Mosaic Community Care Limited

Fresh Fields Nursing Home

Inspection report

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Date of inspection visit: 21, 22 July and 5 August 2015
Date of publication: 27/01/2016

Ratings

Overall rating for this service	**Requires Improvement**
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?	**Requires Improvement**

Overall summary

This inspection took place across three dates 21 and 22 July and 5 August 2015. The first day of the inspection was unannounced. This means we did not give the provider prior knowledge of our inspection. The second and third day were announced. The provider became legally responsible for the home in April 2014 and this was the second inspection we had carried out since ownership changed.

The last inspection of Southwold Nursing Home was 20 and 23 January 2015 and the service was rated as inadequate overall, with 'inadequate' ratings in four of the key questions and a 'requires improvement' rating in place for 'is the service caring'. At the last inspection on 20 and 23 January we found a number of breaches of the Health and Social Care Act 2008. These breaches were in relation to the care, welfare and safety of people who lived at the home, the numbers of staff available to meet their needs and the support available to staff. In addition

Summary of findings

insufficient quality monitoring checks were carried out, people told us they were not involved in their care and we saw care documentation was not accurate and easily understood.

We carried out this inspection in order to see what progress the provider had made in dealing with the breaches identified at the inspection in January 2015.

Southwold Nursing Home is registered by the Care Quality Commission to provide accommodation and nursing care and support for up to 41 older people. At the time of the inspection 27 people were living at Southwold Nursing Home. The home is located in the Wythenshawe area of Manchester. The home is situated across two floors with lounge facilities on both floors and dining facilities on the ground floor. Each floor has bedrooms and small lounge areas known as bays. The first floor is accessed by a lift. The home is a large detached property set in its own grounds with off road car parking available.

The manager and operations director were available throughout our visits and received continuous feedback during the inspection. The manager was employed by the provider in May 2015 and told us that they intended to apply to 'The Commission' for registered manager status. 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.

We engaged with most of the people living at the home although feedback varied due to some people having limited communication abilities. We spent time observing care delivery and spoke with relatives and friends who visited the service.

We received mixed feedback when we asked people if they felt safe living at Southwold Nursing Home. We found that people were not always protected against avoidable harm and quality assurance systems at the home failed to identify or resolve associated risk, therefore placing people at potential risk of harm and neglect.

We found that people's safety was being compromised in a number of areas. This included unsafe moving and handling procedures, how well medicines were managed and administered, infection prevention and staff knowledge of essential care standards. We also found suitable staffing was still an issue.

We found a number of premises issues that compromised residents' safety, these included hazardous areas, for example, sluice rooms left open and failure to action maintenance checks.

The principles of the Mental Capacity Act 2005 (MCA) had not been embedded into practice and we identified concerns relating to how people's mental capacity had been assessed prior to depriving them of their liberty.

We found insufficient evidence of staff training and development. Staff told us that they felt supported by the manager; however the staff explained that because of previous lack of leadership, care standards had deteriorated which the manager was addressing.

We found that people's dignity was not always considered. People were not always responded to in a timely manner and we observed people to have unmet requests for support, such as calling out, asking for drinks and requesting support. Staff did not seem to acknowledge non-verbal signs of communication for people living with dementia and we observed care to be task focused.

We found that people's health care needs were not appropriately assessed therefore individual risk factors had not been fully considered, placing people at risk of avoidable harm. We looked at care records and found significant gaps in reviews of people's needs. Care planning was not person centred.

We received variable feedback from relatives; some expressed positive comments about the care provided whilst others were concerned about the lack of responsiveness from the provider when they raised concerns.

We did find some evidence of new management systems in the home and although we saw many good aspects of quality assurance, it was not always carried through to positive outcomes for the residents. This meant it was not effective in protecting the people living at the service from potential risk.

Staff had not previously been provided with effective support, induction, supervision, appraisal or training. The

Summary of findings

manager had started the process of supervision with all staff. The provider had recently introduced some governance systems to ensure that improvements could be made however they had not been established long enough to provide evidence.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to people's safety, staffing, the safe administration of medicines, premises safety, governance, person centred care and consent. We have deemed that the overall rating for this service is 'requires improvement'.

Following on from the inspection in January 2015 some improvement is evident however not enough improvement has been evidenced across the key question Is the service safe. For this reason enforcement action has been taken. You can see what action we have taken at the end of this report.

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 appropriate and effective systems in place to identify the possibility of risk and to prevent avoidable harm to people living at the service.

The processes in place to ensure that people received their medicines as prescribed were not robust and placed people at risk of potential harm. Medicines were not always obtained when needed. Administration of medicines and records was poor.

Staffing levels at the home did not support effective provision of care.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights were not always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not being followed.

Some interactions between staff and people who lived at the service were poor, people were not responded to in a timely manner and staff members did not always understand individuals' needs and preferences.

People were not at risk of malnutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

Residents did not always receive care that was appropriate for their needs.

Residents were not involved in the planning and delivery of their care.

Some staff supported people well, with compassion and understanding.

Advocacy information was not accessible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Planning and delivery of care was not always person centred.

Some of the processes in place to make sure people's health and social care needs were properly assessed and planned were inappropriate and ineffective.

The service failed to respond to people's changing needs by ensuring amended plans of care were put in place.

Summary of findings

Liaison with other health care professionals was good.

Is the service well-led?

Requires Improvement

The service was not always well led.

The processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care were not robust and some were ineffective. Some policies were out of date.

Some of the records we asked for were not readily available. Due to this we were unable to confirm whether some key quality processes took place.

We saw new aspects of quality assurance and there were some systems in place to look at the quality of the service. However in some cases the systems had not identified many of the areas for improvement that the inspection team identified during our visit.

