Yorkshire Parkcare Company Limited

Meadow View

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 28 February 2017. The home was previously inspected in April 2016, and at the time was meeting all regulations assessed during the inspection, but was overall rated requires improvement. Previously the service had been rated Inadequate. We brought this inspection forward due to concerns.

Meadow View is a care home providing accommodation for older people who require personal care and nursing care. It also accommodates people who have a diagnosis of dementia. It can accommodate up to 48 people over two floors, which is divided into two units. The floors are accessed by a passenger lift. The service is situated in Kilnhurst near Rotherham.

There was not a registered manager for the service in post at the time of the inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, there was a new manager who had commenced in post on 13 February 2017.

The provider had systems in place to protect people from abuse and staff were aware of the procedures to follow. However, we identified these had not always been followed. People had not been protected and we made safeguarding referrals to the local authority following our inspection.

People were not always protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines but these were not always followed.

We found there were adequate staff on duty to be able to meet people's needs. However, the ineffective deployment and direction to staff meant people's needs were not always met. We also found a high use of agency staff.

We saw that appropriate pre-employment checks had been carried out to ensure staff were of good character and suitable to work with vulnerable adults.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However we found it was not being carried out in practice and conditions were not being met.

A well balanced diet that met people's nutritional needs was provided. However, we found people were not always supported appropriately to be able to eat and drink. We found best practice guidance was not always followed for people living with dementia in respect of aids for eating and adaptations to the

environment.

Staff had undertaken training to give them the skills and knowledge to carry out their roles. However, as we found staff not always following best practice it was not clear if the training had been effective. The new manager had identified additional training was required and had booked more training for staff to attend.

People and their relatives we spoke with were aware of how to raise any concerns or complaints. Some complaints had been raised and appropriate action had not always been taken. The new manager was aware of the need to take any concerns seriously and follow the appropriate procedure so people were listened to.

There were processes in place to monitor the quality and safety of the service. However, we saw these had not always been followed and the processes had not identified issues identified at the inspection.

We saw the process in place to ensure incidents were reported appropriately to the Care Quality Commission had not been followed and incidents had not been notified.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report. However, following our inspection the provider agreed to a voluntary suspension of any further placements until improvements had been made. They have also provided an action plan of intended improvements.

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.

Although people told us they felt 'safe', we found that people were not always safeguarded from the risk of harm. During the inspection we saw that safeguarding concerns had not been reported appropriately.

Sufficient staff were on duty to meet people's needs. However staff were not effectively deployed.

We found there were arrangements in place to ensure people received medicines as prescribed, however the systems were not always followed.

Is the service effective?

Inadequate

The service was not effective.

People had their needs assessed and preferences and choices were documented. However these were not always met.

Staff had completed training in the Mental Capacity Act and understood how to support people whilst considering their best interest. However, this was not followed in practice and conditions of Deprivation of Liberty Safeguards were not always followed.

Staff had not always been appropriately supported or supervised to carry out their roles responsibilities.

Staff had undertaken training, however, this was not always effective. The new manager had identified additional training was required.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw some good interactions between staff and people they supported, however, some care and support we observed was task orientated.

People's privacy and dignity was not always maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans detailed their needs and choices but we found they had not been reviewed or updated to reflect people's changing needs. People told us there was not much to do and lack of stimulation. In particular people who were nursed in bed.

People felt that any concerns or complaints raised would be taken seriously by the new manager but felt they had not been addressed appropriately prior to this.

Is the service well-led?

Inadequate

The service was not well led.

A new manager had been appointed and had been in post for two weeks and people told us they were more confident they were listened to now. However, the service had lacked consistent management and nursing staff and a high use of agency had increased inconsistencies and poor deployment of staff.

There were systems in place to monitor the quality of the service however; these had not identified issues that were picked up at inspection so were not effective.

Meadow View

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 on 28 February 2017 and was announced. The inspection was carried out by two adult social care inspectors 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.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority commissioners and safeguarding team. This information was reviewed and used to assist with our inspection. We did not request a Provider Information Return (PIR) as the inspection was brought forward. The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make."

