Rushcliffe Care Limited

Partridge Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on the 23 July 2015 and was unannounced. At our last inspection on 28 April 2015, although we found no breaches of the regulations, we asked the provider to make several improvements. This was because the service was not consistently Safe, Effective, Caring, Responsive or Well Led. At this inspection we found the provider had not taken sufficient action to remedy these concerns.

Partridge Care Centre is purpose built home set over three floors. It provides personal and nursing care for up to 117 older people and for people who live with dementia. At the time of our inspection 83 people were using the service.

There is a manager in post who is currently not registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal

Summary of findings

responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the manager was in the process to register with CQC.

This inspection was carried out in response to information of concern received by CQC. The inspection considered whether the service was safe, effective, caring, responsive and well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Partridge Care Centre on our website at www.cqc.org.uk.

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had not been made forall thosepeople whose freedom had beenrestricted. We saw staff using some forms of restraint. People were sat in wheelchairs with belts on and on several occasions staff held residents hands down to ensure they were moved out of the way if they refused to move, or to prevent them physically assaulting the staff who was closely supervising them.

We found that the effectiveness of staff deployment lacked consistency across the home and there were insufficient staff to cope with the demands placed upon them. The quality of care provided suffered across the home mainly because of lack of staff. People and staff told us that they felt their needs were not met safely at all times due to lack of staffing.

Where incidents of avoidable harm or potential abuse had been identified, the management team had not taken appropriate action to investigate and report these. As a result people's care had suffered and they remained at risk of harm or abuse.

Safe and effective recruitment practices were not followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs, gaps in employment were not investigated.

We found that medication had not been administered following best practice guidelines. We found that records were signed to indicate that medicines were administered, however when we counted the medicines we found that there were more in numbers that it should have been.

People were not protected from the risk of infections. The environment was well maintained however the equipment used for manual handling was not clean. Wheelchairs that had dark brown stains on the seats and staff used these to move people. Crash mattresses and alarm mats were stained and sticky.

Some of the staff we spoke with could not recall training they had received in how to safeguard people against the risks of abuse. However records were seen that demonstrated to us staff signed the training attendance. They were not able to describe what constituted abuse and the reporting procedure they would follow to raise their concerns.

Communication was not effective between management, staff and people. People were not aware of the recent management changes in the home and not able to tell us who the manager was. This meant that leadership in the home was not visible at all levels.

Records were not current and had not been reviewed when people's needs changed, or when required by the provider's policy.

As a result the provider failed to recognise and report incidents to the local safeguarding team.

The manager had not implemented robust systems to monitor and improve the quality of the service provided. They were not monitoring or analysing the high staff turnover and the inability of the service to retain the employed staff.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

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 safe.

There were not always sufficient numbers of suitable staff available to meet people's needs and ensure their safety.

Staff were not able to describe how to recognise and report allegations of abuse. Issues that should have been investigated and reported were not.

People's medicines were not managed safely.

Staff who worked at the service did not always go through robust recruitment processes.

People were not adequately protected against the risks associated with health care related infection.

Is the service effective?

Inadequate

The service was not effective.

People ` s day to day needs had not always been met effectively or in a timely way.

Best interest decisions had not been made for those people who lacked capacity to do so themselves.

People did not have a DoLS authorisation in place to ensure they were not unlawfully restrained or deprived of their freedom.

Staff were not supported and had not received the training to develop skills to meet people's needs effectively.

Is the service caring?

Requires improvement

The service was not always caring.

Staff had not understood the needs of people living with dementia.

People were not involved in decisions about their care.

People's dignity and privacy was not always promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive personalised care from staff.

People were not provided with the opportunity to pursue their hobbies and interests.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The manager had not developed systems to monitor and improve the quality and safety of the service provided.

The manager was not able to demonstrate through a robust system of governance that staffing levels matched the level of needs of the people.

The manager had not ensured the records reflected people`s needs and these were not regularly updated.

The manager had not ensured the service met the fundamental standards.

People told us the manager did not communicate with them well, and they were unaware of the recent management changes in the home.

Partridge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations. We carried out the inspection to look at the safety of the service and the quality of the leadership.

This inspection was carried out in response to information of concern received by CQC. The inspection was carried out on the 23 July 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We carried out observations in communal lounges and dining rooms and used the Short Observational 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 due to their complex health needs.