Fresh Fields Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place across three dates 21 and 22 July and 5 August 2015 and was unannounced on the first day. On the first day of the inspection, two adult social care inspectors were present as well as a specialist advisor who was a nurse in dementia care, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for someone living with dementia. For the second day of the inspection, there were two adult social care inspectors and the expert by experience. Finally on the third day there were two adult social care inspectors.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from community professionals, such as the Nursing Home service, the Community Diabetic service and social work professionals from the adult safeguarding team at the local authority. We also received information from families and relatives of people who used the service.

We were told by Local Authority Commissioners that the service was under continual contractual monitoring by Manchester Council since January 2015 and we received minutes from previous safeguarding strategy meetings held to discuss safeguarding concerns.

We engaged with most of the people who lived at the service; however feedback was variable due to some people living with dementia being unable to communicate. We spoke with 15 residents, 14 relatives and/or visitors, 10 care assistants, the head of housekeeping, the quality and compliance director, the care manager, the manager and the operations director, We had email contact with the training manager.

We looked at 10 people's care records, staff duty rosters, five recruitment files, training records, management audits, medication records and quality assurance documents. Over the lunchtime period on day one of the inspection, we conducted a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Feedback from some people living at the home was mixed due to limited communication abilities and advanced dementia care needs. However we asked residents "Do you feel safe?" and some comments included: “Safe, oh yes.” “I’m safe and treated well.” Another resident told us that they felt as “Safe as I’ll ever be.” This resident qualified their answer by saying “That’s the trouble, not enough time to see to you. Staff (are) rushed.” One resident expressed concern about their clothes, “Sometimes my clothes go missing; there’s none in my drawer.”

One relative was hesitant; when asked about safety they commented: “Not necessarily right place for [person], but problem finding somewhere else. “ Another relative told us “[person] is safe here, most of the time care is O.K.” However they expressed concern about the safety of belongings and mentioned that their relative’s glasses had gone missing. They were found later that day in the lounge.

We read an email from the training manager to the manager dated 14 July 2015 stating that some staff had not received safeguarding or adequate induction training to ensure that they understood what constituted abuse and how to report abuse. Some staff members we spoke with were able to explain the basic principles of protecting people from abuse, however when we looked at how this was put into practice, we saw that staff were not always carrying out safe care procedures. For example we observed unsafe handling by a member of staff of a resident in bed. We reported it to the manager and operations director who dealt with the incident quickly.

We looked at safeguarding notifications from the provider and information supplied by Manchester City Council. We found that five safeguarding cases had been reported since January 2015; recurrent themes were reported by staff, visiting professionals and relatives. For example, inadequate standards of care and support, medicine errors, concerns about management attitude and response to people's concerns and staffing levels. The service was closely monitored by Manchester City Council and the provider was given specific action plans from the Council to provide an opportunity for the home to improve. The provider also developed their own detailed action plan in February 2015 which was monitored by the provider’s quality and compliance director. Some improvements had been made as a result of the action plans, for example, we saw the record of the provider’s safeguarding central monitoring log which recorded the nature of safeguarding alerts, actions taken and outcomes. However we did not see how any learning from safeguarding outcomes had been put into daily practice. We also saw that the provider had not raised safeguarding alerts with the local authority safeguarding team to consider and investigate, for example, serious medication errors.

Following the inspection, we raised safeguarding alerts with the Local Authority. The provider failed to protect people from the risk of avoidable harm. This amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at five people's care records and found poor risk assessment, monitoring and care planning. We looked at the provider’s procedure for reviewing risk assessments and associated care planning and found that this was expected to be at minimum monthly or more regularly if required. We saw records of twelve care audits undertaken by the manager in June 2015 where the manager had identified concerns, for example, pressure area risk assessment, activities and residents’ weights. It was recorded on all twelve care audits that the care plans needed updating. At the time of the inspection, we did not see that any of care plans had been updated.

Some accident records were appropriately kept in line with data protection guidelines. This helped to ensure people’s personal details were maintained in a confidential manner. We saw an analysis of accidents from January to June 2015 however whilst there was some analysis we did not see any evidence of further outcomes, for example, one person had eight accidents between the hours of 22.00 and 07.30, in or near their room. We did not see any documentation as to what action had been taken based on this analysis. We discussed with the senior management team the requirement to notify the Care Quality Commission about accidents/incidents, for example if people had sustained serious injuries.

We found the home did not assess or mitigate risks to protect people who lived in the home. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked residents about their call bells and the response times. One resident said: “After a while they come, sometimes I wait a long time.” Another said, “ I Feel safe. If I

press the buzzer the staff respond quite quickly. Staff help me a lot." However during the inspection, we observed on three separate occasions staff delays in responding to call bells ringing or residents shouting out for help, for example, we heard a resident calling out for help for five minutes and no staff responded. We found a member of staff who then helped him. The member of staff said the resident had put the bell on the radiator. We saw, on more than one occasion during the inspection, that call bells were placed out of reach of residents, for example, on the floor. We discussed this with the manager and operations director on day one of the inspection, who told us that they had spoken to all staff and told them leaving call bells out of reach of a resident, was a disciplinary matter.

Many people we spoke with including residents, staff and visitors expressed concern about staffing levels. Resident's comments included: "Enough staff? no, they're rushed." Another resident told us, "Not enough staff, Sundays it's like a morgue in here." "Sometimes we need to be patient if staff are busy." "We sit here for hours waiting for staff. There aren't enough staff and they haven't time for a chat."

