Caldwell & Beling Ltd

Merok House

Inspection report

46 New Brighton Road
Emsworth
Hampshire
PO10 7QR

Tel: 01243372155

Date of inspection visit:
15 July 2016

Date of publication:
19 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 15 July 2016. Merok House provides accommodation and care for up to 22 older people. During the inspection 13 people were being accommodated. The home was undergoing extensive building work. This meant people had limited space in the communal areas, but all people had chosen to stay at the home during the building work.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff understood the principles of keeping people safe, but in practice these had not been followed. We found serious injuries had not been reported to external bodies or investigated by the registered manager meaning people may not have been safeguarded from potential abuse. Some people had relevant risk assessments in place to meet their needs, but for some people relevant risk assessments were not up to date. This meant there may have been risks associated with people's care which staff were not aware of. Staffing levels had not been planned to meet the needs of people, but these were increased following the inspection. There was a training programme in place for staff but this did not cover all the areas needed, which meant staff did not always have the knowledge to meet people's needs. Recruitment checks had been completed before staff started work to ensure the safety of people. Medicines were administered and stored safely.

Staff had a basic knowledge of the Mental Capacity Act 2005 but this had not been properly followed or put into practice. This meant people did not have their mental capacity assessed and restrictions had been placed on people without their agreement or being in their best interests as authorised by proper processes. People enjoyed their meals and were offered a choice at meal times. People were supported to access a range of health professionals.

People did not always have their needs planned in a personalised way which reflected their choices and preferences had been considered. This meant staff may not always have the best information on how to meet an individual's needs and preferences. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

People felt the staff were caring and kind. However the lack of staff available and their lack of training in areas meant they did not always respond to people in the most appropriate manner. The home did not always have an open culture where staff felt they could raise concerns and they would be listened to. Staff felt supported by the registered manager. Records were not always accurately maintained and there was not an effective quality audit process in place. Notifications were not being submitted as required.

We found breaches in 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and

one breach of the Registration Regulation 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?

Requires Improvement

The service was not always safe.

Safeguarding concerns had not always been reported or investigated.

Risks regarding individuals' care had not always been identified or updated to reflect the current risk.

Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staffing levels had not been planned to ensure the needs of people could be met.

Medicines were safely stored, administered and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training or regular supervision, to ensure they had the knowledge and support to meet people's needs.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been used appropriately.

People received support to ensure they ate a balanced diet.

People were supported to access a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by caring staff who mostly respected people's privacy and dignity. However staff were very busy and did not always have the knowledge of how best to support people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff felt supported by the registered manager but she was not always aware of her responsibilities.

People's records were not always accurate and well maintained; the quality assurance process did not identify or address all the issues needed.

Notifications were not always submitted as required.

Merok House

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 15 July 2016 and was unannounced. The inspection was carried out by one inspector, a specialist advisor in nursing and the care of frail older people, especially those living with dementia and an expert by experience who spent time talking with people.

Before the inspection, we reviewed previous inspection reports, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

The service was last inspected in August 2014 and at that time was found to be compliant with the regulations looked at. During the inspection we spent time talking to thirteen people, four visitors, two members of care staff, two members of the management team and the registered manager. We looked at the care records of six people and staffing records of three members of staff. We saw compliments and the complaints log, policies and procedures, fire risk assessment and training records. Certain policies were sent to us following the inspection. We were given copies of the duty rota for a month, which included the week of the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff. We received written feedback from two health and one social care professionals.

Requires Improvement

Is the service safe?

Our findings

Staff had knowledge of safeguarding people at risk and most staff had received training to support this, in the last 12 months. Care staff were aware of the policies regarding safeguarding and which agencies should be informed if there were safeguarding concerns. People felt safe and were confident staff would raise any concerns if they reported they did not feel safe.

However we could not be assured the registered manager and staff were aware of how to recognise abuse or of when to use the policies and procedures to ensure people were protected from abuse. We found reports of two separate incidents which related to two people sustaining serious injuries whilst receiving care and support from staff. There were also three reports of people who had unexplained bruising. These incidents had not been investigated and no referrals had been made to the local safeguarding team. When asked, the registered manager advised us she had considered making a referral but had decided it was not necessary after discussing with the provider. The failure to report these incidents meant people may not have been safeguarded from potential abuse. Following the inspection we reported these incidents to the local authority responsible for safeguarding matters. The management team offered us some reassurance all future incidents would be reported to the safeguarding team, where appropriate.

