Mrs Saima Raja

Victoria Lodge Residential Care Home

Inspection report

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Date of inspection visit:
06 July 2016

Date of publication:
18 August 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
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 6 July 2016 and was unannounced. The home was previously inspected in January 2016 and February 2016. At the January 2016 inspection we found five breaches of regulations. We found that the provider was failing to ensure people's care and welfare needs were met, did not have arrangements in place to protect people from unsafe management of medicines, had ineffective arrangements in place to monitor the quality of service provided, was failing to treat people with dignity and respect, and was failing to obtain or act in accordance with people's consent. We rated the home as inadequate following this inspection.

We are taking enforcement action in relation to this inspection, and will report on it at a later date. Additionally, we also placed the service into 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. We imposed a condition restrict admissions to the home without the prior approval of the CQC.

The inspection in February 2016 was a focused inspection, which we undertook in response to concerns we had received about the service. During this inspection we identified concerns in relation to the safety of equipment and premises, the safety of people using the service, and found the provider did not have adequate systems in place to manage medicines safely. As this was a focused inspection which only looked at part of the service, we did not provide a rating for the service on this occasion, and the home's overall rating therefore remained inadequate.

You can read the reports from our previous inspections, by selecting the 'all reports' link for Victoria Lodge on our website at www.cqc.org.uk

Victoria Lodge Residential Home is a care home providing accommodation for older people who require personal care. It also accommodates people who have a diagnosis of dementia and can accommodate up to 24 people. At the time of the inspection there were 12 people using the service. The service is situated in Edenthorpe near Doncaster, close to local amenities and public transport links.

The registered manager had recently left their post. However they had not cancelled their registration at the time of the inspection and therefore remained registered. A new manager had been recruited but they had not yet registered with CQC. 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.

At this inspection we found that the provider had failed to make significant improvements in the way the home was run. The provider had introduced a new system of auditing the quality of care provided. However,

this was ineffective, as it did not identify shortfalls or areas of concern. The provider had described this system as "robust" and had failed to identify its inadequacies.We asked the provider to complete a Provider Information Return (PIR) before the inspection but they failed to do so. This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. The home's most recent rating was on display in the home, but the provider had failed to add it to their website, which is a legal requirement.

Staff were kind and friendly in their approach to people, and people responded positively to this. However, records showed that people did not always receive the care they had been assessed as requiring. The mealtime we observed was a pleasant experience, where people obtained the support that they needed in a discreet and respectful manner, and appropriate equipment was provided to enable people to eat.

Staff had received updated training in moving and handling, although our observations showed that they did not always carry out these procedures in a safe manner, putting people at the risk of harm or distress. Improvements were required in the way medicines were managed; recording had improved, but medicines were not always administered when required.

We saw that there appeared to be staff in sufficient numbers to meet people's needs. However, prior to the inspection the provider told us that they did not intend to increase staffing should the home be fully occupied. As there were only 12 people using the service at the time of the inspection, with the home having a maximum capacity of 24, this meant that the provider had not considered the dependency or needs of potential service users.

The provider had failed to ensure they obtained informed consent from people in relation to their care and treatment. Where people lacked the capacity to give informed consent, the provider did not follow appropriate procedures, as required by law.

The availability of activities had improved at the home. However, the arrangements for responding to people's changing needs were not adequate, meaning that people's care plans, and, accordingly, the care they received, did not always meet their needs.

We noted that some refurbishments had been carried out to the environment, including steps to make the home more dementia-friendly. However, additional work needed to be carried out as some fixtures and fittings were damaged.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People's risk assessments did not always cover all areas where they were vulnerable to risk.

Staff had received updated training in moving and handling, although our observations showed that they did not always carry out these procedures in a safe manner, putting people at the risk of harm or distress.

Improvements were required in the way medicines were managed. Recording had improved, but some types of medicines were not administered when required.

Is the service effective?

Inadequate

The service was not effective. The provider was failing to ensure they obtained informed consent from people in relation to their care and treatment. Where people lacked the capacity to give informed consent, the provider did not follow appropriate procedures.

Mealtimes were a pleasant experience, where people obtained the support that they needed in a discreet and respectful manner

Is the service caring?

Requires Improvement

The service was not always caring. Staff were kind and friendly in their approach to people, and people responded positively to this. However, records showed that people did not always receive the care they had been assessed as requiring.

