Loxley Health Care Limited

Hilcote Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We inspected Hilcote Hall on 19 November and 24 November 2015. The inspection was unannounced. This was the first inspection since the provider had registered with us (CQC).

The service is registered to provide accommodation and personal care for up to 44 people. People who used the service were over 65 years old and have physical and/or mental health diagnoses. At the time of our inspection there were 39 people who used the service.

At the time of the inspection the registered manager had left the service and was in the process of deregistering with us (CQC). The service had another manager in place and they were in the process of registering with us (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.

Risks to people's health and wellbeing were not identified and managed by staff safely. We found there were not enough staff available to deliver people's planned care or keep people safe.

People were not protected from the risks of harm because staff did not recognise when people's safety was

compromised and incidents of possible abuse were not reported as required.

We found that medicines were not administered in a consistent and safe manner at a time when people needed them.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

People did not always get the support they needed to eat. Staff were not always available to monitor people were eating sufficient amounts. This meant some people's nutritional needs were not met.

Staff told us they received training. However, we found that some of the training they had received was not effective. There were no systems in place to ensure that staff understood and were competent to support people safely and effectively.

People were not always consistently treated with dignity in an environment that protected their privacy and dignity.

People and their relatives were not involved in the planning of their care. People's preferences had been sought, but staff had a varied knowledge of people's care preferences. This meant that people were at risk of receiving inconsistent care.

Advice was sought from health and social care professionals when people were unwell. However, we saw that people were not always referred to specialist health professionals to ensure their health needs were met effectively.

People told us they were treated with care and given choices. However, we saw that improvements were needed to ensure that staff were able to interact with people in a way that met their needs.

Some people were given the opportunity to be involved in social and leisure based activities. However, improvements were needed to ensure that everyone had the same opportunities.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. We found that assessments had been completed with the involvement of other health professionals and representative, which ensured that decisions were made in people's best interests.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and wellbeing were not identified and managed by staff safely.

There were not enough staff available to deliver people's planned care or to keep people safe.

People were not protected from the risks of harm because staff did not recognise when people's safety was compromised and incidents of possible abuse were not reported.

We found that medicines were not administered in a consistent and safe manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always get the support they needed to eat sufficient amounts because their nutritional needs were not assessed or monitored effectively.

We found that some of the training staff had received was not effective. There were no systems in place to ensure that staff understood and were competent to support people safely and effectively.

People had access to healthcare professionals. However, improvements were needed to ensure that people were referred to specialist professionals, if required.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity in an environment

that protected their privacy and dignity.

People told us they were treated with care and given choices. However, we saw that improvements were needed to ensure that staff were able to interact with people in a way that met their needs and made them feel cared for.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives were not involved in the planning of their care. People's preferences had been sought, but staff had a varied knowledge of people's care preferences.

We found that improvements were needed to ensure that everyone had the same opportunities to be involved in social and leisure based activities.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

The provider was not notifying us (CQC) of any incidents that had happened at the service as required.

Hilcote Hall

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 associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 November 2015 and 24 November 2015 was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has had experience of this type of service.

Prior to the inspection we had received concerning information from local authority commissioners about the service. During the planning of our inspection we reviewed information we held about the service. We reviewed information that we held about the provider and the service which included notifications that we had received from the provider about events that had happened at the service. For example, serious injuries and safeguarding concerns. We also had concerns about the way safeguarding and serious injuries were being managed at the service.

We spoke with eight people, five relatives, five care staff and the manager. We observed care and support in communal areas and also looked around the home.

We viewed ten records about people's care and records that showed how the home was managed. We also viewed six people's medication records.

Inadequate

Is the service safe?

