and improper treatment in accordance with this regulation.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 were not being complied with.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not provided with care and treatment which was safe and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of the service and this led to people receiving care which was unsafe.