Coate Water Care Company (Church View Nursing Home) Limited

Woodstock Nursing Home

Inspection report

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Barnwood
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Gloucestershire
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Tel: 01452616291

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Woodstock Nursing Home on the 15 June 2016. This was an unannounced inspection. Woodstock Nursing Home is a nursing home for up to 28 older people. 19 people were living at the home at the time of our inspection. Nearly all of the people living at the home had been diagnosed with dementia.

We last inspected in July 2015. At the June 2015 inspection we found that the provider was meeting all of the requirements of the regulations at that time. A recommendation was made to the provider regarding record keeping in relation to maintaining a current record of people's care.

There was a manager in post who was applying to become registered with the Care Quality Commission. The last registered left the service in May 2016. 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.

People's care records were not always personalised to their needs and preferences. They were not always current and accurate and did not always give staff adequate information and guidance such as people's required fluid intake,

However staff monitored and recorded people's support needs, such as repositioning or assisting people with their nutritional needs.

People were at risk of being cared for by unsuitable staff because recruitment processes were not as robust as they should be. People were at risk of not receiving their medicines as prescribed, however the manager and clinical lead were taking action to address this concern.

The management had systems to monitor the quality of service people received. These systems however were not always effective and were not always consistently used. People and their relative's views were not always consistently sought. The provider had not always informed CQC of notifiable incidents.

The provider had assessed people's mental capacity to make specific decisions and ensured the outcomes of these assessments had been documented. The provider worked with external healthcare professionals to ensure people's legal rights were protected.

People and their relatives were positive about the home, the staff and management. People told us they were safe and looked after well. Staff managed the risks of people's care and understood their responsibilities to protect people from harm. People, Relatives and staff felt there were enough staff to meet people's needs.

People had access to plenty of food and drink and received a diet which met their needs. Staff ensured their

on-going healthcare needs were met. There was a friendly, pleasant and lively atmosphere within the home. People enjoyed the time they spent with each other and staff. People were offered choices about their day.

The manager and clinical manager had plans to ensure that staff received support and had access to effective training, supervision and professional development. Staff spoke positively about the recent change in management and felt supported.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulation 2009.

You can see what action we told the provider to take at the back of the full version of this 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. Current recruitment processes lacked certain checks to ensure people were safe from being cared for by unsuitable staff

People were at risk of not receiving their medicines as prescribed, however the clinical lead and manager had taken immediate action to remedy this concern.

There was enough suitably skilled staff deployed to meet the needs of people. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Good

The service was effective. People's legal rights were protected. The service ensured where people were being deprived of their liberty, this was done in the least restrictive way.

People were supported by staff who were skilled, trained and had access to professional development. Relatives and healthcare professionals praised the long standing nursing and care team and the stability and care they provided to people.

People received support to meet their nutritional needs and had access to plenty of food and drink.

People had access to external healthcare. Where staff had sought the advice of external healthcare professionals to meet people's needs they followed their advice.

Is the service caring?

Good

The service was caring. People were at the centre of their care, and were supported to spend their days as they chose to do so. Staff respected people and treated them as equals.

Staff provided people with emotional support, and supported people to maintain their personal relationships.

Staff knew people well and understood what was important to them such as their likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care was not always personalised to each person's needs. Staff did not always keep a consistent record of the support they had provided people with their food and drink.

People were supported with activities within the home and were engaged throughout the day by staff.

People and their relatives were confident their comments and concerns were listened to and acted upon by the registered manager.

Is the service well-led?

Requires Improvement

The service was not always well well-led. The audits being carried out by the manager and operations manager did not always enable them to identify concerns within the service.

The views of people and their relatives were not regularly sought. The manager and operations manager informed us new audits and a survey of people's views were being implemented.

Staff told us they could raise ideas and were involved with decisions made within the home.

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

This inspection took place on 15 June 2016 and was unannounced. The inspection was carried out by two inspectors.

At the time of the inspection there were 19 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with a local authority commissioner and three healthcare professionals about the service.