Our findings

We found that people did not receive the correct care to minimise their risk of harm. We spoke with a person who used the service who told us that they were uncomfortable in their wheelchair. They said, "This chair is lousy. There's no comfort in it at all, it's like bare wood". We saw that this person had been assessed as at risk of pressure damage and required a pressure relieving cushion when they were sitting down. We saw that this person was not sitting on their pressure cushion. We asked staff if this person needed anything in place to lower their risks of pressure damage. Staff said, "No, they don't need anything". We saw that the daily record sheet that had been filled in showed that this person was on a pressure cushion, but we saw they were not. This meant that their risk of pressure damage was not being lowered because staff were unaware of the risks for this person and did not follow the plan of care.

We saw three people being assisted to move by staff in an unsafe way. For example we saw two people being assisted to move by staff using a stand aid hoist, which meant the person needed to be able to have the ability to stand and control their own weight. Both of these people were unable to stand, but staff continued with the transfer. We had to intervene and stop the staff from continuing to assist one person because the transfer was unsafe and there was a risk that the person would be injured if they carried on. We asked the staff what people needed to be able to do to use the stand aid safely and we were told, "They need to be able to stand", which the people we observed could not manage. We viewed the risk assessments and care plans for these people, which stated that they were able to use the stand aid. These had been recently reviewed and no changes had been identified. This meant that people were at risk of unsafe care because risk assessments were not updated when people's mobility needs had changed and staff were not following safe handling procedures.

We also saw that accidents were not managed effectively to lower the risk of harm to people who used the service. The manager had an accident log in place, but we saw that this did not give details of the accident or any actions needed to lower the risk of further incidents. For example; one person had suffered from a serious injury because they had fallen in the lounge. We saw that a door sensor had been activated in this person's bedroom, but there had been no measures put in place to lower their risk of falling in the lounge area. There had been no changes to this person's risk assessments or care plans after the accident had occurred. We asked the manager if they had considered using preventative equipment such as a pressure mat under their chair to alert staff that assistance was needed and we were told, "No, we haven't put anything like that in place".

We found that people's medicines were not managed safely. We viewed the medicine administration records (MAR) for six people and we saw that people did not always receive their medicines as prescribed. For example; one person had been prescribed two types of pain medicine to be administered regularly three times a day. We spoke with this person who told us they were uncomfortable and they were in pain. The records showed that this person's medicines had been administered by staff as an 'as required' medicine rather than a regular medicine and this person had not received their pain medicine on numerous occasions over a period of time. We asked staff why this person had not received their medicine, but they were unable to answer why this had happened. This person continued to be in pain because they had not received their

medicine as prescribed. Another person had been prescribed food supplements because they were at risk of losing weight. The MARs showed that this person had not received their prescribed supplements for a period of seven days. Staff told us that this was because they were out of stock. The weight records we viewed showed that this person had continued to lose weight. This meant that people had not received their medicines as prescribed to keep them well.

We checked the balance of medicine stock that the home held against the balance recorded on the MARs for six people. We found that the stock did not balance for three people, which meant that we could not be assured that these people had received the medicines they needed. We asked staff why the stock did not balance and they were unable to give an explanation for this and were not able to identify if these people had received their medicine as prescribed.

The above evidence showed people were not supported in a safe way because appropriate actions were not taken to manage risks effectively. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out an observation in the dining room of the home during lunchtime. We saw that one person became anxious because they were waiting for their lunch. We saw that another person who used the service slap this person around their shoulder and told them, "Shut up". There were two members of staff in the dining room at this time who also witnessed this incident. We asked staff about these two people and we were told that this behaviour was 'usual' between the two people and they did not report every incident that occurred. One member of staff said, "This is how they are together, I don't always report every incident, and they don't cause any injuries, but maybe I should?" We spoke with the manager who was unaware of the incident because staff had not reported this to them. We checked the care records for the two people involved and saw that there was no guidance in place to manage these people's behaviours and keep them safe. We reported the above incident to the local safeguarding authority as we did not have confidence that this would be carried out by the manager. This meant that people were not protected from abuse because staff and the manager were unaware of their responsibilities to keep people safe from harm.