Is the service responsive?

Requires Improvement

The service was not always responsive. The availability of activities had improved at the home. However, the arrangements for responding to people's changing needs were not adequate, meaning that people's care plans did not always meet their needs.

Is the service well-led?

Inadequate

The service was not well led. The provider had introduced a new system of auditing the quality of care provided. However, this

was ineffective, as it did not identify shortfalls or areas of concern.

Victoria Lodge Residential 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 checked 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.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit took place on 6 July 2016. The inspection was carried out by two adult social care inspectors and a pharmacy inspector.

During the inspection we spoke with staff and the home's manager. We spoke with four people who were using the service at the time of the inspection, as well as one person's visiting friend and a visiting healthcare professional. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. We also checked information provided by the local authority, who were carrying out regular, documented visits to the home. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. The provider failed to return this.

Requires Improvement

Is the service safe?

Our findings

We spoke with two people who were using the service about whether they felt safe at the home. They both told us they did. A visitor, who was visiting a friend who was using the service, told us they believed the home to be very safe and said they had never had cause for concern in relation to this.

During the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We saw that when people required assistance, staff were on hand quickly, and we also noted that staff had time to sit and chat with people rather than simply carry out tasks. The home's manager said that staffing numbers had been reviewed earlier that year to better meet people's needs. We looked at the minutes of a team meeting which took place in June 2016, which stated "when admissions are up, staffing levels will be increased in line" which reflected that the home had 12 vacancies at the time of the inspection. However, prior to the inspection the proprietor contacted CQC to say that the current staffing figures were the level they intended to maintain if the home increased the number of people using the service. This showed a lack of recognition of the need to assess people's needs to ensure staffing levels were appropriate. This could put people at risk of harm due to insufficient staff numbers.

We checked whether staff had received training in moving and handling, to ensure whether they knew how to support people to mobilise safely. The provider's training matrix showed that all staff had received moving and handling training, with many receiving it relatively recently. The home's manager told us that they had worked closely with the local authority to ensure staff received this training. However, when we observed moving and handling practices, we saw that they were not always carried out safely. We saw two staff assisting one person to move from an arm chair to a wheelchair by means of a hoist. Staff had not prepared the area adequately, which meant that the distance that the person travelled in the hoist was further than necessary. This increases the risk of the hoist tipping while the person is in it. Another person was assisted by two staff to move from an arm chair to a wheelchair while using a frame. The staff members concerned did not apply the brakes to the wheelchair, which increased the risk of it moving as the person lowered themselves into it, which could cause injury.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had received training in the safeguarding of vulnerable adults, and there was information available on display in the home to guide staff in relation to appropriate safeguarding procedures. We checked records we held about safeguarding notifications made by the provider, and found that the provider had made appropriate notifications where abuse had occurred or was suspected.

Recruitment procedures at the home had been designed to ensure that people were kept safe. Staff we spoke with told us they had undergone Disclosure and Barring Service (DBS) checks before they commenced work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the

registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees. We checked a sample of four staff members' personnel files, and found that all appropriate pre-employment checks had been undertaken.

We checked six people's care plans, to look at whether there were assessments in place in relation to any risks they may be vulnerable to, or any that they may present. We found that people's care plans contained risk assessments, but they were not always personalised, instead some had identical wording. The home's manager acknowledged that there was work to be done in relation to ensuring people's risk assessments were suitable to their needs, and said that some were not yet tailored to people's individual needs. Two people's records showed that they had recently lost a considerable amount of weight, around ten per cent of their bodyweight in both cases. There were no risk assessments in their files relating to the risk of malnutrition, and no information regarding what steps staff should take to protect people from such risks.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the premises, and found many areas were damaged and in need of repair or replacement, which meant that they could not be cleaned to a hygienic standard. For example, we noted a bath hoist which was rusted, and in another bathroom there was damaged woodwork. We saw some of the bedrooms contained rusted radiators and damaged woodwork. Rust and damaged wood surfaces can harbour bacteria and therefore present risks to people.

We checked arrangements for the management of medicines at the home. We looked at records for 11 people and spoke with the deputy manager who was responsible for giving medicines, as well as the home's manager.

The room used to store medicines was secure, with access restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs, including record keeping, although there were none being kept on the premises at the time of our inspection. There was a medicines fridge within the medicines store room; fridge temperatures had been recorded daily as recommended in national guidance. Records showed the temperature of the room used to store medicines had been maintained within recommended limits.