One relative reported a recent issue with staffing levels. They told us, "Not enough staff especially at night." The relative also reported that they recently arrived on a Sunday lunchtime and they could not initially find any staff in the lounge but, "Two staff were in the computer room." Concern was expressed by different relatives that lack of staff could be a risk to residents. The concern was if a resident got upset whilst no staff were about an incident could happen. Further comments from relatives included, "There are different nurses and carers all the time." Another relative also said, "Not enough staff, but there never are." They also expressed safety concerns. Comments included, "No staff presence in the day room/lounge for up to an hour but it does seem to be improving."

We discussed staffing levels with staff and their comments included: there were enough staff to "interact emotionally with residents." Another said "At the moment not too bad. There have been odd days when we've been short but we manage. We do three hours upstairs and three down. It gets very tiring," This staff member said they were told by the manager that if they were concerned about staffing they should go to the nurse or to him, and "my door's always open." One member of staff told us there was, "Enough staff just about at the moment we can manage." However they went onto say, "Not enough time with residents as support is task orientated. It is difficult to meet demands and we can't have time to sit and chat with residents or offer emotional support."

Through our observations of staff and our conversations with residents and relatives we found there was sometimes not enough staff to meet the needs of people who lived at Southwold Nursing Home. We checked the day rotas for 3 and 4 August which showed there were two nurses and six care staff from 08.00 to 14.00 hours, however the number of care staff dropped to four from 14.00 to 20.00 hours to support 27 residents, some of whom had complex needs with high dependency levels and required two staff to help them. The overall staffing at night was one nurse and three care staff for all the current residents. The quality and compliance director showed us a staffing guidelines document which was based on the dependency level of residents. We discussed with the senior management team how to assess staffing levels based on the assessed needs of the residents.

The lack of suitable staff to meet the needs of people who lived in the home was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw the provider's recruitment policy dated January 2015 and job descriptions for various posts within the home. We discussed the quality of some of the job descriptions with the senior management team as they had last been updated in 2012 and did not reflect current practice in health and social care or employment practice. We looked at five staff recruitment files. We found that the provider received checks from the disclosure and barring service 'DBS' prior to employing people. These checks help to ensure that people working at the service do not pose a risk to vulnerable adults.

We saw that medicines in current use were stored in an ad hoc manner. The locked medicines trolley was secured to the wall in the hairdressing salon which was not locked. We were told the reason the trolley was stored in there was because the clinic room was too warm, for example, the room temperature in the clinic room at 12 midday was noted to be 26 degrees, food supplements should be stored at temperature below 25 degrees. The temperature of the room is vital to keeping medication safe. The provider had shown some awareness by keeping the medicines trolley locked and secured to the wall.

Inadequate

Is the service safe?

The drugs fridge was located in the nursing office which was unlocked, the fridge itself was also found to be unlocked. Items in the fridge were appropriate and in date. The controlled drug cupboard was also in the nurses' office and was a separate standalone cupboard placed against the wall. The external office window had no additional security features above general restrictors. Controlled drugs should be held in a secure area with limited access. They should be held within a separate locked cupboard within a locked cupboard. The controlled drug register was fully completed and legible.

We observed the main part of the medicines round which took place in the main communal area. We saw the Medicines Administration Record (MAR) was signed immediately after medicine was administered and the nurse treated the residents respectfully during this time. We asked the nurse how they ensured that there was a safe period between prescribed doses when the round ran late. They showed us a list of residents on lunchtime medications and said they would adjust the time of the next dose accordingly. The nurse told us that they had not had their competency with medicines assessed even though they were responsible for the medicines administration. We saw four individual daily medications audit sheets completed by the manager, comments on the audits included, for example, 'arrange meeting to re-focus on practice'. This showed us that the manager was actively planning to ensure practice was up to date for all staff.

We checked the MAR charts of three residents and identified risk on the charts, for example, the resident's medication was out of stock for two days. The impact of the missed medication could be significant as the resident needed to take regular doses to maintain their wellbeing. There was no system in place to ensure sufficient stocks of medication. We saw evidence of an investigation by the provider where a nurse was dismissed for medication errors in July 2015. This demonstrated a robust disciplinary policy however when spoke to the nurse in charge and the manager about protocols for medication errors, we were told that currently there was no procedure or form in place to record any errors. The manager agreed that they would look into developing a protocol.

We found all these shortfalls amounted to a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure the proper and safe management of medicines.

We were told that an infection control policy was in place; however we noticed that staff did not comply with safe procedures for the prevention and spread of infection and disease. We observed some staff use personal protective equipment (PPE) whilst providing personal care and then fail to remove their PPE before leaving the area where intimate care was provided. This increased the risk of cross contamination of infectious disease. We found that clinical waste management systems were inadequate, soiled waste was stacked in a pile on the ground floor corridor. This was an infection control issue as should the bags become damaged the carpet could be soiled. Over the three days of inspection, on five occasions, we saw the four sluice rooms were unsecure. We continually raised this issue with the manager and operations director who agreed it was a safety matter and that any staff found leaving the sluice door unlocked would be disciplined.

During the walk round the building on day one of the inspection, in the presence of the manager, we pulled back the bedding on a recently made bed and found dried faecal matter and crumbs on the mattress. In another bedroom, we saw wet faeces on the carpet. The manager ordered the bed and carpet to be cleaned immediately.

These shortfalls in infection control and prevention amounted to a breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the safety and suitability of the premises. We had concerns regarding trip hazards. The carpet in the main corridor was a significant trip hazard along its full length. The décor of the premises was 'tired' although the cleanliness of the premises was very good. We did not detect any odour anywhere in the home.

We looked at maintenance records and found good systems had been developed to monitor specific risks within the home. There were relevant certificates for external professional testing of equipment including fire

Is the service safe?

safety equipment, the lift and gas and electrics installations. We saw the maintenance person completed checks on different aspects of home safety including testing of bedrails, profile beds and water temperatures.