During the inspection we spoke with six people who lived at the home, five relatives, 14 staff members, one health care professional, the deputy manager, the provider and the home manager. We also spoke with officers from the local authority and reviewed the local authority monitoring reports and action plans developed in response to the findings of the reports. We looked at care records relating to six people and four staff files and looked at records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People were not protected from avoidable harm or abuse, and the management team could not demonstrate what actions they took in response to concerns. At our previous inspection on 28 April 2015, we found that the management team had made referrals to the local authority for safeguarding concerns. However when we looked at the actions taken in response to these the manager was not able to demonstrate what actions they had taken to keep people safe.

At this inspection on 23 July 2015, we found this poor practice had continued. There were instances where the management team had not reviewed concerns of harm or abuse, and had taken little or no action to learn from concerns and keep people safe. For example, one person's care records and noted that following a fall four days prior to our inspection visit, staff had identified two injuries and documented these on the person's body map. However, on the following day, a second member of staff documented a further twelve bruises and skin tears for the same person. We found this had not been reviewed by the management team and there had been no investigation into how the injuries were sustained. Subsequently this person's mobility deteriorated and they were sent to hospital for further investigation. One staff member told us, "I've passed on what I think needs to be done in the incident form, but I've had no feedback from management."

People were not always kept safe by staff who were able to recognise signs of potential abuse or restraint. Six staff out of 14 we spoke with were not able to describe what constituted abuse or how and when to report concerns. When one staff member was asked to tell us about the provider's whistleblowing procedure for raising concerns they told us, "If we hear a whistle for example, we know the particular place and run to help."

The systems in place to safeguard people from abuse or improper treatment were not efficiently implemented or followed by staff which meant that safeguarding concerns were not reported or properly investigated.

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

People did not receive the care they needed at the right time because there was not enough staff. One person's relative told us, "I am always worried for [person] when I am not here, they are short staffed all the time." Another person told us, "They [staff] do as much as they can but more staff is needed."

We reviewed the minutes of recent team meetings and saw that lack of staffing had been discussed in staff and relatives meetings. One relative was concerned that they visited the home on a weekend and for twenty minutes they had not been able to locate a member of staff to assist a person to use the toilet. Staff had raised concerns to management in the meetings about the shortage of staff and that they felt the reason for staff sickness on numerous occasions was due to the heavy workload.

People using the service were elderly and frail so needed regular supervision to ensure they were safe. However we saw that on several occasions people were left for periods of time without staff being present. In one area people who had been assessed as being at high risk of falls were left without staff being present for over ten minutes. We spoke with one visiting health professional who told us, "It's understaffed; they [staff] can't be in two places at once. Sometimes when I walk onto the floor I can't find a single staff." Staff we spoke with told us there were insufficient staff to provide the levels of care required. One staff member told us, "Sometimes we are just one staff on the unit for 18 people."

Staff told us that on occasions they had to carry out care that required two staff members on their own. One staff member said, "At times I have to use the hoist on my own and assist people who need assistance from two members of staff on my own because there is nobody else to help." A second staff member told us, "We are so short at times that we drop from five staff to one and the nurse. When this happens there is no time for dressings just medication and we do what we can. By the time help comes it is too late." Staff we spoke with understood that this could put themselves or the person they were helping at risk but felt they did not have any other option in order to provide the care the person needed promptly.

We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that there were sufficient numbers of suitable staff to meet people`s need safely.

Inadequate

Is the service safe?

Risks to people's health and well-being had not been effectively assessed. Although there were some risk assessments in place, they had not been updated as people's needs changed. Staff did not understand how to minimise and support people to reduce the risks. For example staff did not know how to manage when people's behaviour put them and others at risk. There was no plan in place to ensure staff took a consistent and safe approach to intervene and deescalate situations when people became frustrated or angry. In several cases we saw that the approach taken by staff did not effectively support people and they became more upset or withdrawn. Their wellbeing and their effect on others wellbeing had not been considered. In other examples we found risk assessments did not reflect what the individual needed. Where bedrails and protective bumpers were being used staff were unable to explain the risks as to why some people needed them and others did not. The manager reassured us they will look into this matter and ensure that bedrails were being used appropriately.