As part of this inspection we spent some time with people who used the service talking with them and observing support. We looked around the service including bedrooms, bathrooms and communal areas. We looked at documents and records that related to people's care, including four people's support plans. We spoke with nine people who used the service and two relatives.

During our inspection we spoke with a registered manager from another service that was supporting the new manager, the new manager, the deputy, two nurses, six care staff, one domestic and the cook. We also spoke with two visiting health care professionals to seek their views. We also looked at records relating to staff, medicines management and the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe in their rooms. One person told us "I am safe in my room but it is like a prison staring at the same four walls, but nothing else to do." They told us they didn't like going into communal areas as staff didn't manage people's behaviours that could challenge and they did not feel safe. Although another person told us they felt safe and said, "I am well looked after." Visitors told us that mostly they felt their relatives were safe; however, they had concerns about the use of agency nursing staff who did not know the people who lived at Meadow View.

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were knowledgeable on procedures to follow including whistleblowing procedures. Staff could tell us how to recognise and respond to abuse. However, we found people were not protected as the provider had not always identified abuse. For example, we identified that staff had recorded incidents in people's care files that were safeguarding incidents but they had not been reported appropriately. When we spoke with the deputy and the manager they both said they were not aware of the incidents. Correct procedures had not been followed to safeguard people. We also identified a concern raised by a relative which was being investigated by the safeguarding team, yet we had not received a notification from the service to inform us of this.

We looked at records in relation to accidents and incidents and found an analysis tool was in place to record actions and to monitor trends. However this was not always fully completed. We looked at care records and found some incidents which should have been recorded and analysed but they were not evident on the monitoring form.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Relatives and people who used the service who we spoke with told us there was not always enough staff on duty. However, staff we spoke with told us there was usually enough staff working with them but the company used agency nursing staff so was not always consistent leadership. Through our observations we saw there were enough staff to meet the needs of people, however, on many occasions staff were together in communal areas and staff were not always deployed effectively to meet people's needs.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We looked at two recruitment files of staff who had been employed recently and found the provider had a safe and effective system in place for employing new staff. The staff files we looked at contained pre-employment checks which were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable

people.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found medication storage rooms had air conditioning installed and this was set to 18 degrees centigrade. However, in the downstairs unit the medication trolley was kept in a different area to the air conditioning. We asked the nurse if the temperature was checked in this area and they said there was not a thermometer so it was not possible to determine if the storage room maintained the correct temperatures.

We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines. For example we found one person's medication had not been dispensed for the current monthly cycle and the total dispensed minus the total administered did not tally with the amount left in stock. The staff member when asked thought this was because the carried over amounts were not always recorded. This meant staff could not always evidence medication was given as prescribed. We also identified people's medication was not being given as prescribed. For example one person was prescribed medication for constipation. This was prescribed to be given three times a day, this had not been signed as given during the previous two weeks. We checked this persons records and found their bowel movements had not been recorded, it was therefore not possible to determine if this person required this medication or not.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, pain relief and to alleviate agitation. We found people did not always have PRN protocols in place these would detail when to give PRN medication and explain how people presented when they were in pain and agitated. Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to determine when it was required. This was particularly important when the service was using a large amount of agency nurses who did not know the people well.

We found on occasions people did not receive topical medication as prescribed. We found an additional MAR was in people's rooms for care staff to sign when the creams had been applied. We looked at a selection of these MAR's and found staff did not always sigh that the creams had been applied as prescribed. There were three month records in rooms, these had not been reviewed or evaluated by the nursing staff to determine the topical medications were being administered or effective. For example one person was prescribed a cream to be applied daily. We looked at the January and February records and it had only been signed as applied on ten occasions over the two months. Another person's cream was to be applied every time they were incontinent to ensure their skin was protected. We saw the staff had recorded the change of continence wear four times on the day of the inspection, but had only signed the MAR twice to show the cream had been applied. This meant the person's topical medications were not being applied as prescribed and put them at risk of developing sores.

The medication was administered by staff who had received training to administer medication. The deputy manager told us all staff had received competency assessments, yet we found errors were still occurring so these were not effective. The medication audit completed on 23 February 2017 did not identify all the issues we saw. For example it was marked 'yes' to show medicine records were maintained and organised appropriately to ensure a clear audit, yet we found medicines were not recorded appropriately.

