Alpine Health Care Limited

Alpine Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alpine Lodge is a nursing home. It was providing personal and nursing care to 58 people at the time of the inspection. The service can support up to 67 people across four units. One of these units specialises in supporting people who live with dementia.

The home is purpose-built with en-suite bedrooms and communal areas. The home has a secure garden accessible from the ground floor.

People's experience of using this service and what we found
Risks were assessed but had not been reviewed so people's safety was not managed and monitored. Infection prevention and control was not adequately managed. Systems, processes and practices were not embedded to ensure people were safeguarded from the risk of harm or abuse. Sufficient staff were not evident in all areas of the home and appropriate checks on staff recruitment had not always taken place. Accidents and incidents were not analysed so lessons could not be learnt to prevent recurrence. Medicines were mostly administered as prescribed, however improvements were needed to the management of some time-sensitive medicines.

There had been inconsistencies in the management of the home and a lack of effective leadership of staff to promote good quality care delivery. The provider's governance framework had not identified the issues found during our inspection. Issues identified at our last inspection had not been addressed. Residents meetings took place, as did some staff meetings. Surveys with people and staff had taken place, however these had not been analysed so their feedback had not been acted on.

People's needs and choices were assessed, however there was limited information about people's needs made available to staff. People did not always receive a choice of food. People who required a modified textured diet were not given a choice for their main meal. Staff were trained, however there was no evidence new staff members received an induction. The environment was not always suitable for people who lived with dementia. Information about choices was not always given in the most appropriate way to support people's understanding.

We have made a recommendation about how the staff and environment could better support people who live with dementia.
People received good access to health professionals. People's consent to care was recorded. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care plans lacked detail about people as individuals. People did not always have appropriate end of life care plans. Complaints were not always logged.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 December 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection the provider had not made enough improvement and we found they were also in breach of additional regulations.

Why we inspected
We received concerns in relation to record keeping, staffing and infection control. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risk have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, responsive and well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report form our last comprehensive inspection by selecting the 'all reports' link for Alpine Lodge on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety, the provision of person-centred care, and good governance.

Please see the action we have told the provider to take at the end of the full report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to

understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the provider's 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.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Alpine Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors undertook the inspection.

Service and service type
Alpine Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service, including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with 12 members of staff including the regional manager, quality lead, nurses, care staff, domestic and activities staff, and the cook.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Staff told us they were not kept up to date about risks to people. One staff member said, "We don't get a lot of information about risk. We have to go onto the computer to look for information." Another told us, "Someone told me a couple of days ago [name of person] has got pancreatic cancer. No one ever told me this."
• Risks relating to some aspects of the environment had not been identified. Action had not been taken to address or review the known environmental risks. For example, doors were left open when it had been identified these should be kept closed, despite signs reminding staff to do this.
• Risks relating to people's diabetic needs were not widely understood by staff. For example, staff were unsure what food was diabetic appropriate.
• People had risk assessments in place and these were reviewed monthly. However, these were not always consistently reviewed after incidents had taken place which meant there was a higher risk of recurrence.

We found no evidence that people had been harmed however, systems were either not in place or were not robust enough to demonstrate risks to people were assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was meeting shielding and social distancing rules.
• We were not assured the provider was admitting people safely to the service. Domestic staff were unable to describe how they would clean people's rooms if they were isolating.
• We were not assured the provider was using personal protective equipment (PPE) effectively and safely. We witnessed staff members wearing PPE inappropriately. In one instance a staff member was not wearing a mask.
• We were assured the provider was accessing testing for people using the service and staff.
• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. PPE was not stored hygienically. Cleaning schedules were not in place. Cleaning hours had reduced during the COVID-19 pandemic and staff told us cleaning was poor. One staff member said, "Cleaning has fizzled out."
• We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed. The provider's policies had not been reviewed recently and staff were not adhering to good IPC practices.

• We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The number of visits was restricted each day.