We found that several falls were recorded by staff in the daily notes for a person however no incident forms were completed to detail these falls. Although the person's risk assessments had been reviewed after these falls the information in the risk assessment was contradicted by other sections of the person's care plan which meant staff did not have the appropriate information to support the person safely. Another person was identified as needing a sensor mat to alert staff if they moved due to the risk of falling. However we observed that this was not placed near them. We brought this to the attention of the deputy manager who confirmed it was required and moved the mat to the front of the person chair.

Where there had been a deterioration of people's needs this had not always triggered a review of the risks for the person. Where people's mobility, risk of falls or health needs had changed, the provider's policy required a reassessment of the person's needs to be carried out at the time the changes were identified. However, staff had not followed this process.

We found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe and effective recruitment practices were not followed to check that staff were of good character and physically and mentally fit for the role and able to meet people's needs. Gaps in employment history had not been investigated. When we spoke with the manager about this they were unaware of the gaps in employment.

People`s medication was not administered safely. Staff administering medication were regularly interrupted and they had to stop several times to provide care and support to people. This meant that there was an increased risk of potential errors and people not receiving their medication in a timely way. They continued to administer medicines past 10 o'clock, which included medicines that were required to be given with or just after food despite breakfast being served from 8 o'clock. One relative told us their family member had to wait for their medicines "Sometimes [person] has to wait. Like this morning, [person] had their tablets at 9.50, what use is that when they are to be given with breakfast."

Records for medicines were unreliable; Some records were incomplete and medicines were not signed for as given. In another example there were more tablets in the boxes than accounted for in the medicine administration record. As staff could not explain the discrepancies we could not be assured that the medication had been administered as it should have been. Another person had been prescribed a medicine to help them sleep. This had been stopped by the person's GP after a review but staff continued to administer it for another eight days.

Although internal audits had identified similar issues the actions taken to ensure practice improved were not effective as errors continued to occur. Medicine errors where harm could have occurred were not reported to the local authority safeguarding team.

Where people were required to take their medicines disguised in food, staff had not followed the appropriate process to ensure this was done safely. We saw that although the GP had given their approval for the use of covert administration, staff had not sought the advice of a pharmacist to ensure there were no risks with disguising tablets in food or crushing the tablets.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they had not ensured the proper and safe use of medicines.

Equipment used in the home, such as wheelchairs, hoists and crash mattresses were not clean. For example, we

Inadequate

Is the service safe?

found a person's wheelchair had dark engrained brown marks. We later saw the person using the chair. We spoke with the housekeeping manager who told us that cleaning equipment such as wheelchairs, crash mats and mattresses were the responsibility of the night time care staff. However there were no schedules cleaning this equipment and staff could not show us how they adequately protected against the risks associated with health care related infections linked to the use of these items.

We found sluice rooms unlocked throughout the day and accessible to people who were at risk of injuring themselves. On one occasion we found a chemical descaler in the sluice room and a bag with used incontinence pads. Risks to people's safety had not been appropriately mitigated to ensure that they did not have access to dangerous chemicals or waste.

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

Inadequate

Is the service effective?

Our findings

The service was not effective because staff and management did not take action to ensure people had received robust training that provided them with the knowledge and skills to carry out their roles safely.

The manager told us that staff received an induction which included a classroom based training day covering areas such as safeguarding. The provider was also introducing the new, 'care certificate,' which is developed to enhance the current induction process. However they were unable to provide us with an explanation as to why some staff were unable to recall this training or how they put it into practice, for example staff were unaware of the process for reporting safeguarding concerns. In addition the manager was unaware that a new member of staff was supporting people on their own, even though they were at that time on induction and the provider's policy was that they should always be accompanied and/or shadowed during this period. It was additionally confirmed that two other new members of staff had worked unsupervised during their induction period.

One staff member told us no one had checked their competency to ensure they could complete moving and handling safely. We also talked with a staff member who recently started working at the home. They completed two days of shadowing more experienced staff on the units however on the third day, the day of our inspection we saw them assisting people with complex needs on their own. The staff member and the manager confirmed they had no formal training in how to safeguard people or in moving and handling. We spoke with this staff member who demonstrated little knowledge of safeguarding and how to raise concerns.