The failure to report these concerns and follow systems and procedures to keep people safe was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks relating to people's care had not always been identified, which meant some people did not have appropriate risk assessments in place to ensure staff knew how to care for people safely. For example risk assessments had not been updated following the incidents raised in the above paragraph regarding safeguarding incidents. For some people their care plans had not been updated as their needs had changed. As a consequence risk assessments had not always been updated to reflect the change in the risk, which may have been increased or decreased. For example, for one person their care plan recorded they were mobile and continent. However this was not reflective of their current abilities and did not reflect the risk associated with their current care needs in terms of especially their mobility.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were appropriate risk assessments in place regarding the building works taking place and people told us the disruption to them had been kept to a minimum. A fire risk assessment had been completed and people had personal evacuation plans in case of a fire.

The registered manager told us the staffing levels were static, with three care staff on in the morning, two care staff in the afternoon/ evening and two staff worked a waking night duty. We were advised there was always a designated senior on duty who was responsible for medicines. There was no method for assessing and ensuring there was adequate staff on duty to be able to meet people's needs. During the inspection we observed staff being very busy and at times there was evidence there were not enough staff to be able to

meet people's needs at all times. People were left alone in the lounge and one person who was identified as a risk of mobilising alone regularly got up to walk. One staff member told us "We are always a bit pushed but I like it that way, no two days are the same". Another member of the care staff told us "Sometimes in the afternoon it is difficult as we have three people who need to be repositioned then there are meds (medicines). The phone, the doorbell and then if something happens to a resident it is tough to get through it all". One resident told us staff spent a lot of time with one person who had end of life care needs which meant at times staff numbers were limited. The relatives of one person expressed the view that there were not enough staff to support their relative to manage their behaviour. Following the inspection the provider contacted us to inform us the staffing levels had been increased to three staff members on the afternoon shift.

We looked at the recruitment records for three members of staff. For two we found relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded. However for the third person only one reference was available and the person had no photographic evidence and no application form and no details of previous employment and qualifications. Following the inspection the provider sent us the relevant documentations for the third member of staff.

The lack of ensuring there were adequate staff on duty was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's medicines were stored safely. There was good stock control and up to date records of medicines for disposal were maintained. The records for the administration were on the whole good. We found two minor errors, one recording of a 30mg Codeine and Paracetamol mixture and one regarding the medication page numbers of controlled medicines but when we pointed these out to the senior carer they recognised this and corrected them immediately. Topical medicines in people's rooms an 'opened date' recorded on them, which was good practice. The senior carer responsible for medicines had a good understanding of the medicines prescribed for people.

Requires Improvement

Is the service effective?

Our findings

We were given copies of the mandatory training staff had completed, which included moving and positioning, health and safety, mental capacity, fire training, food preparation, infection control, safeguarding and medication competencies. However there was no records of any other training staff had completed. For example, we could not be assured staff had received training on working with people with cognitive impairments or behaviours which challenged. Staff needed to have this knowledge and skills to be able to meet people's needs. Staff could not remember undertaking this training and there were no records available.

There was a list which demonstrated the aim was to provide staff with on-going support in the form of supervision. However it was noted four people had not received a session and all the other staff listed, had a due date which was in the past, mainly in May and June 2016. Only two staff were recorded as having had received an appraisal. It was not possible to establish staff received an induction which was accredited, for example the care certificate of the common induction standards. The registered manager advised they would ensure staff worked as an extra on shifts before they started to work to ensure they knew people. They would then identify any gaps the staff member felt they had and try and provide training in this area. The registered manager told us she was aware of the gaps in this area and the new in post provider's compliance manager told us this was the area they were going to focus on. They showed us a new form, which was going to be used for supervision which included doing more direct observations.

The lack of staff training to ensure they could meet people's needs and the lack of regular supervision and annual appraisal was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014

Staff had a basic knowledge about mental capacity but this had not been put into practice. 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. Out of 16 staff, 10 staff had received training on Mental Capacity

The registered manager told us no restraint was used in the home. We found the Mental Capacity Act was not being used appropriately. For example, one person's consent records had been signed by their relative, but there was no evidence of a Lasting Power of Attorney for Health and Welfare for the relative, which meant the provider did not know if the relative had the legal right to make these decisions. For another person the consent forms had been signed by a relative who only had a Lasting Power of Attorney for property and finance. This meant they did not have had the legal right to have signed a consent form relevant to health and welfare on their relatives' behalf. This person's 'Mobility Needs Care Plan' dated 16 March 2016 stated "(Person) is not mobile and the relative spoke to (the person) and to the manager and (the relative) made a best interest decision that even when (the person) is requesting to be left in bed all day, the staff have to assist (the person) to get up and transfer to the lounge for a few hours every day if possible.