We looked at medication administration records (MARs) and found the majority of medicines had been given correctly, as prescribed. Stock balances of oral medicines were checked and found to be correct. We also observed the morning medicines round; staff gave medicines in a caring and considerate way taking into account the individual needs and preferences of service users. Liquid medicines and eye drops were marked with the date of opening and expiry to ensure they were fit for use. The amount of variable dose painkillers given was routinely recorded, and body maps were in use to aid the safe application of topical medicines.

During the medicines round we observed one person who was being given inhalers. They were prescribed two doses of a preventer inhaler according to the MAR and medicine label. However we observed they were only given one dose. We checked the MAR which stated 38 doses had been administered, but when we checked the dose counter on the inhaler we found only five doses had been administered since 27 June 2016. This meant the medicine had not been given as prescribed. The person was also prescribed a reliever inhaler to be taken when required. We observed this was given routinely without checking if it was required. There was no additional information to guide staff on when and how to administer this inhaler. This meant that medicines may have been given when they were not required. We checked two further inhalers for

another person and found fewer doses had been administered according to the dose counter than the MAR stated had been given.

We found a lack of information to guide staff how to safely administer when required medicines. Some people had "when required" medicines protocols, although these were lacking in detail. In particular, we found a lack of information to describe what physical signs of pain people living with dementia might display if they were unable to communicate effectively with staff. We also found that laxatives, which were prescribed on a "when required" basis, were being given regularly without appropriate monitoring of bowel habit. The staff member administering this medication told us that stool charts were checked before giving laxatives. However we checked records for one person and found no entries had been made on the stool chart for the last three days although laxatives had been regularly given. The stool chart had only been completed on 12 days in June 2016 and 10 days in May 2016.

We reviewed records which showed some of the senior care staff had attended a safe administration of medicines training course in February 2016. The manager told us that staff supervision in relation to medication was not formally recorded, but that medication competency assessment forms were completed every four months. We checked staff training files and found competency assessments had last been performed in 2015.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A new system had recently been implemented to reconcile stocks of when required medicines. This was carried out twice each day to ensure balances were accurate and any doses given had been correctly recorded. Any discrepancies were investigated and brought to the attention of the manager or deputy manager.

Inadequate

Is the service effective?

Our findings

We asked two people using the service about the food available in the home. They told us that food was good, and that they enjoyed their meals. We observed lunch taking place in the home, and saw that staff provided people with discreet support where required, and ensured that the atmosphere during lunch was pleasant. The meal service was unhurried, and people appeared to be enjoying themselves. We observed the cook had asked each person what they wanted to eat for lunch earlier in the day, and offered people choices. There was a menu on the wall and on each table. However, it was in small type and not easy to read, particularly for people with visual impairments. There were no alternative menus, such as in pictorial or easy read formats, which would be suitable for people living with dementia.

We checked six people's care records to look at information about their dietary needs and food preferences. We found that information was limited or lacking personalisation. Each person had a record of how much fluid they had consumed each day, but there was no information about the amount of fluid each person should be supported to have. None of the files we checked contained information about how staff should monitor or manage the risks of malnutrition or dehydration, although we noted that two people had lost weight in recent months. The proprietor of the home told us, after the inspection, that these people had been referred to their GP in relation to their weight loss

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

We looked at the arrangements in place for complying with the requirements of the Mental Capacity Act. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

CQC records showed that the provider had made DoLS applications where required, and completed the appropriate notifications to alert CQC to these applications, as required by law. The home's manager was aware of which people using the service were subject to DoLS, and was familiar with the process for making applications.

We checked people's care records to look at the arrangements for obtaining people's consent, or reaching best interest decisions where people lacked capacity to give consent to their care. We found that the requirements of the MCA had not been met. For example, one person's records showed that they lacked the capacity to consent to their care. We found in their file there was a document stating that they agreed to their care. It was signed and dated, but it was unclear who had signed it, or whether it was in the person's best interests.

Another person's file also showed that they lacked the mental capacity to give consent, but again, there was a form in their file stating that they had given consent to have their photograph used by the provider. There was no evidence that this decision had been reached in the person's best interest, and there was no information about who had contributed to the decision making process.