We confirmed through our observations that staff did not to recognise poor practice. We saw inappropriate use of restraint with no assessments or instructions for staff about how they should support people when they became distressed. For example we observed one person who had become agitated and anxious and when asked to move from the corridor. We observed one staff member hold the person's hands down and physically move them.

The manager confirmed that six different training topics were delivered in the same day. For example one staff member had training in safeguarding, infection control, dignity in care, managing challenging behaviour, MCA and DoLS and Health and Safety all on one day. However staff did not consistently demonstrate to us through discussion an understanding of these subjects. We saw this through their poor practice and their inability to tell us what actions they would take to ensure people's rights and welfare were protected.

Some staff spoken with were aware that their lack of training and support affected people using the service. One staff member said, "I'm not able to manage the workload, I thought this was a job where I could give something back, but I've not had the support or training to do this."

We were concerned that although the service provided care for people with dementia and/or those with increasing healthcare needs, some staff had not had relevant training in these areas. For example, of 133 staff, which included ancillary and care staff, 37 had not completed dementia awareness training and 35 had not completed infection control training. We identified concerns with the quality of the service in these areas.

Staff we spoke to and observed did not demonstrate an understanding of supporting people who live with dementia in a positive and individual manner. For example, people had little interaction with staff. Staff were unsure of how to support people who became distressed or frustrated.

This affected the wellbeing of the individual and others around them. There was no overall approach to ensuring that staff understood the individual needs of those they cared for or how those needs should be met.

The manager told us they identified that the training had not been effective and they were in the process of changing the training system they used. They told us they were working with the provider's training department to access further training for staff, and a new induction system was to be implemented. However, no action had been taken to address the lack of knowledge for the existing staff, and they were unable to tell us how long it would take to implement further robust and sufficient training.

We found that the provider was in breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

We found that the provider had not followed the requirements of the Mental Capacity Act 2005, and that people were being restrained without action being taken to refer to external professionals to ensure this was lawful and protected their rights.

Some care plans identified it was unsafe for people to leave the home unsupervised. Staff had assessed people and satisfied themselves that the person was not able to keep themselves safe away from the home as they did not understand or recognise the risks. However, the manager had not made the necessary referrals to the local authority so that independent assessments could be made and agreed to ensure these arrangements were appropriate, safe and complied with the law.

In another case a person's records showed that to ensure their safety, staff had increased their level of supervision. Staff had moved the person to the lounge area, where staff were able to continually monitor them. Daily records of care showed us that the person had continually, every 15 minutes requested to return to their bedroom which was refused. Due to the level of supervision the person was placed under, the manager was required to consider whether they were depriving them of their liberty, and submit an urgent authorisation. However, they had not done so, despite staff suggesting this and noting it in the person's record.

We later saw people had been taken into the lounge area and supervised by staff which was not their choice. People were not free to leave the lounge as they wished, however the staff or management had not considered that due to the close supervision used to keep people safe, they should consider if they were restricting people's liberty. When we spoke with staff about this they told us that people we kept in the lounge because there were insufficient numbers of staff to keep them safe.

We found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they had not taken the appropriate action to make sure people were not unlawfully deprived of their liberty.

We saw from records of professional visits that people had access to a range of health care professionals. These demonstrated to us that professionals such as GP's, psychiatrists, occupational therapists, dentists, and chiropodists frequently visited people in the home, or that people were supported to attend appointments in the community. However we also found at times that referrals to health professionals were not made when required. For example, one person who staff had observed had experienced a deterioration of their mobility had not been referred to have this checked by an appropriate health professional.

Staff were observed at breakfast and lunchtime encouraging and assisting people to eat and drink. However, we also saw that people were rushed and interrupted during meal times with no options of second helpings given, or alternatives offered where people had not eaten much.

Requires improvement

Is the service caring?

Our findings

People had mixed views about staff. One person said, "[staff name] came in yesterday with her little boy that was lovely." They continued to say, "Staff are nice, it would be nice to have time to sit and talk to me for five minutes." Another person said "Some are nice some are rushed."

We saw that people`s dignity and privacy was not always protected. Bedroom doors were often left open where people were still in bed. Staff was not able to tell us if people preferred their door open or not. This was not documented in the care plans. We heard staff knocking on bedroom doors and greeting people where people were able to communicate verbally. However, where people were not always able to voice their needs, staff did not always knock before entering people's rooms.