We viewed the incident forms for October 2015 and November 2015 and found that potential incidents of abuse had not been acted on. For example; we saw that where residents had become aggressive towards one another the manager had not considered that these incidents constituted abuse. We spoke with the manager who was unaware of the incidents and told us that these had not been reported to the local safeguarding and they had not carried out their own investigation. This meant that people were at risk of further abuse, because actions had not been taken to safeguard people from further harm.

The above evidence showed people were not protected from the risk of alleged abuse. This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and relatives told us that there were not always enough staff available, especially at meal times. One person said, "There are not always enough staff; especially at mealtimes and on Sundays, where there only appears to be one or two around". Another relative said, "The home is permanently short-staffed and they [the provider] frequently use bank staff to fill in the gaps". We saw that people's needs were not met and not at a time that they needed it. For example; call bells were not answered in a timely manner. One person's call bell alarm had been sounding for a period of 30 minutes. The care records showed that a door sensor was in place in a person's room to alert staff that this person was moving and to lower the risk of falls. The person was found by an inspector at their door and they were unsteady on their feet. We saw that staff did not respond to the call bell because there were no staff available to provide the required support. This meant that there were insufficient staff available to respond

in a timely way to meet this person's needs and lower their risk of falling.

We saw that people were not supported or monitored by staff when they were in the dining room, which impacted on people's wellbeing and nutritional needs not being met. For example, people who were at risk of falls were not monitored throughout the day and people did not receive sufficient amounts to eat. We saw one person required prompting when they were eating and staff were not available in the dining room to support them and they did not eat their food. We saw people who were at risk of falls were attempting to mobilise without their walking aids that they had been assessed for to keep them safe. There were no staff available because they were supporting people in other areas of the service and they were unable to monitor these people and prompt them to use their walking aids as assessed. This meant there were not sufficient staff deployed across the service effectively to support people with their needs at a time when they needed it.

We saw one person at breakfast who appeared hungry who was trying to get food from the trolley in the dining room, which had been left by staff. We saw that this person touched all of the cutlery and crockery that was waiting for other people to use. This person also put a spoon into the sugar bowl and started to eat the sugar and they then drank from another person's cup of tea that had been left on the table, which meant there was a risk of cross contamination. Staff were not available in the dining room for long periods of time, and were not aware that people were at risk because there were insufficient staff available to monitor and support this person and ensure that other people's safety was maintained.

We saw another person cleaning the bathroom and corridor floor using a used toilet brush. Staff had not been aware of this until we alerted them to it, because they were unable to supervise and monitor all of the areas across the service. This person and other people that used the service were at risk of cross infection because there were not enough staff sufficiently deployed to lower risks and monitor service users to ensure that they remained safe from harm.

The above evidence shows people were not supported in a way safe way because there were insufficient, suitably deployed staff available to meet people's needs. This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with told us that the food did not always meet their relative's needs. On relative said, "Pureed food doesn't happen, this is not fair as food is their [person who uses the service] last enjoyment". Another relative said, "They [provider] don't think about people who don't have teeth when providing food". For example; two people were unable to chew certain types of food. The care records we viewed and staff told us that this person had a normal diet and no soft diet was needed. We asked the manager about the two people and they told us that they were given a softer diet so that they were able to eat the food that had been prepared. During our observations we saw that these two people were not given a soft diet and were unable to eat what had been prepared. We saw that one of the people who did not have their food in a way that met their needs had lost a significant amount of weight in a month and no actions had been taken to lower the risk of further weight loss. This meant that people were not supported effectively to ensure that they received sufficient amounts to eat in a way that met their needs and maintained their health and wellbeing.

We saw that one person required support because they did not know how to eat their breakfast. This was because their dementia had impacted on their ability to understand what they needed to do. The person kept touching their breakfast and received no prompting from staff, which meant they did not eat it. This person left their food on the table when they left the dining room and they were not offered any alternative. We viewed their diet and fluid care plan, which stated they needed encouragement to eat The weight records we viewed, showed this person was a low weight and had fluctuating weight loss and they had also been prescribed nutritional supplements, which we found had not been provided. This meant that no action had been taken to ensure that this person's nutritional needs were met and they were at risk of further weight loss because their nutritional needs had not been assessed or monitored effectively.