We saw people's risks had been assessed and documented in their care files. However, we saw many of

these had not been reviewed or evaluated since December 2016 and when people's needs had changed had not been updated. For example one person's risk assessment stated they were sat out in a specialist chair for safety, yet the last review stated they were now nursed in bed. The care plan had not been updated to reflect the changes it was therefore confusing and not clear how the person's needs were met.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Inadequate

Is the service effective?

Our findings

People we spoke with told us staff respected people's choices and decisions. From observation we saw people were given choices. However, we found much care and support was task orientated and choices were limited.

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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. We checked whether the service was working within the principles of the MCA.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However we identified people's conditions in relation to the authorised DoLS were not being followed so they were being deprived of their liberty. For example, one person's condition was to participate in one to one time with staff in their room providing stimulation and company and to also access the wider community. There was no evidence this was happening yet during our visit the person was asking to get up, the person did not have access to a call bell to be able to alert staff when they required assistance. There was a best interest decision in place which stated the person was unable to use the call bell, this however, was not the case. We spoke with the person and they were able to use the call system but said they didn't have one. It was therefore not clear if the person was being deprived of their liberty.

We looked at care records and found that mental capacity was not always clearly recorded. We saw one person who had a DoLS in place with a condition to ensure the person received social stimulation. However, on the day of our inspection this person spent the day in their room, with their music on, but the only interaction they received was task focused. For example, when meals and drinks were offered. We spoke with the management team about this and the deputy manager told us that social activities were recorded on a separate form. We looked at the form and found that the only activity recorded was mealtimes.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We observed meals on both units, the food looked appetising and was well presented. However, we found the experience was poor for people who used the service. Staff were task orientated and unorganised. On the downstairs unit there was a choice offered but people were struggling to choose, staff eventually decided for them. Staff did not consider showing them the food to be able to make a decision and there were no picture cards to use to aid choice for people living with dementia. Staff served people their meal in

the dining room and then proceeded to take meals to people in their rooms this left only one member of staff in the dining room and we saw four people required assistance with eating in the dining room. One person sat playing with their food, staff gave no encouragement to eat and did not offer support, the person plate was taken away and they had eaten nothing. This meant people were not adequately supported to eat a balanced diet. We saw one person who had been given their meal and was eating this laid down resting the meal on their chest. Staff had not positioned the person properly to be able to eat their meal. There was no understanding from staff regarding positioning of the person or thought as to how the person would manage to eat their meal in this position.

On the upstairs unit we noted that there was no choice offered at lunch time. One care worker asked the staff member serving the meal, "What's the choice." The person replied, "There isn't one today as the cook had been working on their own." We asked staff if there was usually a choice and they said, "It just depends. Sometimes they do, sometimes they don't." There didn't appear to be any reason for this.

We saw a board on the wall in the dining area which indicated it was for recording the day's menu. However, at breakfast there was no menu written on the board. The lunch menu appeared a little later on during the morning. There were no picture menus which would have been useful for people living with dementia to understand the menu on offer.

We saw that people had access to healthcare professionals such as physiotherapists, dieticians and G.P's. However, this was not always done in a timely manner. For example, one person's care plan stated that the person should be referred to the Speech and Language Therapist if they had a concerning weight loss. This had not been done and the person had lost weight. On the 4 January 2017 the person weighed 45.2kg to 38.3kg on the 26 February 2017.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred cared treatment.

We looked at records in relation to staff support and training. The new manager had a schedule in place to complete staff supervision sessions. These were one to one meetings with their line manager. Staff we spoke with told us that they had received supervision sessions from managers. We also saw most on line training was up to date and the manager had arranged further training courses in March 2017 for tissue viability, end of life and safeguarding. Staff were knowledgeable and felt they received adequate training. The new manager told us during supervision she was determining the effectiveness of the training provided to ensure suitable training was provided.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and they told us the staff were nice. One person said, "The staff are good, they chat to me." Another person said, "The staff are wonderful, but there's no place like home."