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate effective infection prevention and control was in place. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes to safeguard people were in place but the provider had not ensured they were operated effectively.
• Records about safeguarding incidents were inconsistent. There was a lack of understanding about safeguarding processes amongst staff, however staff felt able to report incidents.
• Safeguarding was not promoted and people were unaware of how to report concerns. However, people told us they would feel safe to do so.
• There was no evidence staff had received training about how to recognise the signs of abuse.

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate the provider had effective oversight of safeguarding procedures. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People and staff told us there was not enough staff. One person said, "If I want the toilet they don't bother with you. Can shout for half an hour and no one comes." Staff members' comments included, "Staff? No not enough", "Staffing levels are the main (problem)", and, "Sometimes short of staff". The regional manager told us they had increased staffing as a result of their observations and staff comments. Increased staffing had only started the week of our inspection visit.
• Our observations found care and support was relaxed and unrushed. A dependency tool was used to calculate how many staff were needed on each shift and staffing rotas corresponded to the findings from this.
• Staff we spoke with told us there needed to be a better staffing mix. One staff member said, "Improve staffing mix of skills, carers could be more balanced." The regional manager told us the new manager planned to review staffing rotas to support this.
• The regional manager told us they were in the process of reviewing people's needs and planned to review staffing levels to support these needs. Recruitment was taking place for activities and domestic staff.
• Comprehensive recruitment checks on new staff had not been fully completed. Two recently recruited staff members had not received their DBS check prior to starting work. The service had undertaken all other appropriate checks. The quality lead told us the service had already started a process to review all staffing files and ensure all required documentation was in place.

We found no evidence that people had been harmed however, systems were either not in place or were not robust enough to demonstrate effective recruitment processes. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• People mostly received their medicines as prescribed. However, some improvements were needed to the management of time-sensitive medicines. Some people who should receive their medicines before food

were not given it at this time. We were told by staff this was because people had chosen to receive their tablets at this time, although there were no records to support this. We discussed this with the provider who confirmed following the inspection action had been taken.
• Staff were trained and assessed as competent to administer medicines.
• Regular medicines management audits took place and staff identified medicines errors. These were mostly appropriately reported, however we identified a delay in reporting during our inspection visit. We discussed this with the quality lead who took steps to address this.

Learning lessons when things go wrong
• A report was produced each month detailing the numbers of incidents that had occurred in the service. However, these were not analysed. This meant any potential learning from these incidents was not identified or recorded.
• The interim manager had recently started a programme of supervisions with each staff member to share the outcomes of a recent Local Authority visit. This supervision discussed the required improvements as a result of their findings.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments were undertaken before people moved to the home, however, these assessments contained limited information about people's needs and preferences. This meant people's needs and choices were not adequately recorded. One person, when asked about care delivery, said, "We do what they (staff) want not what we want."
• Care plans were not always reviewed regularly. Care plans were reviewed when people's needs changed, however, these records were not comprehensive which meant staff did not always have clear enough guidance to follow.
• The service used an electronic recording system which ensured any changes to people's care and support needs were tracked and recorded. However, a staff member told us, "Handheld units are not straight-forward. They don't have the person's full name or number of the room on. We have to go through all different pages to get to what want to know."

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate people received care that was appropriate, met their needs or reflected their preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People who required a modified textured diet did not receive a choice for their main meal. A staff member, when asked how they supported people to understand what the food choice was, responded, "Well we just put it on", meaning they put the food on people's plates without providing choice or explanation.
• The dining experience varied between the individual units. On one unit condiments and tablecloths weren't available, there was no music playing, and people did not receive a choice for their main meal. On another unit some people were offered an alternative choice to both the main meal and pudding, whilst other people were not offered any choice.
• Staff were not always aware of how to accurately support people with diabetic needs. For example, one person who was diabetic had been served a pudding which was not suitable for them.
• People were encouraged and supported to eat and drink and maintain a healthy diet. One person had chosen chopped apple for breakfast and this was freshly prepared. Another liked banana on their porridge and staff went to find one.
• People told us the food was good. One person said, "Meals are good. Cooking is excellent."