We looked at the Provider Information Return for the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who were using the service and with two people's relatives. We spoke with 12 staff which included four care staff, a cook, an activities co-ordinator, a nurse, the clinical lead, the manager, the operations manager and Director of operations. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed seven people's care files, staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk of being cared for by unsuitable staff because recruitment processes were not as robust as they should be. The majority of staff had all the relevant checks in place, including checks of people's criminal histories via the disclosure and barring service (DBS). However in two of the staff files we looked at, there was no recorded evidence that gaps in their work history had not been explored. Where people had concerns raised in previous employment there was a lack of documented exploration of the issues at interview by the provider to provide assurances of their suitability. There was also not always a risk assessment in place to manage the situation safely whilst waiting for further information.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not always receiving their medicines as prescribed. Staff had not always adhered to the providers policies regarding the proper and safe management of medicines. For example, staff had not given one person their prescribed medicine, however had signed the person's medicine administration record to show this medicine had been given. The clinical lead and home manager had carried out a recent audit of people's prescribed medicines which were administered from boxes rather than a monitored dosage system. This audit identified that 23 medicine stocks were not always correct. This meant that people were at risk of not receiving their prescribed medicines. The clinical lead explained the actions they were planning to implement to ensure that people received their medicines as prescribed following completion of this audit.

People's medicines were stored securely and were stored at temperatures in accordance with the manufacturer's guidelines. Where required medicines 'as required' medicines such as pain relief medicines, the provider had clear protocols for nurses to follow to ensure people had access to these medicines in a safe way. Nurses asked people if they required pain relief medicine and respected their decisions. Where people requested pain relief, nurses clearly recorded the support they received to ensure the risk of the person receiving too much medicine was reduced. One person told us, "They always ask me if I'm in pain."

People told us they felt safe living at Woodstock Nursing Home. Comments included: "I'm safe, I'll tell you, they look after you"; "I'm safe, it's important" and "I'm safe, why would I not be safe." One relative told us, "I really do think they are safe there."

People were kept safe from the potential risk of abuse because staff understood their role in protecting people and keeping them safe. Staff had received safeguarding training. The staff we spoke with said that they were confident in the safeguarding process and knew who to contact if they had any concerns including the relevant external safeguarding agencies.

People's needs were met by sufficient numbers of staff. People and their relatives told us there were enough staff deployed to meet their needs. Comments included: "They come to me if I press the bell"; "I think we're well covered, plenty of staff around" and "If I wanted some help, they'd (staff) be here within a flash."

The majority of staff we spoke with told us that there were enough staff. One member of staff said "I think there is enough staff." Another staff member said "They seem to have more care staff here than any other place I've worked." There was an issue raised about the pressures on staff at weekends however when we fed back to the manager they informed us that they were employing extra staff to cover the weekends. The rotas demonstrated that the provider's required number of staff were in place and where there were gaps, staff were offered the opportunity to work or bank staff were utilised with a small amount of agency staff as needed.

The atmosphere in the home was calm and lively. People enjoyed the time they spent with staff and supported people with all their requests. Staff were not rushed when supporting people. For example, care staff supported one person with their mobility, the person was encouraged to mobilise independently at a slow and calm pace. This promoted the person's independence however also gave them the safety and support they required. Care staff and the manager spoke confidently of the support this person required.

People had been assessed where staff had identified risks in relation to their health and wellbeing. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled staff to help people to stay safe. Each person's care plan contained information on the support they needed to assist them to be safe. For example, one person was being cared for in bed and needed assistance to reposition. Care staff repositioned them every three hours to protect them from the risk of pressure damage. They assisted the person to reposition at regular intervals to protect them from the risks of pressure damage.

Where people required assistance from care staff and equipment, there was clear guidance on how staff should support them. The equipment needed, including wheelchairs, hoists and personalised equipment were clearly detailed. Staff knew how to use equipment to support people. Care staff took time to assist people with their mobility. For example, two care staff assisted someone into a chair using a stand aid. One staff member talked to the person throughout, ensuring they were comfortable and safe.

People were cared for in a safe environment. Fire extinguishers and equipment was regularly checked to ensure they were fit for purpose. Fire checks were carried out by staff in the home. There was a clear documented record of the checks conducted on the premises to ensure they were safe.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about care staff. Comments included: "Yeah, they're very nice. They do make it nice"; "The staff are all very good and caring"; "They look after me well to be honest" and "The care staff are wonderful and I can't fault them. The clinical lead is definitely someone I feel I can talk to."

People were cared for by staff who felt supported and had received the training they needed. Staff we spoke with said that they received support from the manager and senior staff when they needed it. One member of staff said, "Our seniors are amazing they show us everything and provide brilliant support." However formal one to one support with their manager, where they could receive feedback on their performance and discuss development needs had not been completed on a regular basis, as per company policy. To date 12 staff had undergone a one to one meeting in 2016 with the majority having taken place in March 2016. The manager informed us that a supervision time table was being set up so that there would be a clear overview of when supervision was due for each member of staff to ensure they were effectively supported.