However we noted clinical equipment was not as well maintained. We noted that the suction machine was not ready for emergency use as it was very dirty. There was no label to indicate when this was last cleaned and the record of daily checks was incomplete. The daily checks of the oxygen were also not being recorded regularly; the last check recorded was 12 July 2015. The purpose of the daily check is to ensure the equipment is immediately available in an emergency.

We saw the fire safety co-ordinator had completed a fire audit in July 2015; however some of the repairs identified had not been fixed. We saw a call bell audit of 8 July 2015. The audit stated as urgent that the call bell panel in one of the bays had 'still got a faulty screen and can't be read, needs an engineer asap.' We saw the same broken call bell panel on 5 August 2015 and asked the manager about it. He told us the display did not work so staff had to "go round and check whose bell was ringing". The manager agreed to get an engineer in to fix it as soon as possible. He did not have an explanation as to why it had not been fixed.

This shortfall in the maintenance of premises safety amounted to a breach of regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the service if they felt staff were competent and suitably trained to meet their needs. Feedback from residents was consistent, residents' comments included: "Staff are well trained; they know what they're doing." Another resident repeated this sentiment. However when we discussed the provision of training with five staff, we were told by one member of staff that "They [management] need to match training to meet the needs of the residents for example, stroke awareness." Another member of staff said they had been offered some training (manual handling) but was unable to do it due to family commitments. They told us they were also booked for training on 'swallowing' but said the hospital had organised it and they had cancelled the training. They told us they had completed training on safeguarding but this was in their previous job. In response to the question whether staff were skilled enough to deal with residents they told us, "Staff are qualified to deal with difficult situations because they've been here a long time."

Another member of staff confirmed they had completed manual handling training and was planning to attend a "Sage and Thyme Workshop" on dementia. They said they had attended safeguarding training in the hospital in January 2015. They added they had supervision with the manager recently where they discussed their training needs and interests.

We noted that the nutritional needs of a resident were being met via a Jejunostomy. This mode of feeding is different to the more common PEG (Percutaneous endoscopic gastrostomy) tube feeding as it doesn't require the tube to be rotated as it is held in place with three sutures. The care plan did not contain instruction on the care of the site and the prevention of infection and common early indicators of possible infection. This nursing care plan was created by a senior member of staff who was not a registered nurse. This amounted to a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.

We looked at staff training and supervision records and found evidence of robust systems to ensure that staff were suitably trained and supervised. We looked at four staff training files. Some training was out of date, for example, one person's training in moving and handling had not been updated since September 2013. We saw a report from the provider's training manager to the manager in July 2015 where some mandatory training was identified as necessary, for example, essential food hygiene/nutrition and hydration. We received an email on 29 July 2015 from the provider's training manager which stated the training would be delivered over the next few months.

We received an email on 29 July 2015 from the provider's training manager who told us there was an action plan in place to address outstanding training of staff at the home including nurses. We found that only 33% of the staff were QCF (qualifications and credit framework)/NVQ (national vocational training) qualified or working towards the qualification. The training manager informed us that, "the focus of the team leaders is to make sure that staff demonstrate good practice. The tool used is the national occupational standards. All training is linked to QCF and the competency assessments that are linked to them." We saw a completed competency assessment tool dated July 2015 for a member of the care staff. However it was not fully completed, the answers were not competency based or signed off by an assessor. We discussed this with the senior management team who agreed to review the process.

We saw that the provider used agency staff recently and we were informed there was an agency staff protocol in place which we asked to see it however it was not available. We saw the handover sheet for night staff was not very informative. We were informed that the clinical lead identified what the agency and permanent nurses needed to know at handover. We were told that agency/bank staff were asked to attend thirty minutes prior to their shift starting for information/handover in their own time. We discussed with the senior management team that the process for information sharing and handover needs to be tightened up in order for the process to be functional and effective and ensure the safety of the residents.

Records showed that staff had not been supervised or received appraisals in line with the provider's policy and procedure up to June 2015. We spoke with a mixture of staff at different grades and they told us that the manager had commenced one to one supervision meetings with all

staff, since his appointment in May. These shortfalls in staffing requirements amounted to a breach of regulation 18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care plans and risk assessments for one resident created on the 15th July 2015. An entry relating to consent on the 16th July stated "[person] has been assessed as unable to make informed decisions. "This had been signed by a senior member of staff. However an entry the previous day by another senior member of staff stated "[person] has capacity." The pre-admission information supplied by a social worker clearly stated that the person did have capacity. The nurse in charge we spoke with confirmed that the resident did in fact have capacity. This meant the person was at risk of not receiving the correct level of support or asked to give their consent as information contained within their care plan was conflicting.

The Care Quality Commission has a statutory duty to monitor the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). The aim is to make sure that people in care homes, hospitals and supported living who lack the capacity to make decisions for themselves are looked after in a way that does not inappropriately restrict their choices.

We asked the care manager about deprivation of liberty safeguards (DoLS). They had recently sent in eight applications to the Local Authority and were waiting for the outcomes. However they told us that they needed an update to their training. We saw the training manager had identified in their email dated 14 July 2015 to the manager that all staff needed awareness training in DoLS.

We saw that a mental capacity care plan was in place that told us the person is 'unable to make decisions that affect their life and wellbeing'. The plan did not detail what these choices or decisions were and we could not see any evidence of decision specific capacity assessments being completed. We saw that only very basic information was contained within the care plan around management of this person's mental health. The care plan stated a best interests meeting had taken place however we could not find any evidence of the meeting.