Other people we spoke with told us most staff were kind and caring. One person said, "they respect me and they look after my possessions." but they added, "I had another lady's top once in my wardrobe." They were able to identify this was not theirs but were concerned some people would not know, so people could have the wrong clothes on.

Another person told us they though the care was adequate, but felt that the home was short staffed, they said, "Staff do their very best but there's too many people to look after in the morning, don't always get up and dressed on time."

A relative we spoke with told us their relative wasn't always clean and explained that for their last two visits there had been a stain on their relative's top. They were unsure whether this was in fact the same top or whether the drink spilled in the same place was a recurring episode as they were left lying down in bed. Another relative told us they weren't sure that their relative's dignity was being maintained because they suspected that they no longer wore underwear but were being put into continence products. They felt this wasn't very dignified for their relative as they had always been very proud of their appearance and presentation.

Throughout the service we saw personal information displayed on walls that people could read. For example, the menu board in the dining area upstairs said, '[name] does not have pork. This is in the care plan.' Another example was dietary information was displayed such as 'thickened fluids.' We also saw personal information was in communal areas, daily records, food and fluid charts and personal care records were in files on tables in the dining room. This meant anyone could walk in and read the records not maintaining confidentiality. This had not been identified by the quality monitoring or audits in place.

We saw that several people had a note on their bedroom door which said, 'Due to my circumstances I am unable to make use of the call system so please check on me regularly through the day and night.' We saw one person who appeared able to use the call system on some days, but told us they had never tried. There was no access to the call system. Staff should be aware of people's needs as these should be documented in their plans of care not on notices on doors and walls. This did not respect people's privacy or dignity.

We saw some very positive interactions between people and staff. We saw staff engage in conversations talking with people about their families and hobbies, it was obvious from the conversation that the members of staff knew the people very well. We saw people were enjoying the conversation and laughing and smiling with the staff members. However, other interactions observed between staff and people who used the service were task focused. For example, we saw one care worker move a person from the dining area to the lounge without communicating with them. Another example was that staff constantly told a person to sit down each time they stood up. The staff did not explore what the person wanted and did not

offer any social stimulation to occupy the person. We saw meals placed in front of people with no explanation and staff rushing to get the meal finished and cleared away not making it an enjoyable experience for people.

We saw life stories were available in care records which gave detail about people's hobbies, interests, likes and dislikes. People's rooms were personalised and homely. However, we found many people nursed in bed with no social stimulation to ensure a positive sense of well-being. We found people with smooth music playing or the television on but no other activities apart from staff bringing in the meals.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Requires Improvement

Is the service responsive?

Our findings

People told us most staff were very good. However relatives told us there was a high use of agency staff so there was lack of consistency in care provision. One relative said, "There has been so many managers and nurses change every day there is no consistent management and things get missed."

We looked at care plans and found they were not always a true reflection of people's current care needs. For example, one person's care plan stated that they were at risk of losing weight and to offer meals six times a day and foods to be fortified to add extra calories. This was based on professional advice given by the dietician in November 2016. We looked at the food and fluid charts for this person and found they did not record that six meals a day had been offered and lacked information regarding how foods had been fortified. The dietician had also recommended that the person be weighed every week. This was not clear as records of weights were recorded in several different places making it difficult to monitor any weight loss. We saw although people's care needs had been identified, the care delivery recorded to meet people's needs did not give sufficient detail to show how the care should be delivered to be able to respect their preferences and choices. Therefore this did not ensure staff were responsive to people's needs.

Another person's care record had a plan in place for mental capacity which stated that the person was confused and disorientated but was able to express their needs. There was also a care plan in place for being unable to use the call system as the person was not aware of risk. This did not give the person their own autonomy.

There was a dedicated activity co-ordinator employed at the service. On the day of our inspection there were opticians visiting the service to carry out sight tests. The activity co-ordiantor was involved in taking people through for their appointments so there were no activities taking place. We spoke with the activity co-ordinator while they stayed with people and chatted to them while they waited for the optician. The co-ordinator had a caring attitude and sat at eye level talking with people holding their hands. They told us that activities were organised for people and included crafts, games, hand massage and bingo.