New staff were given access to the training modules within the Care Certificate. The Care Certificate is awarded to those staff that have completed training in a specific set of standards that demonstrates they have the relevant knowledge and skills. However recorded evidence of the completion of the formal induction process which included being made aware of the company's policies and procedures was not always evident in the staff files viewed. Each new starter would be assigned a mentor who would sign them off as competent at the end of their induction. This process was overseen by the manager. The manager told us the action they were planning to take to ensure staff induction was effectively recorded.

Staff told us they had access to the training they needed to support people. Training included manual handling and infection control. Some staff had been identified as dementia leads and were currently undertaking training for this. A training matrix was in place to give an oversight of what training was needed by who and when. However the matrix contained gaps where it was not currently known if staff had received specific training. We were told by the manager that it was a "work in progress."

The manager, nurses and care staff supported people to reduce their anxieties. For example, one person who was living with dementia was often anxious. We observed one staff member responding to their needs. They provided them with reassurance and ensured they were comfortable. The person's care plan contained clear guidance for staff on how to support the person and reduce their anxieties. The person's relative told us, "They staff manage it very well."
Staff were aware of triggers which could cause people to be anxious. For example, one person was at risk of becoming anxious when they saw a stranger. Staff were aware of this, and ensured that the person was informed of who the inspector was, and they were happy to talk to us.

Staff we spoke with had undertaken training on the Mental Capacity Act (MCA) 2005. 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. Care and nursing staff showed a good understanding of this legislation and were able to explain specific points about it. Comments included: "It's about providing people with choice and asking their permission" and "We don't make decisions for them, we promote their independence."

The provider and manager ensured that where someone lacked capacity to make a specific decision, a best interest assessment was carried out. For example, one person did not have the capacity to make a decision regarding a personal relationship. A best interest assessment was carried out and a decision was made in the person's best interest to protect them from harm. Where people did not have the mental capacity to make a decision this was clearly recorded in their personal care plans.

Three people living at Woodstock Nursing Home had a Deprivation of Liberty Safeguard (DoLS) authorisation in place. 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). For one person a best interest decision had been made as the person no longer had the capacity to understand the benefits and risks of refusing support with their personal care. A decision was made in the person's best interests with their social worker and family present. The provider had also made a DoLS application for this person which had been approved.

People spoke positively about the quality and quantity of food available to them in Woodstock. Comments included: "The food is nice, lovely. I couldn't complain"; "The food is very good, there is plenty of it and it's a good standard" and "There is lots of good food, I get a choice of what I like."

We observed the dining room experience of people at a lunch-time. It was a calm pleasant atmosphere with most people sat at small dining tables. This was a social and supportive event. People required different levels of support and had different preferences which were met. There were picture menus on the wall however they were not used during lunch time instead people were given the options verbally. All the people asked appeared to have no difficulty choosing what they wanted this way. Some people preferred to eat in their bedrooms. Those who required help with their food had this help given in a dignified way.

The chef told us that if someone did not like the menu options offered then they would offer them an alternative of their choosing. The kitchen was clean and well organised. The kitchen staff were aware of who needed a specialised diet including those who needed pureed food.

People were supported to maintain good health through access to a range of health professionals. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, psychiatrists, community nurses, speech and language therapists, podiatrists (foot specialist) and speech and language therapists. One healthcare professional told us, "I felt that the home was calmer with staff working together more as a team which was not the case 6 months ago when I visited."

Good

Is the service caring?

Our findings

People and their relatives had positive views on the caring nature of the service. Comments included: "All very good and caring. I'm comfortable here"; "They look after us very well"; "They look after me very well. I'm used to being looked after. They're very caring" and "The staff really do look after her. They are truly very caring." One volunteer told us, "The staff are wonderful and very caring."

People enjoyed positive relationships with nursing and care staff and the manager. The atmosphere was friendly and lively in communal areas with staff engaging with people in a respectful manner. We observed many warm and friendly interactions. People were informed about the purpose of our visit by staff. Staff encouraged people to spend their days as they wished, promoting choices and respecting people's wishes. For example, one person liked to do crosswords, staff supported this person and a volunteer gave the person more puzzles.

People were cared for by staff who were attentive to their needs and wishes. For example, staff knew what was important to people and supported them with their day to day needs and goals. Staff spoke confidently about people and what was important to them. One staff member told us about one person and the support they needed. They said, "They like to stay in there room, they love cups of tea and they like to know when meals are." The person told us that staff regularly came to talk to them and that they enjoyed drinking lots of tea. They said, "Staff are always in and out, I don't feel alone. I've got everything I need." The person also had a board in their room, where they had asked staff to write down meal times. They told us this was really helpful. They said, "I need it as I sometimes forget, it's important." When we were talking to the person a member of staff came to ask them if they wished to join them in going to the dining room. The person enjoyed a friendly chat with the member of staff and went to the dining room.