Staff had limited knowledge about people who were not able to communicate their needs and they made little attempt to get to know the people they were caring for. For example we saw a person who needed close supervision from staff. Staff was following this person around the unit. This caused a lot of anxiety to the person and they often turned around and tried to push the staff member away. The staff member did not interact with the person. When we asked staff if they know what the person wanted and how they should support the person but they were unable to tell us they said, "[person] is agitated anyway, it won`t make any difference."

We saw one person's bedroom door was open and we personal and confidential information about the person displayed on the bathroom door. This information was clearly visible to all visitors on the unit during the day when the bedroom door was opened.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) record in their care plan. We found that for one person this was issued by the hospital and not reviewed when the person joined the service. There was no record of the person or relatives being included in making the decision about whether they wanted to be resuscitated or not. We found for another person they had also had no involvement in making this decision. The provider has not ensured that consent had been obtained prior to a DNACPR being agreed or that the decision was in the person's best interest.

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

Requires improvement

Is the service responsive?

Our findings

People and their relatives were not involved in reviews of their care. One relative said, "I've not ever been asked what I think. Things just happen without us knowing." Although people had assessments and care plans these were not always updated when their needs changed. Staff spoken with did not always have an understanding of the needs of people they were providing care for.

We found that for those people unable to use their call bell the systems in place did not assure that they were effectively monitored to ensure their safety and wellbeing. For example, two people who had been assessed as requiring close supervision due to their deteriorating health needs were not observed as required. The need for close supervision had been identified in their care plans and in discussion during staff handover. One person required 15 minute observations due to a risk of falls. We observed that over a period of more than 45 minutes staff did not check this person until requested to by us. Records showed that this person had sustained a further fall since they were assessed as requiring close observation.

The provider had not made the necessary arrangements to ensure people were able to pursue their hobbies and interest. One relative said, "[Person] either sits in bed, or in the day room. There is a complete lack of anything meaningful for people to do. If you can walk you have half a chance of getting out and about, but not for [person] they are given the bare minimum." There were just one and a half activity coordinator posts employed by the service to organise meaningful activities for the 83 people using the service at the time of our visit. We observed that staff did not always spent time with people or engage in conversation.

We saw another person who told us they were depressed because they were unable to spend time in the garden and so did not want to talk to us. Staff confirmed, "[Person] was depressed because they were moved upstairs and they cannot access the garden. They also have family problems." We saw meeting minutes from recent meetings with relatives. Relatives were asking management to move people from the upstairs unit downstairs in an empty unit so people could have access to the garden. This was request was refused by management without consideration of alternatives or people's individual circumstances.

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found that the provider had quality monitoring systems in place

however these were not always robust. During this inspection we found the systems within the home continued to not ensure people's safety or that care was provided to people to meet their needs.

People, staff and visitors had mixed views about the management in the home. Staff told us, "There is no continuity in management, in three years we had four managers. One person said, "I can pass them on the corridor thinking they are a visitor." One staff member acknowledged that the manager had made some improvements "[Manager] is auditing and picking up things, taking us back to basics which has been good."

A new manager had been in position for two months and told us they had identified some issues in the home. Although they had taken some steps to address these, their actions had not been sufficient to ensure the quality and safety of the service. For example they told us they identified the need for a clinical lead on each floor in the home to ensure that the changes in people`s needs and health were identified more effectively. They had recruited into one vacancy and they were planning to advertise for another position. However they had not taken action to address this shortfall in the meantime and we found instances during our inspection where changes in people's needs and health had not been appropriately recognised and responded to. In one instance our intervention resulted in the hospital admission of a person.

We saw care plan audits which clearly identified where the care plan needed to be updated or improved. We asked the manager if these actions were completed. The manager initially told us they were. However, after reviewing two care plans they confirmed the identified improvements had not in fact been made.

The provider had not identified or acted on risks to people using the service. Out of the 26 safeguarding concerns raised from the 1 April 2015 only two had been identified and reported to the local authority by the provider. The others had been identified by external visitors and other professionals. Incidents and accidents had not been reviewed by management for any recurrent trends and themes. We looked at a copy of the incident review for one unit where the management team reviewed incidents. This did not include any of the falls or incidents that we had identified in records or been told about by staff. This meant that no action had been taken to reduce the likelihood of further incidents and accidents or to review whether appropriate action had been taken immediately following the incident to ensure the safety and well-being of those involved.