The above evidence shows people were not supported with their nutritional needs because appropriate assessments and monitoring were not in place to ensure they received sufficient amounts to eat. This is a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training to carry out their role and they had access to training updates. Staff told us that they had received training to move people safely. However, we saw staff using unsafe techniques to help people to move. For example; staff were observed assisting three people to move in a way that could have caused an injury to people, because people were not participating in the transfer. Staff had not recognised that the way they were attempting to move people was not safe or effective and staff had not raised any concerns or considered an alternative way to assist people to move. Although, we saw that staff were not competent to move people safely, the manager and provider were unaware of these shortfalls in staff knowledge and there were no systems in place to check staff competencies. We requested a copy of the training records for staff, but we did not receive these from the provider. This meant people were not supported by suitably skilled to carry out their assessed support in a safe or effective way.

The above evidence shows that people were not supported by staff who had not received effective training to carry out their role. This was a breach of 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

People using the service and relatives told us that they accessed health services and we saw that some people had been referred to health professionals when required. The provider had an arrangement with the local G.P, who attended the home on a weekly basis to provide advice and health and wellbeing support where required. However, we found that some people were not referred to other professionals when required. For example; one person's relative had raised their concerns about their relative's speech and asked if they could be referred to the Speech and Language Therapists for an assessment. We found that this had not been carried out and this had not been followed up by the manager to ensure this person received the external support required.

Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests, when they lack sufficient capacity to be able to do this for themselves. Most staff were able to explain the basic principles of the Act. We saw that mental capacity assessments were completed when required with the input from health professionals and people's representatives to ensure decisions were made in their best interests. The manager had understood their responsibilities with regards to Deprivation of Liberty Safeguards (DoLS) to ensure that people were not unlawfully restricted. We saw that some people had DoLS in place which set out the support required to keep people safe in the least restrictive way. Staff we spoke with were aware of how to support staff in accordance with their DoLS.

Requires Improvement

Is the service caring?

Our findings

Staff did not always speak with people in a way that protected their dignity. For example; one person was anxious and staff responded using undignified terms when speaking with them, such as "good lad" and "that's a good boy". These terms were undignified because they were an adult and staff had referred to the person in a 'child like' manner. This meant that people were not always supported in a way that gave them privacy and protected their dignity. We saw some examples of staff treating people with dignity. Staff supported people with their personal care in private areas and on some occasions we saw staff talking to people with dignity. However, we observed staff on two occasions providing treatment in a way that did not consider their dignity. For example, one person was administered eye drops at the dining room table on two occasions where this person was having their meals with other people; they were not asked if they wished to go to a private area.

People who we were able to speak with told us they were happy with the way the staff supported them. One person said, "The staff are very good and helpful". Another person said, "Everybody is very helpful". Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "They are lovely, really nice". People and relatives also told us that there were no restrictions on visitors and they were able to see their family and friends at any time. We saw that staff mostly spoke with people in a caring way when they provided support. However, we saw that staff were busy and the interactions were quite rushed. For example, one person became upset and staff did not give them dedicated time in a way that made them feel more comfortable. We also saw that when staff were assisting people to eat, they were rushed and moved from supporting one person to another, which meant people did not always receive care that made them feel they were important.

We saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We observed how people were supported with choices at mealtimes. We saw that people were offered a choice of meals, which they had chosen on the previous day and staff provided people with their chosen meal. Staff were observed asking people what they wanted and respected their choices. For example; at lunchtime staff asked people if they wanted a sauce with their meal and explained what it was and people were able to choose if they wanted this or not. People we also given choices by staff of their preferred places to sit in the dining room and who they wanted to sit with.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they were not aware of the information in their care plans and had not been involved in the planning or review of the care provided. One relative said, "I don't remember being involved at the planning stage of my relative's care and I don't know where the care plan is kept. We were not directly involved in it". We saw that monthly reviews of people's care had been undertaken by staff but we found that these were not effective as staff had not recognised people's needs had changed, therefore the records had not been updated to reflect this. For example; one person's relative told us that their relative was unable to eat certain foods because they found it difficult to chew. This person's care plan had been reviewed monthly and did not show that they needed their food prepared in a certain way and this person was unable to eat the food provided because the records had not been updated. We also saw that one service user's pressure care plans were contradictory because one care plan stated they required pressure relieving equipment and another pressure care plan stated that no equipment was needed.

We found that people's preferences had been considered in the planning of their care. Care plans we viewed contained details of people's likes and dislikes in the way they received their care. However, we found that staff were not always aware of people's preferences and people did not always receive care in line with their assessed preferences. For example; we saw that one person did not like potatoes and this was detailed in their care plan. We saw that this person received mashed potato with their meal on two occasions and they did not eat this part of their meal. Staff told us that this person did not have any specific likes or dislikes and they liked most food. We asked staff if they were able to read the care plans but we were told that they had very little time to look at the care plans because they were busy. This meant that staff were not responsive to this person's preferences.

People told us that there were times when there was nothing from them to do. One person said, "I am sometimes bored". Another person said, "There is very little to do." People told us that when any entertainment or activity took place, if they were not in the room at the time they missed out on being involved. We saw that some people were encouraged to take part in a group activity during the morning in one of the communal lounges where the activity took place. However, people who were not already in the lounge were not encouraged to take part or given assistance to take part in the activity available. We did not see that people had been involved in the planning of activities to ensure that they met their preferences or interests. The provider employed two members of staff to provide activities and ensure people's emotional wellbeing needs were met. We found that one of the workers was unavailable to provide this support as they were needed to undertake a care staff role to people because there were not enough care staff available. This meant that the provider was not always responsive to people's emotional wellbeing.

Relatives we spoke with knew how to raise a complaint and told us that they were comfortable raising any issues with the manager. One relative said, "I would complain if I wasn't happy, the manager is approachable". The provider had a complaints policy in place which was available to people who used the service, relatives and visitors. We looked at the complaints log and found that there were no complaints recorded, this meant we were unable to assess whether complaints that had been made were responded to appropriately by the manager. We spoke with the manager who told us that they had not recorded concerns

raised by relatives because these were not formal complaints so they had not been logged as a complaint.

Inadequate

Is the service well-led?

Our findings

We saw that there was an accident/incident log in place that had been completed, but this did not contain details of the accident/incident and the action in place to prevent further incidents. We found three incidents had occurred that could potentially have been life threatening. We saw an incident form where a person had slipped out of the bath chair onto the floor and another person had slipped off the bath chair and was held up by the straps. No action had been taken to ensure this equipment was safe to use in the future. Another person was found with the weighing equipment on top of them in a corridor, this equipment was still in the corridor at the time of the inspection and no action had been taken to make the environment safe. We asked the manager what action had been taken and we were told that no actions had been put in place to lower the risks of further serious harm. This meant effective incident and accident management was not in place to lower the risks of further harm to people.

The manager did not have any systems in place to monitor and assess the quality of care provided. They were unaware of any of the concerns that we had raised at the inspection. For example, the manager was unaware of the concerns we raised about medicine management, inappropriate and contradictory care plans and risk assessments, people receiving unsafe care, staff competencies and knowledge in providing safe and consistent support. We saw the provider's Quality Manager had completed an audit of the home and noted areas of improvement. This plan identified some areas that we had raised but no actions had been taken to ensure that improvements were made by the manager or provider. For example, we saw that audits had been identified as being required, but they had not been carried out. We saw that the improvement plan identified that potential safeguarding incidents had not been reported, but no action had been taken to rectify this. The manager had completed an action plan but they told us the required actions had not been implemented because the paperwork had not been made available to them. This meant that the provider had failed to ensure improvements had been completed to ensure that people received safe and effective care and support.