Care staff were supported to spend time with people and they spoke positively about this. Comments included: "If I've made somebody happy then I'm happy"; "I can honestly say this is the best place I have ever worked"; "We definitely have time and it's important to get to know people."
We observed staff talk to people about football and which teams were playing. People clearly enjoyed discussing their views and lives with staff and enjoyed jokes. For example, one person asked for a cup of tea, which a staff member provided. The staff member had a friendly joke with the person that it was their turn to make it next time, which prompted a witty response. The person was clearly comfortable to joke with staff. The person said, "They're (staff) lovely."

People told us their dignity was respected by all staff at the home. Comments included: "They're (staff) respectful" and "Treated well and with dignity." One relative praised how staff respected the dignity of their loved ones. They told us how they observed two staff assist their relative, they said the staff explained what they were doing and worked at a calm and relaxed pace. They also told us, "someone knocked on the door to empty the bin. The staff stopped, made him comfortable and didn't continue until the staff member left the room. I was impressed in how they talk and have a laugh, they are respectful."

People, where possible, were supported to make decisions around their care and treatment. People's care

plans and risk assessments were written by nursing and care staff with people. For example, one person's care plan clearly documented their views and also their wants and wishes regarding end of life care. This person had also made a decision to refuse resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans.

Requires Improvement

Is the service responsive?

Our findings

The care and support people received was not always personalised to their physical needs. A number of people were having aspects of their care and treatment recorded such as their food and fluid intake and personal hygiene support requirements even though no individual risks or a therapeutic need had been identified. For example, one person's personal hygiene was being monitored; however there was no understanding of why this was being done, or how this recording was being used to identify concerns or changes in their needs.

Where staff recorded people's needs, they did not always have the information they needed to effectively monitor those needs. Care staff we spoke with said that people were on food and fluid charts if they had lost weight or needed their fluid balance monitoring because they were unwell. However staff could not explain the goal of the food and fluid charts or what the 'ideal' intake was for specific people. People's care plans did not always contain information to guide staff on how much fluid was needed, or if they needed to be on food and fluid charts. Therefore there was a risk that although charts were being completed staff would not know when to flag up concerns based on the amounts recorded.

People did not always have access to a variety of meals which met their dietary needs. One person's relative told us, "We're trying to get their diet sorted. There isn't much variety; they have a lot of yoghurts." One member of staff raised a concern with us that there was a lack of options for those people on specialised diets such as gluten free. We raised this with the manager who said that they were aware of this and had asked staff to think about creative ways the home could better meet this need, for example gluten free cake baking.

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

People's care plans were mostly current and personalised to their needs. People's care plans included information relating to their social and health care needs. They were written with clear instructions for nursing and care staff about how people's care should be delivered. People's care plans and risk assessments were reviewed monthly and were often changed to reflect people's needs when changes had been identified. However sometimes when changes had been identified, these had not informed the person's care plan. For example, care staff had documented that one person's weight had significantly changed, however this had not informed the person's care plans or risk assessments. For another person, care staff had identified they were at risk of choking due to a reduced swallow reflux. A referral had been made to speech and language therapists for assistance; however this concern had not informed the person's care plan. We discussed these concerns with the manager, who told us they would take immediate action to ensure people's changing needs were documented.

The manager had also recently implemented a 'resident of the day' programme. The aim of this programme was for care and nursing staff to discuss the needs of one person per day. On this day, every area of the person's care and support was reviewed including their care plans and room maintenance.

People spoke positively about their lives at Woodstock Nursing Home and told us there was a lot for them to do. Comments included: "Always something going on"; "Plenty for me to do" and "There is a lot of people around, lots of music."

People were free to undertake the activities they enjoyed. The home had an activities coordinator who had been there since March 2016. She also assisted one day a week in the provider's sister home. The activities coordinator explained that since their arrival they had taken time to get to know people and what they liked to do. They told us that a lot of people enjoyed quizzes so they made sure that these were in place on a regular basis. People were also visited by a variety of external entertainment such as singers and pet therapy. There was also a regular summer fete.

Activities encouraged people to reminisce about their past. For example, we observed Mind Song (an external entertainment company) come to sing with people. They and the activity co-ordinator encouraged people to talk about their lives, as the songs often reminded people of different things. Where people talked, the activity co-coordinator and entertainers respected this and engaged them in conversation. People were engaged in the activity and enjoyed singing and talking.