A third person's file showed that they had the mental capacity to consent to their care. We checked records within their file, and found that a decision had been made stating that the person would be unable to vote in elections. This had been "authorised" by the person's relative. Given that the person had mental capacity, it was unclear why a decision had been made that they would not participate in the electoral process, or what authority their relative had to make such a decision on behalf of someone in possession of mental capacity. We had raised concerns in relation to best interest and consent during the inspection of January 2016, but did not see improvements in this inspection. We discussed this with the home's manager. However, they did not show a substantial awareness of best interest arrangements, or the legal framework within which decisions should be reached on behalf of a person who lacks mental capacity.

During the inspection of January 2016, we identified concerns in relation to staff knowledge of the Mental Capacity Act, consent and the Deprivation of Liberty Safeguards. Following that inspection, the provider contacted CQC to say that this area would be discussed in staff supervision. At this inspection we checked a sample of four staff members' supervision records, but did not see evidence that these areas had been discussed.

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

Requires Improvement

Is the service caring?

Our findings

We asked three people using the service about their experience of the care and support they received. Their responses were all positive. One person was receiving a visitor during the inspection. They told us that the home was very caring and they found staff to be kind and patient. We spoke with a visiting healthcare professional who told us they were impressed with the caring approach of staff at the home. They said that they had seen improvements, and felt that staff knew people using the service well.

We carried out observations of staff interactions with people using the service during the inspection. Staff were consistently reassuring and showed kindness towards people when they were providing support, and in day to day conversations and activities. We noted that staff had time to sit and chat with people, and people's reactions to this indicated that this activity was valued. We spent time in the communal areas during the inspection. We listened to conversations between staff and people using the service, and it was apparent that staff knew people, their needs and preferences, well.

We saw that staff respected people's dignity and privacy and treated people with respect and patience. For example, we saw care workers speaking discreetly to each other when planning care tasks, to ensure that the person received appropriate support while maintaining their dignity and not breaching their right to privacy.

The environment of the home was undergoing a programme to make it more dementia-friendly. The home's manager was overseeing a programme of people's bedroom doors being painted in different colours, to assist with orientation. There was still work to do in regard to this programme. The home's manager told us that various items had been ordered to enhance the dementia-friendly aspect of the home. During the January 2016 inspection, we had noted that bedroom doors were all one colour, and many bedrooms were sparse with little personalisation. At this inspection we noted some improvement in relation to this, and the home's manager described that this was an on going programme.

We checked six people's care plans to look at how involved they had been in planning their care. We could not find any evidence of this. Where decisions had been made about how people should be cared for, there was no evidence that they had been involved in contributing to the decision making process. For example, one person's care plan stated that they did not wish to have a key for their room, and another person's care plan stated that they wished to have a gate across their bedroom door. These records did not show that people had been involved in planning this. The home's manager told us that the home had access to an external advocacy service, which could be used to assist in involving people in making decisions about their care. However, none of the records we checked showed that an advocacy service had been used in this way.

The care plans we checked set out how people should receive care and support, but their daily notes and other records showed that staff were not always adhering to this. For example, one person's care plan stated that they wished to have a bath twice per week. However, records showed that they had not had a bath for ten days. Another person's care plan stated that they needed to wear glasses and that staff should ensure this. However, we met the person and saw that they were not wearing glasses. There was nothing in their

daily notes which stated they had been offered, and refused, their glasses.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service responsive?

Our findings

There were two activities co-ordinators at the home, and an organised programme of daily activities. During the inspection we observed people playing dominoes, sitting in the garden and reading newspapers. The home had a pet rabbit, which was in the garden while people were sitting outside. People we spoke with told us they liked having the rabbit at the home.

We saw a programme of planned activities which included activities taking place in the home as well as trips out. However, when we checked people's daily notes, which were very detailed and described what each person had done each day, we found little evidence of participation in activities. The home's manager told us that was because some people preferred not to take part in organised activities.

We checked care records belonging to six people who were using the service at the time of the inspection. We found that people's care plans were detailed, and set out the steps that staff should take to ensure people received the care they were assessed as needing. However, we noted that the provider had not always responded to people's changing needs by reviewing care plans appropriately.