We saw a 'mental capacity assessment' within another care plan. This was completed in June 2015 and was very generic. It was not decision specific. We saw that this assessment concluded that the person had capacity however '[Name] has some memory loss appropriate to her age' no additional information was contained with their care plans to show what the memory loss consisted of and how this person could be supported to make decisions.

These shortfalls in consent to care and treatment amounted to a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the residents how they found the quality of food provided and if they felt enough choice was available. We observed that drinks were served throughout the day and residents were supported or prompted to drink appropriately. There were jugs of fruit juice and a water dispenser in the lounge/dining area however there were no cups in the dispenser. We did observe staff dispense water into the more robust plastic beakers for residents.

Residents arrived for breakfast throughout the morning. All were appropriately attired and were supported with breakfast by staff. Staff sat appropriately beside people who required support to eat and the process was unrushed. One member of staff was observed and heard to interact positively with a resident whilst supporting them to eat whilst another staff member interacted minimally. One resident arrived at 10.15am and was greeted with eggs on toast which they told us they had ordered earlier and they enjoyed them. The cook frequently came into the dining area enquiring whether the residents still seated at the table had had enough or required anything else.

We asked staff to show us the fluid charts for three residents who needed support with eating and drinking. The food and fluid charts were fully completed and corresponded with meal times and drinks given in between meals. However we noted that the last entries of the day were around 6pm and the first entry for the following day was between 8am and 9am. This meant that either residents who required support with their fluid intake received no fluids for over 12 hours or it was not recorded. We were unable to find out which meant we could not be assured that people using the service were adequately hydrated.

We observed lunch being served to nine residents at tables in the lounge. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing

Is the service effective?

care to help us understand the experience of people who had difficulty communicating. We observed support provided in the communal areas including the dining room and lounges during lunch. We observed most people required prompting and encouragement to eat but the amount of encouragement varied. There was very little dialogue between residents sitting at the same table and between staff and residents. One person was offered an alternative after they had only eaten a little. We observed people were offered choices at mealtimes and could have more if they wanted.

We asked people if they enjoyed their lunch and opinions about the food varied. Comments included: "The food is very good we have choices of fish or meat." And "The food is ok there's enough of it". However one resident told us, "The food is so so, sometimes it's good, sometimes not." And there is "Not really much of a choice." One resident said there was, "Certain things I don't like, but they don't like you saying anything so I eat up and shut up."

During the lunchtime observations we noted one person had not touched their plate of salmon and potatoes. A member of staff took it away as it was cold. It was brought back after reheating and they were persuaded to try some of the meal. We observed drinks being served in the lounge and to some residents in their rooms. This happened after lunch, mid-morning and mid-afternoon. Cake was offered with the mid-afternoon drinks as it was a resident's birthday.

We looked at training records and found that staff had not received training around nutrition and hydration. This lack of training had been identified by the training manager in July 2015. We saw an email to the manager dated 14 July where the training was to take place over the next few months. We spoke with the Community Dietetic Assistant who visited the home during the inspection. The role of a community dietetic assistant is to support the nursing homes in the South Manchester area. They offer nutritional support for anybody where there is concern except for people on a peg feed. They also provide Malnutrition Universal Screening Tool (MUST) training to staff which is now in use as a 'Nursing Home Nutrition Support Plan'. Residents should be weighed monthly or weekly if there is concern. Anybody on the plan should be having their weight monitored weekly. We saw a weights results comparison chart dated 29 June 2015 which showed 12 residents out of 22 had lost weight between the dates of the last two weigh ins. We looked at the care plan of a resident who had lost weight and was assessed as medium malnutrition risk. The care plan stated the resident must be re weighed weekly however the weighing record showed the resident had only been weighed four times in the last seven weeks. the manager assured us they would address this.

The chef told us that they had been working at the home for five to six years. They explained that supper was the care staff responsibility. The nurses and night staff had a key to the kitchen. The chef told us there was a summer and winter menu which was rotated four weekly. They said that the residents were involved in menu planning a month or two before the menu changed. Residents influenced what was put on the menu for the following season for example; chips were requested more often so now they were on the menu at teatime to supplement the chips on Friday.

We were told that no special foods were provided for diabetics and were told that the nurses monitored the blood sugar levels of residents who were diabetic. We were assured steps would be taken if the blood sugars rose.

The chef was aware of residents who were on specialist diets for example, gluten free, peg, soft, pureed, no milk/ dairy. We saw a diverticular disease diet sheet which the chef had downloaded from the internet. We discussed diets and foodstuffs for people of low weight and the community dietetic assistant told us that certain commercial yoghurts contain a substantial amount of calories which are recommended for people of low weight. These were not used at the home as the chef made his own yoghurts consisting of whipped cream, caster sugar and berries.

The hygiene rating for the kitchen was five (5) and the chef told us the food budget was sufficient. We saw the daily fridge temperatures were recorded and saw evidence of the cleaning schedule. The chef informed us there was stock rotation in operation with not much waste. Chef informed us that kitchen practices were working well.

The service had basic directional signage to help people living with dementia find their way around the building.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. People who used the service told us, "Staff are brilliant. I like it here." And "They're kind and caring, best as they can be." One resident told us "They check out if it's alright. to give you a shower." Another resident told us that they were, "Looked after well. Nice atmosphere and staff are very, nice, always pleasant and kind."

The relatives we spoke with during our inspection were positive about the care their family members received and we were given some positive feedback about the caring attitude of the support staff. Staff were heard to warmly welcome visitors to the home and have a positive rapport with them. Comments included: "First impressions we were made to feel very welcome. We were offered tea and coffee." Another relative told us, "We're a big family and all have been made welcome."