The relative thinks that (the person) will benefit to sit in a recliner chair". This relative had also signed the person's bed rail consent form and their care plan review. The person's Evaluation of Care record stated on 23 March 2016, "The person's relative made a decision in (the person's) best interest to be transferred to the lounge for a few hours each day in their best interest. Even if (name of service user) says they would like to stay in bed, the staff have to assist (the person) to get her up and into the lounge". On 31 May 2016 the evaluation of the care plan recorded "(The person) is regularly asked if they would like to come down for a while. She more often than not refuses; she can be quite irritated if you insist at times". This demonstrated the person was expressing a decision which was not respected but the choice of the relative who did not have the legal right to make a best interest decision was being respected.

A senior carer told us regarding this person "(Name of person) spends all of their time in their room now they are so frail but it was a bit difficult before because (the person's) relative said one thing and we had to implement it but it made (name of person) cross so it was hard for us". When we asked if they thought it was an appropriate process they told us, "Thinking about it we did not know she did not have the rights, we thought she had power of attorney". This demonstrated the registered manager and staff did not have a full understanding of the Mental Capacity Act. Staff did not have the legal right to enforce this decision as it involved a potential form of restraint. The Mental Capacity Act states; that someone is using restraint if they: 'Restrict a person's freedom of movement, whether they are resisting or not'. We were assured by staff and the registered manager this practice had stopped and would not happen again.

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). We found the service was not always working within the principles of the MCA, and people were not always being deprived of their liberty within the principles of the Act.

For example, one person had a Deprivation of Liberty safeguard in place from a previous home, which was due to expire. However the person had a very recent mental capacity assessment at this home and it had been deemed they had capacity. The pre-admission assessment stated they had capacity to make non-complex decisions. However a sensor mat had been put in place to monitor this person's movement. We spoke to a senior carer about this who told us, "We need to know when (name) leaves their bedroom because there have been problems and this alerts us to them coming out and we go and stop them". There was no mental capacity assessment for the use of alarm mats which are a potential form of restraint when used in this way.

The lack of assessing people's capacity and having regard of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People reported the food was good and they were able to make a choice between two dishes at meal times. If they didn't like either option they could choose something else. Some people ate in the dining room; others chose to eat in their rooms. One person told us, "I have just had had a lovely lunch, scampi and chips and bread and butter pudding." Another person told us, "I preferred the meals at home. Meals are passable here. I like steak and chips, you don't get that here".

People reported they had enough to drink and they had jugs of cold drinks in their rooms. We observed meal periods at the home and found most people who sat up to the table ate their food and seemed to enjoy it. One man was supported in their room and the staff member provided mouthfuls of food when he was ready, he ate very slowly and the member of staff made no attempt to rush him. However we did not see 'vision boards' (showing pictures of food). These are helpful in the support of people with cognitive impairment

because visual understanding may remain after verbal understanding has been impaired. Staff were patient and kind in their support of people at mealtimes.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records.

Requires Improvement

Is the service caring?

Our findings

People reported staff were good. One person told us, "Staff are very good, no complaints. If they can help you, they will". A relative commented, "The staff are nice, very patient". One person told us about the staff, "We have a laugh" and another person told us, "I can always speak to staff, but they are very busy".

There were affectionate interactions between staff and people and a great number of terms of endearment were used. It was clear there was great efforts by the staff to ensure people were cared for well. There were concerns due to the staffing levels especially in the afternoon, and the lack of skills and understanding of staff at times meant people's needs were not met in the best manner. Staff did not seem to grasp some people did not understand spoken words. For example, during the afternoon the assistant manager was interacting with people in a friendly way and made four people cups of tea. They gave one person a cup of tea saying "It's a bit hot so maybe leave it for a bit". The person replied "What does that mean"? We noted when some people were given their meals they did not know what they were getting. Some asked, "What is it" and "why have I got this" and "do I like it". The staff were patient and kind in their support and replies but did not seem to grasp people's lack of understanding and how best to approach this with people.