Although the provider had sought feedback from staff and from relatives they had not taken action to address concerns raised. Minutes of meetings held showed staff and relatives raised repeated concerns about staff shortages; staff retention; activities; infection control and medicines. However the manager had taken little action to address the issues raised.

We saw that the manager had completed a dependency assessment which had identified shortfalls in staffing numbers and carried out a staffing review. However, they had not taken the necessary steps to address the shortfalls and ensure sufficient staffing levels to meet people's needs. Throughout our inspection we saw that insufficient staffing was having a detrimental impact on people's care.

We found that the local authority has conducted a monitoring visit in June and identified concerns about the service people received. We found that the manager to address the issues raised by the

local authority. The action plan contained limited detail about the action needed and how the necessary improvements would be made. Many of the areas of concern identified in June had not been addressed and the concerns identified were of a similar nature to those we found during our inspection.

Due to lack of accurate recordings, lack of systems to identify shortfalls of the service provision and the lack of responsiveness to improve the quality of the service provided we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information shared with us by the local authority regarding several on-going safeguarding investigations being conducted by the local safeguarding team. Although the local authority had made the provider

Inadequate

Is the service well-led?

aware of this information the provider had failed to notify CQC about these incidents. This meant that the provider had not ensured that they deliver a service which is transparent and open.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 (1) (2) (3) Systems were not in place to safeguard people from abuse or improper treatment or to effectively report and investigate safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) and (2) (a) There were not sufficient numbers of staff deployed to meet people's needs and staff had not received appropriate training to ensure they were provided with the knowledge and skills to carry out their roles safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) and (2) (a), (b), (c), (e), (f), (g), and (h). People's care needs were not assessed when their health needs changed, and all that was reasonably practicable to mitigate any such risk had not been reviewed or carried out to ensure service users received safe care and treatment. Safe and effective recruitment practises were not carried out. Medicines were not managed safely. People's equipment had not been maintained safely and was unclean. Toilet and communal areas had not been maintained and cleaned sufficiently to prevent the spread of infection.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1), (2) and (3) The provider had not acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 (1), (2), (a) and (b) People's dignity and respect was not always protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) and (f) People and their relatives were not involved in developing a plan of care that reflected people's views, interests and preferences. People were not enabled supported to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1) and 17(2)(a), (b) & (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to monitor and mitigate the risks to service users. Accurate records in respect of service user's treatment had not been

This section is primarily information for the provider

Action we have told the provider to take

maintained. The provider had not ensured staff were provided with appropriate training, and failed to recognise and report incidents under the safeguarding procedure.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 Incidents that are required to be reported to the commission had not been carried out as required.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1) and (2) (a), (b), (c), (e), (f), (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Service users safety was not protected, there were insufficient numbers of staff deployed to safely meet the needs of service users. Risk assessments in relation to all aspects of service user care were incomplete and not reviewed when changes to a person health needs occurred. Medicines were not managed safely and equipment in place to support service users was dirty.**

The enforcement action we took:
The Registered Provider must not admit any service users to Partridge Care Centre without the prior written agreement of the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13(1), 13(2), 13(4)(b), (c) & (d), 13(5), 13(6)(b) &(d) and (7)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Service users were not protected from the risk of harm or abuse because effective processes were not operated effectively. Deprivation of liberty safeguard applications had not been made in all circumstances where required. People were observed to be unlawfully restrained by staff. Documentation had not been maintained to record and investigate injuries to people, and some staff were unable to describe what constituted abuse.**

The enforcement action we took:
The Registered Provider must not admit any service users to Partridge Care Centre without the prior written agreement of the Commission.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the proivder did not ensure that there were sufficient numbers of suitable staff to meet people`s needs safely.**

The enforcement action we took:
The Registered Provider must not admit any service users to Partridge Care Centre without the prior written agreement of the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) and 17(2)(a), (b) & (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to monitor and mitigate the risks to service users. Accurate records in respect of service users treatment had not been maintained. The provider had not ensured staff were provided with appropriate training, and failed to recognise and report incidents under the safeguarding procedure.**

The enforcement action we took:
The Registered Provider must not admit any service users to Partridge Care Centre without the prior written agreement of the Commission.