We conducted an observation known as a SOFI (Short Observational Framework for Inspection). We observed one member of staff who was assisting a person who could not eat independently, was very caring and mindful when they were supporting the person to eat. The member of staff sat at the table with the person they were supporting, facing them and at eye level. The member of staff was very engaged in what they were doing. They took care not to offer any more food until the person had finished their previous mouthful, they took care not to offer too much food at any one time and waited until the person was ready for more. They offered positive and encouraging facial expressions and maintained good eye contact with the person. However we observed there was no dialogue or verbal interaction whatsoever throughout the whole meal time. At the end of the meal the member of staff carefully put the person's glasses on and gently turned the wheelchair round from the table to face the lounge area, however they did not tell the person what they were going to do or why. We saw, at times, there did not appear to be many staff around and not all staff were engaging positively with the residents although some staff were very caring.

Some staff were heard to give explanations of interventions to residents, explain about times of meals and in a patient and appropriate manner. Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and managed several difficult situations in the communal lounge calmly and sensitively.

We found the atmosphere within the home was noisy at times, and staff appeared busy throughout the day. We found a lot of interactions were task orientated and staff did not always engage with people in a kind and caring manner. We found that the quality of care provided differed throughout the home and people were not always treated with dignity and respect.

We observed people's dignity be compromised throughout the inspection. For example, we asked the nurse in charge why so many bedroom doors were fully open given that people were asleep in their bedrooms. They told us there was no known reason it was historic practice. Only one bedroom door was closed and we were told that the occupant had requested this and had been supported to make a positive choice. We saw one lady who lived on the ground floor, getting dressed with her door open wide. We asked her about it and she told us it was always open. She allowed us to pull the door closed to give her some privacy.

We asked the residents if their independence was respected. One person said of the staff, "They promoted independence at my level." Another resident said "They know me well, treat me with respect." Another resident added, "They help me to be as independent as I can. Sometimes they get over enthusiastic, I tell 'them I'm 90 not 19 but they always respect me." One resident acknowledged staff can be busy, "Sometimes I need to be patient if staff are busy. I get support if I need it there are enough people about."

We asked the residents about personal care. One person told us how they felt about the staff undertaking personal care with them. They said, "They look after me well; when they wash me, they're gentle." Another resident said, "I'm asked every day if I want a shower." However we were told by a different resident that they had, "Never had a shower since I've been here. I smell sometimes." A relative spoke to us and said, "With regards to dressing and washing, the family feel it's a bit hit and miss, It's not happening at a reasonable time." The relative added, "There were some concerns initially that staff were not following instructions."

Requires Improvement

Is the service caring?

A few minutes later this visitor mentioned they thought their relative had soiled themselves. They were not sure if staff had not noticed or checked their relative. We found two members of staff who quickly attended to the resident.

We did not find any evidence of involving people who lived at the service in decisions made about the general running of the home. We asked the manager if resident meetings were held and they told us that there had been no meetings recently and they were unable to evidence when the last meeting was held prior to their employment.

We saw a notice, pinned above the signing in book in the reception area, a list of advocacy services and telephone numbers however when we asked if people had their own list, the manager said, "No". We discussed with the manager if people who used the services knew how to access advocacy services, the manager told us that they only had access to the list in reception, the list was not given to them individually. We looked around the home and did not see any literature that would assist people in making independent decisions or any evidence that advocacy services had been used. This meant people may not be aware of advocacy services which are available to them.

We recommend the provider ensures individuals are given access to advocacy services and supported appropriately should they wish to access them.

We saw the end of life care policy updated Sept 2013. The policy was out of date therefore the service was not following current guidelines in end of life care.

We recommended that the service finds out more about the latest guidelines in End of Life care for example National Institute of Clinical excellence (NICE) guidance to ensure that end of life care and support is person centred, uses good communication and has shared decision making between staff, relatives and patients where appropriate.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we asked residents and relatives about their care and whether it was individual to them. Some residents were not happy about how responsive the staff were to their needs, comments included, "Some [staff] are no good, most are alright." Another resident told us, "Staff say you shout, but I can't get the staff they just ignore me." For example, we were in the corridor when a resident was shouting, "Help, help." We noted that staff ignored the person and continued seeing to other residents for approximately four minutes. This showed us that there were times when staff were not responsive to the residents' needs however we acknowledged that it was difficult for staff to respond to one person immediately when they are undertaking personal care of other residents.

When we discussed choice of bed times one resident said, "It depends how busy they are." They added, "I don't always get a shower when I want. It's management's fault not staff." This was because the resident felt there was not enough staff on duty. Another resident told us, "Everyday with choices, staff respect them." However they added "Sometimes I feel I want to stay in bed but can't." The resident explained this was because staff have to see to others.

The provider had invested in a computer based care planning and home management system called Care Docs. All the care plans were held electronically with the most recent care plans printed off and stored in the nurses' office along with the risk assessments.

In all of the care plans we reviewed we noted plans were developed with a focus on the task rather than on the individual. Plans were developed around activities of daily living including eating, mobilising and personal care. Plans were very generic and did not include any information from the individual perspective. Neither residents nor relatives we asked said they had seen a care plan or been involved in drawing up a plan.

One resident's risk assessment identified them at high risk of developing pressure ulcers so repositioning was essential in prevention. The night care plan dated 15 July 2015 stated they required hourly or half hourly checks. We asked the nurse where the checks were documented. The nurse could not find a chart that could evidence that the checks were carried out and could not recall having seen such a record. If records are not kept of essential support interventions there is a risk they have not happened and people are not receiving the support they need.

We found people were not directly involved with how their care was delivered. They were not involved in assessments and support provided did not always meet their needs. This is a breach of Regulation 9 (1) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The home employed two activities organisers; we spoke with the one who was very enthusiastic about their role. One person described the coordinator as "[name] goes to a lot of trouble." One resident said they enjoyed the entertainment which included a person playing the guitar but they said, "He doesn't come as much now."