We noted staff took a different approach to one person, which was not caring in its nature. This person sat a dining a table and immediately went to sleep with their arms on the table. There were three care staff in the room all of whom took the same approach with this person. The first staff member approached the person and said in a brisk manner, "Take your elbows off the table (name)" and "Sit up (name)". The person did not respond. The person's food was brought to them but they ignored it and other staff took the same approach with the person. One said "You have got to eat or you will never get well". The person responded to this saying, "But I am not well I have a pain in my chest". We asked the person if they were alright. They told us "No I am ill I have a pain in my chest", to which a staff member replied, "It's only your pacemaker (name), it is nothing to worry about". We spoke with the staff member away from the person who told us, "(name) is a bit of a drama queen, he always does this - puts on a great display, and he's a real attention seeker and wallows in attention". We asked how the staff supported the person. They told us, "We just put up with it but he is not really ill and we have to be quite strict with him". The senior carer on duty told us, "(name) is like this he likes to be the centre of attention. I have told him there is nothing wrong but if he keeps crying wolf one day there would be and he would be really ill". This did not show empathy or respect for the person and there was no behaviour support plan in the person's care plans regarding this behaviour.

People sitting in the lounge area did not have access to a staff call bell but requested assistance when they required it as staff walked closely though from one area to another. This meant there did not appear to be an adequate amount of time for the staff to support people in their rooms as well as those in the lounge. While the staff behaved warmly towards people they did not have a great deal of time to spend with individuals which meant opportunities for caring were relatively short when compared to the tasks that needed to be carried out. A staff member told us, "In the afternoon we often have to get the cook out if she has time or ask one of the management to come down to sit with people but then you feel you have to rush others because they need to get back to their office work so in one way its good but in another it just adds more pressure".

There were no restriction on visiting and people could visit at any time. Visitors told us they were made welcome and it was clear they had a good relationship with staff.

The lack of treating people with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People were assessed before they moved into the home. From these assessments people had care plans developed. It was not possible, from the way care plans had been written, to establish people had been involved in the development of their care plans. Care plans had the same format and tended to include information in the same areas, rather than being individual to each person's needs and preferences. There was some information in people's care plans about their lives and their preferences but these were stand-alone documents and were not widely used throughout the care plans. As a consequence care plans were not significantly personalised.

Some people's care plans had information which was out of date, which meant staff would not be able to respond to people's needs in a positive and appropriate way. There were also recordings of incidents but these had not resulted in changes to people's care plans. For example, in the health record of one person it recorded they were, 'red sore under her breast' but the skin integrity care plan had not been changed. Sometimes where a care plan had been evaluated this reflected the person's needs had changed but the care plan had not been updated. For example, the care plan for one person recorded they walked with a stick. However the care plan evaluation recorded the person was not mobile and needed the assistance of two staff to help with transfers and a wheelchair for mobility.

People did not have appropriate care plans to support their behaviour and guide staff on how they should support people at these times. For example one person's care plan detailed references to at least 23 incidents of what staff considered to be "inappropriate" behaviour. The records relating to their behaviour were recorded on, 'Distress Monitoring Charts' and 'Daily Records'. However there was an absence of clear step by step guidance about how staff could ensure the safety of other people living at the home while protecting the rights and the quality of life of the person concerned.

In another example the daily records of another person recorded; "Buzzed and was sat up in bed said he had a bad dream. I asked what was wrong and he started screaming. I asked him to stop as he would wake other and he responded (swear words) for three minutes. I left him to calm down". The record read as if the person had a nightmare, which to a person with dementia can be terrifying because it is difficult to separate what is real from a terrifying dream. To isolate a person who is experiencing fear exacerbates their fear and distress. The staff did not have access to information about supporting a person with dementia in terms of responding to aggression and recognising the difference between this and the imposition of what can be seen as punishment through the withdrawal of company. There was no further entry about how long they left the person or if they returned. The person's care plan did not provide clear guidance for staff to follow.

Pain assessments were not routinely used at the home, which are essential to understanding if people have pain; if it changes in location and severity; and should always be used with people who live with cognitive impairment such as dementia which applied to a high number of people at the home. The care plan of one person stated they had a particular serious health condition and 'does not have any prn (take as necessary) medications but staff should look for signs of pain and discomfort. Staff can ask (person's name) if feeling ok and (person's name) can communicate verbally. It may be difficult to know if (person's name) gives the

correct information due to her lack of understanding". This indicated the person could have experienced pain but staff may not have known the particular signs of pain for the person and been unable to support the person control any pain they experienced. A pain assessment would have supported the person's pain to be better managed.