The activities coordinator and care staff were aware of the risks of social isolation for those people who either chose not to join in group activities or could not leave their room. The activities coordinator told us that they would regularly visit people in their rooms to spend one to one time with them. All activities were recorded in an activities book so that it would quickly be apparent if people had stopped taking part in an activity they normally enjoyed.

People and their relatives knew how to complain. Comments included: "I'd see the boss if I was unhappy"; "If I'm not happy I'd say something" and "I would talk to the manager if I wasn't happy." The service had received one complaint in 2016. The complaint had been investigated and appropriate action had been taken in response to the concerns.

Requires Improvement

Is the service well-led?

Our findings

Whilst the provider had systems to monitor the quality of the service, these were not always effective and not always carried out consistently. The quality, safety and effectiveness of the service was monitored by a variety of audits this included infection control and care plans. However there was no evidence that audits were carried out on a regular basis and in some audits there was no documented evidence of actions which were needed to address any concerns. For example a care planning audit showed no evidence that concerns which had been identified had been actioned. Therefore the audits were not wholly effective in identifying risk and driving improvement.

People and their relative's views had not always been sought consistently, and their views had not always been acted upon. A quality assurance survey of people had been carried out in 2015; however this information had not been reviewed and analysed to identify any concerns or trends. Additionally resident and relative meetings had not been carried out regularly. The operations manager had carried out a recent relatives meeting which they had used to discuss management changes in Woodstock. People and their relatives views were encouraged and actions taken from the meeting. For example, some relatives raised concerns that they were not always made aware if their loved one had an accident or incident. Actions from these meetings had not yet informed the service's action plan, however we were assured action would be taken. The manager also planned to immediately complete a survey of people, their relatives and healthcare professional's views following our inspection.

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

The provider had not always informed the Care Quality Commission (CQC) when applications to deprive people of their liberties had been authorised. Three people were currently being deprived of their liberties under the Deprivation of Liberty Safeguards. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers. We raised this concern to the manager and operations manager who took immediate action to complete notifications for each application.

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

We found the CQC inspection ratings from our inspection in June 2015 had not been displayed on the provider's website in accordance to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we raised this with the operations manager they took immediate action to address this concern. They additional contacted managers from other home's the provider owns to ensure all ratings were published.

The new management in the home were taking action to implement new systems to monitor and improve the quality of care people received. The new manager showed us a range of audit tools they were implementing. Each tool was based around the safe, caring, effective responsive and well led domains

measured by the CQC. They appeared detailed and robust. A pilot audit had taken place in May 2016 utilising a slightly different format. The audit findings were clear and actions had been undertaken to improve the service, for example the need for the service to have a mission statement. The Director of Operations for the provider informed us that going forward it would be the operation manager's responsibility to undertake these audits on a monthly basis.

Immediate action had been taken by the manager and clinical manager around the management of medicines. The clinical lead was implementing clear systems to ensure people received their medicines safely.

Staff told us that they were happy and confident to express their views and offer their ideas to the manager. For example one member of staff had looked at how to maintain a consistent approach amongst the staff with encouraging and maintaining a person's mobility. They had put forward a proposal that a chart of the person's exercise regime be made available for staff to sign when completed. The same member of staff fed back to the manager that they wanted to make it easier for staff to access relevant assessment records. This would be done by placing all relevant charts in a single file for that person. The aim being to encourage accurate and contemporaneous record keeping.

The manager had introduced an 'Ideas Book' where staff could write down their ideas on how to improve the service. The intention was for this to then link in with staff meetings and generate discussion. Ideas included having a feature wall full of photos of the residents at different ages.

Staff we spoke with told us that they had not had a staff meeting for some time. The manager explained that going forward it was planned that a meeting would be held one afternoon a week for staff to 'drop in'. There would be the same theme every month which meant that staff would have every opportunity to access this meeting. The manager also said she had an open door policy and staff would approach her with concerns or ideas whenever they wished. One member of staff said "I feel the manager is approachable, she always helps me when I need it."

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 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	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The Care Quality Commission (CQC) had not been notified of all allegations of abuse. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People were at risk of not always receiving person-centred care as their individual needs were not always recorded and acted upon. Regulation 9(1)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service did not always have effective and consistent systems to monitor the quality of service they provided. People and their relative's views were not always sought consistently. Regulation 17(1) (2)(a)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The registered manager and provider had not fully ensured staff employed for the purposes of

carrying on a regulated activity were of good character. Regulation 19 (1) (a).