The programme of activities was clearly displayed in the main corridor and provided a range of social and recreational events throughout the week (Monday to Friday). The activities were all age appropriate and there was a photo board showing recent events held in the home. Residents were given a choice of engaging in the activities or not. The activities co-ordinator told us there were seven residents who were bed bound or did not leave their rooms. Most of the afternoon was given to 1:1's with the residents who were bed bound. Activities for these residents included hand massage, nail care or reading.

The activities co-ordinator gave us a detailed description of what each resident liked to get involved in and what they particularly enjoyed. We observed residents responding very positively when the co-ordinator approached them.

On the first day of the inspection the residents were engaged in making cards. Whilst some were unable to participate fully or had difficulty because of their physical dexterity the activities co-ordinator tried to include and encourage as many residents as possible. We observed one resident in particular was enjoying the activity. This resident was unable to communicate verbally but we could see they understood everything that was said. The resident was keen to show us a card they had made on a previous day that was on display and for sale.

On the second day we observed a number of residents sitting around the room playing a game with a large soft dice. The coordinator added up the scores and a number of small value prizes e.g. toiletries were awarded. We noticed there was a lot of laughter and interaction. Care staff

Requires Improvement

Is the service responsive?

entered and left the room in response to residents when they required support. The care staff generally chatted to residents and encouraged them to take part in the activities. The coordinator also discussed trips out of the home but these were limited as public transport was used.

We spoke with people about the opportunitites they had to share their experiences and improve things if this was required. Two relatives we spoke with felt access to information and communication were an issue. One told us, "If I need to know anything I need to go on the P.C. with staff." This is because there is no available information in resident's rooms. We were told they had spoken with the manager about the lack of communication and it had been agreed staff would leave notes in the room although staff seemed to think this was duplicating work.

Another relative told us they attended meetings for their family member and had missed an important medication meeting due to poor communication. The first they had heard about it was when their relative's G.P. called asking why they had not attended the review meeting for their relative. However we were also told by one relative that communication was good, they told us, "They contact me if there are any concerns and get the doctor."

A member of staff raised concerns about keeping up to date with residents' needs. They explained the process of reporting changes or updates on residents. They said they would tell the nurse who would input the information on the computer. This person thought it might be useful to have some paper in the rooms to record any issues or changes etc.

We recommend the provider reviews the information available to staff, residents and relatives to ensure they have the information they need to support people's needs.

We saw records that demonstrated other professionals were involved in the care of the residents for example, the GP, dietician and chiropodist.

A GP visited the home on the day of the inspection to review a resident staff suspected had an infection. The diagnosis was confirmed and antibiotics were prescribed. This demonstrated how staff were responsive as they were aware of subtle changes in the resident's physical health and had supported the person to access medical services.

We asked visiting relatives if they felt confident in the management team and were able to report their concerns and we were told that some people did not know the manager. Two people told us they had raised concerns about the provider and said that they felt their concerns had been ignored. We discussed this with the manager and operations director and they confirmed that complaint letters had been received and they had responded within the time scale.

We reviewed the complaints policy and procedures which were last updated June 2012 and they did not contain latest guidance about complaints. We asked the manager if there were any records of complaints and associated investigations. We saw a complaints, suggestions and compliments log with analysis which showed for the period April to end of June 2015 there were three formal complaints, two had been closed. Two of the complaints were about attitudes of nurses which had been dealt with by the provider by reducing the use of agency staff. The final complaint was about end of life care. This complaint was ongoing. The manager showed us the correspondence regarding this complaint which was being investigated by the provider's quality and compliance director. From the beginning of July, we saw that there had been one complaint logged.

We also saw three thank you cards from relatives in recent months displayed on the noticeboard which complimented the care staff on the care they had provided to their relatives.

We did not see sufficient evidence to show us that the policy and procedures regarding complaints were robust and user friendly. The results of investigations and analysis were not used effectively to improve the quality and standard of care for residents and relatives.

We recommended the service obtained the latest guidance available from the Ombudsman regarding complaints. The framework also allows a measurement of progress so that providers can determine the action they need to take to improve.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post to manage the regulatory activity. The provider had appointed a manager in May 2015 with the intention that this person would start the process to become the registered manager, registered with the Care Quality Commission.

We asked the manager to explain their role to us. The manager told us they were currently managing the home with overview of all the regulatory and clinical functions. The manager told us that there was a clinical lead in post that was responsible for the nurses and a care manager responsible for care staff. However when we spoke to the person who was identified as clinical lead, they told us that, at the time of inspection, they had not been appointed as clinical lead and had no contract. We discussed this with the manager and operations director who agreed that the recruitment process had not been finalised for the clinical lead and discussions were ongoing.

The manager told us they had received support from the provider's senior management team which included a quality & compliance director and a training manager. The quality and compliance director had recruited and provided the induction training for the manager and continued to work with them on a weekly basis. The manager said they were well supported and we saw records which showed they had made some positive changes since their recruitment. The manager told us that they were unaware of the extent of the concerns within the home when they were appointed. They told us that their understanding of the current issues was a lack of, "Leadership, quality, documentation, audits and care." They told us that there was, "Nothing in place when [they] joined, no supervision, no strategies." We saw a schedule drawn up by the manager for supervisions which had taken place. The manager had undertaken individual supervisions with all staff including supervision of the nurses due to the absence of a clinical lead. We discussed our concerns about the lack of formal clinical supervision which should be nurse led for the nurses with the operations director and the quality and compliance director and were assured this would improve.