When talking to another person they expressed concerns they were not able to spend time doing the things they liked. The person told us they had asked to do these things but had been told they were not allowed due to 'health and safety reasons'. When we spoke to the registered manager they were unaware of these personalised things the person wanted to do. They involved simple requests like making a cup of tea and walking to the post office. When we discussed this with the management team the registered manager was dismissive of these wishes, stating the person would be unable to do these things. However the deputy manager understood and stated efforts would be made to support the person work towards these aims with appropriate risk assessments in place.

Due to the refurbishment of the home, the available communal space was restricted to a small sitting area where the seats were around and fairly close to a television and to access the dining area there was three steps. Between three and five people spent their day in these areas. There was an activities programme displayed on the wall in this area, but these tended to focus on group activities and there was no evidence people had been included in the choices. It was noted the activities for the afternoon of the inspection did not take place and activities were not recorded on a regular basis in people's records.

The care and treatment of people was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager kept a log of all complaints and compliments which had been made. People and visitors told us they could tell staff if they had any concerns and they were confident staff would act on the information. When complaints had been made these had been investigated and a record was maintained and the outcome of the complaint was recorded. It was noted all complaints had been made by staff.

Requires Improvement

Is the service well-led?

Our findings

We found there were aspects of the home which meant it was not well led in those areas and others which demonstrated it was well led in other areas. There was a registered manager in place who was also responsible for being the registered manager for another of the provider's locations. The provider had recently employed a deputy manager and a compliance manager at Merok House who were both very positive about their roles. People spoke positively when referring to the registered manager and staff reported she was supportive. However the registered manager demonstrated a lack of understanding about what action they needed to take to ensure the service was meeting people's needs and ensuring their safety and welfare.

A record was made of some accidents, injuries and incidents but others had just been mentioned in care plans. This meant the analysis was not accurate, so no learning was possible. The registered manager was unable to explain why injuries had occurred and could not demonstrate they had investigated these. This had resulted in CQC, safeguarding and RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrence Regulations) not being notified of some serious injuries. We found records where people had sustained serious injuries, which we had not been notified of.

The failure to notify CQC of these injuries was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It was difficult to demonstrate the home had an open culture. For example staff told us they felt they needed more time to spend with people and in the afternoon in particular, but this had not been reported to the registered manager. However it was positive to see the provider following the inspection discussed the staffing levels with the management team and increased the staff on the afternoon shift immediately. It was concerning people had not been supported to pursue simple tasks which they felt they were able to take part in. On the other hand the home had been able to function even though it was undergoing major refurbishment.

We could see there had been a relatives meeting in February 2016 and surveys had been sent out. The results of these had been collated and it was good to see a letter with the results had been sent to all those who had participated. The last residents meeting was recorded as February 2015 and there had been a staff meeting in June 2016. It was noted the minutes of these meeting's recorded these meetings had been more of management giving information out and there had been little participation from staff and people.

A range of quality audits were carried out on a regular basis. These included checks on cleanliness, medication, food quality, care plans and incidents and accidents. The food audit was carried out monthly and looked at presentation, taste and quality. However it was not possible to establish people eating the meals had been included in the reviews. Whilst we could see there were audits on the care plans and analysis of the incidents and accidents, not all of which had been properly recorded, we were concerned these had not picked up the issues we had identified.

Records were not accurately maintained and needed to improve. For example the recording of incidents and accidents needed to be improved in the home. Records regarding injuries needed to be improved. We noted the care plan of one person identified the person needed to be re-positioned on a regular basis. However from the records maintained it was not possible to establish this happened in accordance with the care plan.

This failure to ensure accurate records and effective systems to monitor the service to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person centred. 9 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of understanding regarding The Mental Capacity Act and depriving people of their liberty. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The lack of effective risk assessments did not ensure the safety and welfare of people. 12(1) (2) (a) (f)

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

Safeguarding concerns were not being reported to ensure people were kept safe. 13 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure accurate records were maintained and effective systems to monitor and drive improvement. 17 (1) (2) (b c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels had not been planned to ensure they could meet people's needs.18 (1) Staff had not received training in all necessary subjects to ensure they could meet people's needs and there was a lack of regular supervision and annual appraisals. !8 (2) (a)