We asked the operational manager if they had a system in place to assess the staffing levels because we had found that there were insufficient staff available to meet people's needs. We were told by that there was not a staffing dependency tool in place. They told us, "We haven't got a dependency tool and there has never been one as far as I'm aware, but we will look into this". We viewed the staff rotas, but we were unable to ascertain if safe staffing levels were in place. We requested the provider's computerised records to show the staff hours over the last two weeks, but they did not have a copy of these readily available and we did not receive them after the inspection as requested. This meant we were not assured that there were sufficient staff available to meet people's needs because there had not been an assessment carried out by the provider to ascertain that the staffing levels met people's dependency needs.

We found that the care records we viewed were out of date and contradictory. We viewed 10 people's care records and found that where people's needs had changed the records had not been updated. We also saw that reviews that had been undertaken were not effective. For example, we saw that three people's nutritional needs had changed and this was not reflected in the care plans or risk assessments, which meant that people received unsafe and ineffective care. We also saw that one person's pressure care plans were

contradictory because the care plan stated they required pressure relieving equipment and another pressure care plan stated that no equipment was needed. We asked the manager how they ensured the records reflected an accurate account of people's needs and we were told that they did not have a system in place to monitor or review the care records because they had not been provided with the audit paperwork to enable them to complete this.

We fed back our concerns to the manager throughout the inspection and found that immediate action was not taken to ensure that people received the right care. For example, we reported that one person had not received their food prepared in a way that met their needs at breakfast. We saw that the manager had made no changes to the way this person had their food prepared at lunch. We also informed the manager of our concern about a person's pain medicine. We checked the records when we returned to the service four days later and found that they had still not received their pain medicine as prescribed. This meant that the provider had not taken account of our concerns and put actions in place to ensure that people received appropriate care that met their needs. When we returned to the service on 24 November 2015, we found that the concerns we had raised had still not been actioned. This meant that the provider had not been responsive and had not acted immediately to the feedback that we provided on the 19 November 2015 to ensure that people received safe and effective care and were protected from the risk of harm.

The above evidence shows that effective systems were not in place to assess, monitor and manage risks to people's health and wellbeing. This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has a duty to notify us (CQC) of any incidents that had happened at the service, which enables us to monitor the service. For example; deaths, serious injuries, alleged abuse and when a Deprivation of Liberty Safeguards (DoLS) had been authorised. We found the provider had not informed us of incidents of alleged abuse that we had been made aware of by the local safeguarding authority and the manager in place was unaware of their responsibilities to report to us without delay. For example, we had been informed by the local safeguarding authority of two concerns that had been raised by a visiting health professional, which we had not been notified about by the manager.

The provider had not notified the commission of other incidents as required. This is a breach of Regulation 18 of the Care Quality Commission (Registration Requirements) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying us of other incidents that occurred at the service. Regulation 18.

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks had not been managed or mitigated to protect people from harm. People were at risk of harm because equipment was not used in a safe way and medicines were not managed in a safely. Regulation 12 (1) (2) (a) (b) (c) (e) (f) (g)

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration

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 People were not protected from harm because there were no systems in place to prevent or investigate alleged abuse. Regulation13 (1) (2) (3)

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

People did not receive appropriate care and support to meet their nutritional needs because they were not assessed or monitored effectively. Regulation 14 (1)

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to ensure that people's health and wellbeing were assessed, monitored and managed effectively. The provider did not have systems in place to assess, monitor and improve the quality of care people received and accurate records of people's required care and treatment were not available. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not met because there were not enough staff sufficiently deployed to meet people's needs at a time when they needed it.Regulation 18 (1) (2) (a)

The enforcement action we took:

We served an Urgent Notice of Decision to prevent admissions to the service and a Notice of Proposal to remove the location from the provider's registration