There was a system of monthly care plan reviews, but this did not always result in changes to care plans or the implementation of new care plans. For example, one person's monthly review recorded that they were at high risk of tissue damage. However, there were no risk monitoring tools or records in their file to ensure staff regularly assessed this risk and responded to any skin changes or damage. Another person had started to exhibit a specific behaviour, which manifested itself as distress or anxiety. No care plan had been implemented to guide staff in how to provide the right support to the person to ensure their care responded to the person's changing needs. One person's care plan stated that the integrity of their skin should be monitored, as they were at risk of injury, such as a pressure sore, from poor skin integrity. The monitoring records for this showed that this monitoring had not been carried out for seven months.

Some people's care plans had been amended following review. However, this was often by means of a handwritten note added to the bottom of the care plan. These were often unsigned and undated, so it was not clear who had amended the care plan or when. For example, one person's care plan in relation to maintaining a safe environment had a handwritten, undated and unsigned note attached stating that they now had a sensor mat in their room. There was no information about who had made this decision, or who had made the assessment behind this.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was information about how to make complaints available in the communal area of the home. However, it did not contain correct information in relation to external remedy. Complaints were monitored by the provider during their monthly visits to the home. We asked some of the people using the service whether they knew how to make complaints. They told us they would feel confident to complain. They said that they would complain to the manager

Inadequate

Is the service well-led?

Our findings

Following the inspection of January 2016, the home's registered manager left their post. However, at the time of the inspection they had not yet cancelled their registration and therefore remained the registered manager of the home. A new manager had been appointed and they were present during the inspection. They told us they intended to apply to register with CQC, although they had not yet submitted an application. Staff we spoke with told us they found the new manager to be approachable and supportive. Visitors also gave us positive feedback, with both visitors with whom we spoke telling us that they had noted improvements in the home in recent months.

There was a whistleblowing policy in place to support staff who had any concerns, and this was available on display in communal areas of the home.

Following the inspection of January 2016, the provider contacted CQC stated that they had undertaken a programme of actions, which had brought the home to a position of compliance. However, we found that this was not the case, as we identified ongoing breaches of regulation.

We looked at the arrangements in place for managers to communicate with staff. The home's manager told us that team meetings took place regularly, and the provider had previously told us that team meetings had been used to address concerns identified in the January 2016 inspection. There were minutes of two meetings which had taken place since the January inspection, which showed that the findings of the January inspection had been discussed.

The provider had implemented a formal monthly audit, in which they checked various issues relating to the running of the home. These included people's wellbeing, safeguarding, complaints monitoring and accidents and incidents. Prior to the inspection, the provider had told us that these new audits were "robust" but we found that this was not the case. These audits had failed to identify areas of concern. For example, the audit of June 2016 stated "all clients [people using the service] are gaining weight." However, this was inaccurate. The same audit recorded that care plans were "very good" but again, we identified issues within care plans that needed remedying.

The home's manager told us weekly medication audits had been introduced in February 2016, and we saw examples of how these were used to monitor stock balances and completion of MARs. However, the audits were lacking in scope and detail because they did not include all aspects of medicines management; for example medicines requiring refrigeration, controlled drugs, medicines disposal and when required medicines protocols. In addition, no action plans or outcomes had been generated from audit results.

We checked the home's audits of care plans. However, we found that no care plans had been audited by the current or previous manager for seven months. Other audits had been carried out more recently, but as with the medication audits, had not identified where work was required. For example, a health and safety audit had not identified areas of damage around the home, and a kitchen audit had not identified where equipment needed to be replaced. There was a room audit, which checked a sample of people's bedrooms

on a weekly basis. There was no detail regarding which rooms had been audited, so it was not possible to corroborate their accuracy. Nor was it possible to assess which rooms needed to be audited next, or which ones had been audited.

We looked at minutes from a team meeting which took place in June 2016. In this the home's manager told staff that there were no major concerns at the home and things were going well. Given that we identified a number of concerns at the home during the inspection, this indicated that the home's manager did not have a good oversight of the home's performance or any areas where improvements were required.

Prior to the inspection, we asked the provider to complete a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. The provider did not return this. When we raised this with the home's manager they said that it had been sent to the previous manager's email address which was no longer in use. When a provider changes details, including contact details, they are required by law to submit a formal notification to CQC setting this out. They had failed to do this.

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

It is a legal requirement for providers to display their CQC ratings in the home and on their website. The most recent rating was on display in the home. However, we carried out a check of the provider's website and found it contained no reference to the current rating of "Inadequate." This meant that the provider had failed to act in accordance with the law in relation to this matter.