We observed some activities taking place that a care worker was organising in the downstairs lounge. Four people were being given a manicure by the care worker. However, there was a long wait as the care worker had to go in search of nail polish remover, which took some considerable time. Therefore the activity was not as enjoyable as it could have been for people as they were left alone for a long time.

We found from looking at records that very few people were involved in any meaningful activity. People who were cared for in bed did not receive any social stimulation and could be isolated. People we spoke with told us there were not many activities and if activities were organised they were not interesting. One person told us, "I don't get involved in activities as they are boring, staff don't organise anything that is interesting." Another person told us they spent time with the chickens in the garden and enjoyed this. Records of activities we saw recorded giving people their meals and watching television as an activity, no meaningful activities that could improve people's well-being were recorded.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The provider had a complaints procedure in place and was displayed in the reception area of the home. We spoke with the regional manager about complaints and were shown a log which contained four complaints received over 2016. These had been followed up in line with the provider's procedure.

Inadequate

Is the service well-led?

Our findings

There had been several changes in management over a short period of time and this had led to some uncertainty. Staff we spoke with told us that each time they get a new manager they have to get used to how they work and one staff member said, "It's like starting from scratch each time."

The acting manager had been in post since 13 February 2017 and was supported by the deputy manager. A registered manager from another service was also in place to offer support and guidance to the new manager. However, we found there were no permanent nursing staff and the provider was using agency staff to cover nursing shifts. This meant there was inconsistent management of the units. Care staff we spoke with were extremely frustrated with the constant changes and lack of leadership and direction. Staff told us there had been three managers in under a year. One staff member said, "They come in and make changes, then leave, the last one didn't even stay two weeks."

We looked at records of audits completed to ensure the service was monitored to maintain a quality of service. Records we saw were limited due to the change in managers, audits had not been completed on a regular basis. We asked the management team why the audits had not been completed since December 2016 and we were told that they had been concentrating on recruitment. The registered manager who was supporting from another service told us that the audits would start again from February 2017. However, we inspected on the last day of February and the majority of the audits had not commenced.

We saw a weight audit which had been completed in January 2017, but this had not identified the weight loss concerns we had raised as part of our inspection. We also saw that a medication audit had been completed on 23 February 2017 which indicated that the medicine room was untidy, medicine trollies were not locked to the wall and the clinical fridge was unlocked. Some dates of opening were not on boxes of medicines and some missed signatures were evident on the MAR sheets. We looked at medication and found many areas that required improvement to ensure people received their medication as prescribed and they had not been identified in the provider's audit. This showed that the quality monitoring and audits were not effective.

There were processes in place to monitor the quality and safety of the service. However, we saw the process in place to audit care plans requirement improvement. For example, we found that some care plans had not been signed and dated by people or staff. We also found that these had not always been updated in response to peoples changing needs. This was particularly important as high levels of agency staff were used and they may not know the people who they are providing care to. During the inspection we also found it difficult to read some people's daily records. It is important that records are legible and easy to read. We shared this feedback with the deputy manager.

We saw the provider had a record in place to record safeguarding concerns but this only recorded the date and the person's name. We also saw that some safeguarding concerns were not listed on this form. There was no other information such as details of the concerns and any lessons learned.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. However, we saw that we had not been notified about incidents that had occurred at the service.

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

We have since our inspection received an interim action plan from the provider, which covers the areas where we provided feedback at the end of our inspection. We have been given some reassurances by the provider who has agreed to a voluntary suspension on any new admissions until things improve. The provider has also placed a regional manager at the service three days a week to support the new manager and external auditors will be visiting to identify areas for improvement implementing a full and robust action plan.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment that was appropriate, met their needs, reflected their preferences and was not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment. Risks were not assessed or reviewed appropriately to meet peoples needs and Proper safe management of medication was not in place.

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 People were not always protected form improper treatment in accordance with regulations. Authorised DoL'S conditions were not always followed. Which meant people's liberty was restricted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed appropriately to be able to always meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems and processes in place were not effective, they did not identify issues and improvements required to ensure the service met the requirement's of the regulations.

The enforcement action we took:

We have issued an enforcement notice that requires the provider to ensure systems and processes are developed, that are effective and improve the quality and safety of the service.