We saw the nurse in charge of the shift was responsive to care staff who came to seek their input and advice on residents' needs and their conditions. During discussions with the nurse in charge on the challenges of supervising staff who perform direct care delivery, they told us, "I observe directly interactions and responsiveness of these staff to the residents as I go about my duties." And, "As I'm doing the medicines rounds I listen to interactions of staff whilst they are providing personal care in resident's rooms or bath/wash rooms. I also have trust in the team and I am confident they would alert me to any concerns."

We asked people who lived at the service if they would be able to speak with the manager about any concerns. One resident told us "Not met them, but my son and daughter may have done." One relative said, "There has been no notification of the manager or of their appointment." One person said they knew the manager and told us, "If I had a problem I'd talk to them."

One member of staff stated things had, "Improved slightly since the manager came in. He's really trying to boost morale." A nurse told us that the manager was, "Very strict, doesn't like lazy people. Goes round and checks things. Makes sure we do our job."

Another staff member said they were told by the manager if concerned about staffing they should go to the nurse or to him. Staff described the manager as approachable.

We found that the service had some limited systems in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included person centred care, medicine management, premises safety, managing risks, staffing and governance. These issues had not been sufficiently identified or managed by the provider prior to our visit which showed that there was a lack of consistent quality assurance systems in place. The provider employed a quality and compliance director who was at the home on day three of the inspection. We saw that they had written a comprehensive action plan for the home dated February 2015. The areas in the action plan included staffing, residents, medication systems, quality assurance, activities, management, audits, complaints, safeguarding, and a business contingency plan. Some of the actions had been completed for example; resident & relative and staff surveys which were sent out to staff and relatives in April 2015. Responses from the surveys undertaken in April had been shared with staff and relatives however we did not see an action plan with timescales which showed us how the issues raised in the surveys had been dealt with by the provider.

Requires Improvement

Is the service well-led?

We saw a business plan dated June 2015 to be reviewed monthly which addressed gaps in service provision, for example, 'allocate named nurses and key workers and compliance'. The timescale for this was, 'immediate and regular audits'. We saw a list of named nurses for residents dated 29 June and memos for key workers stating their responsibilities which had been handed out to staff. However other actions on the business plan which were classed as urgent had not been completed; for example, 'ensure that key documents and practices are connected such as assessments and risk management plans.'

We received an emailed action plan from the manager on 29 July which addressed the priorities identified up to that point from this inspection which included the issues raised about premises, the call bell system, care plans, staff meetings, recruitment, notifications and deprivation of liberty documentation. The manager and provider had taken some urgent action about some of the issues for example, a new job description for key posts of the clinical lead and senior care workers. The rest of the actions were ongoing.

We asked to look at recent audits undertaken at the service and found that core audits such as medicines, infection control, call bells, beds and mattresses audits had been undertaken. Several audits had no action plan or completion date. The infection control audit was completed on 6 June where an issue had been identified regarding cover suction apparatus however we saw on 21 July that this had not been actioned as the suction machine was stored in the nurse's office and was not ready for emergency use.

The provider had policies and procedures in place that covered some areas of health and social care. The operations director told us that the provider paid an independent company for policies they use, however all the policies we looked at were out of date with several policies dated June 2012. For example, participation policy and procedure, service user choice policy and procedure. None of the care and support systems in the home were based on current best practice. The operations director told us that the subscription to the company for the policies was up to date and he could not explain why the policies were out of date. We asked staff if they had opportunity to read and understand the policies and we were told by some staff that they did not have time.

The service did have key staff employed such as administrators, head of housekeeping and cleaners.

We could see that the manager and the quality and compliance director were trying to improve standards and had started to schedule staff meetings regularly. We saw the agenda for the staff nurse meeting on 3 June 2015 and the care staff on 8 June 2015 however there were no minutes from these meetings and no list of who was present. We asked the manager how staff who were not at the meeting knew what had been discussed as no minutes had been taken. They were unable to answer.

Systems and procedures for monitoring the quality of the service delivered at the home had begun to be implemented but there was still much to do. Systems in place were not being best used to drive improvements and they were not effective in identifying breaches to regulations. We found this to be a breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the activities organisers told us that the manager was very approachable. They told us, "I've seen some positive changes since they started." However another member of staff told us that they felt that, "Management were out of touch, just taking people with complex needs and people who need a lot of time." They told us they felt there was "Concentration on a business model rather than care."

We were aware that not all notifications required under the Health and Social Care Act 2008 had been made to Care Quality Commission (CQC). It is a requirement of registration that a provider notifies the CQC for example, when an incident has happened, which could be a safeguarding or has led to a serious injury. Since the previous inspection in January 2015, we had knowledge of incidents including serious medication errors which should have been notified to us by the provider and had not been. Reporting such events is an important requirement as it enables the CQC to monitor care homes and take action when needed. We regarded the failure to notify us as a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager had the responsibility to ensure that notifications are sent to the Commission. They agreed to send in retrospective notifications after the inspection, for

Requires Improvement

Is the service well-led?

example, absence of and application to deregister the previous registered manager and serious medication errors which resulted in safeguarding's being raised with the local authority.

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 9 HSCA (RA) Regulations 2014 Person-centred care **People were not involved with assessments of their own care and their needs were not always met.**

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 **Care and treatment of service users was not provided with the consent of the relevant person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.**

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 **The provider did not have effective systems to monitor and improve service delivery. Quality assurance systems had recently been set up but the information gathered was not used to improve service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	How the regulation was not being met: The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirements of people using the service.

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 The provider had not informed the Care Quality Commission of all notifications in line with their registration requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken steps to ensure staff were able to recognise abuse and stop it before it occurred.