We found no evidence that people had been harmed however, systems were either not in place or were not robust enough to demonstrate people received care that was appropriate, met their needs or reflected their preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff did not receive appropriate training or support. People were supported by staff who had received online training. However, we did not see evidence a training matrix was used to track and record training. This meant the provider did not have good enough oversight of the training staff had completed to ensure staff training remained up to date.
• One staff member who was supporting people who live with dementia told us they had not received dementia training. Another staff member said, "I think there needs to be proper training in place. Because a lot of people have not done care before."
• Staff who were new to care shadowed more experienced staff before they started work. However, neither new nor agency staff received an induction. One staff member said, "Only get shadowing if new to care." Another staff member told us agency workers were shown around but "there is nothing in writing".
• Supervision and appraisal matrices were in place. These showed most staff had received a regular supervision and an annual appraisal. However, a staff member said, "We used to get proper supervision. But the last manager we had just used to send supervisions out and we just signed them. I do not know if this one is any different." The regional manager told us the interim manager had commenced a review of these.

We found no evidence that people had been harmed however, systems were either not in place or were not robust enough to demonstrate the provider had effective oversight about how staff were supported to deliver quality care. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service had clear processes for referring people to other services, where needed. People's records showed communication with health professionals was effective and timely. Advice was documented and followed.
• Staff were vigilant and knowledgeable about identifying required health interventions. Staff described good working relationships with health professionals. The home involved people and their relatives in working with other services.

Adapting service, design, decoration to meet people's needs
• Signage to support people living with dementia was not available throughout all of the dementia unit. Most people's bedroom doors did not show their names or any other easily identifiable sign to aid their navigation around the home.
• Dining room whiteboards containing details of the day's menu were not easily visible.
• People were not provided with pictorial information about the food available, for example, pictures of the main meal or an example plate, to support people with dementia to make choices.
• People had been asked about improvements to the home in regular residents' meetings. We found some actions had been taken as a result of these, however these were not always timely and people had to ask more than once.

We recommend the provider consider current guidance about how to support people who live with dementia and take action to update their practice accordingly.

Ensuring consent to care and treatment in line with law and guidance
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.
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• People's consent to care was accurately recorded. For one person, who was unable to sign their consent, their record showed who had supported them during the care plan discussion and that this person had given their consent verbally.
• Staff were able to give examples of how people were supported within MCA requirements and where they involved people in day to day decisions about their care.
• The provider followed the legal requirements when caring for people who were deprived of their liberty. Timely applications for DoLS authorisations had been made. Where conditions were applied to these authorisations these were being met.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• There was limited personalisation in people's care plans about how people should be supported with each task. This meant there was a risk new staff and agency staff would not have enough information available to them to support people in a personalised way. Despite this, staff were knowledgeable about people's likes and dislikes.
• People's wishes related to protected equality characteristics were identified and used to develop people's care plans. As part of the activities provision, the service had started to talk to people about their family history, occupations, special places, and how people liked to look, to support the development of life history care plans.

End of life care and support
• People were supported at their end of life and received appropriate nursing care. However, end of life care plans lacked detail about people's preferences and wishes. For example, one person's care plan recorded only 'Has DNACPR in place' and another recorded '[Person's name] appears well at present'.
• When asked whether anyone was receiving end of life care, a staff member told us, "We are not always given this information. We are not always informed."
• The home worked closely with health professionals and people who were at end of life had appropriate healthcare involvement.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Activities were limited. The activities timetable showed the activities co-ordinator was deployed to facilitate relatives' visits each morning. This meant people did not receive activities while these visits were organised and facilitated, for example, when visitors needed to be tested for COVID-19 prior to visiting. Staff said, "They (people) do get time but it's not enough. (Testing) takes a lot of time away from people."
• Groups attended the home, such as pet therapy, movement to music, and armchair exercise classes. However, one person said, "Would be better if we could go out." The home had a minibus but staff told us there was no one to drive this. Another person said, "Would like more freedoms." When asked if they could access the garden, two people told us "only sometimes, not as often as we'd like".
• Group activities, such as bingo and making things out of dough, had recently taken place and a lively bingo game was being enjoyed by one unit on the day of our inspection visit. In some communal areas magazines and games were available for people to enjoy. We witnessed people enjoying these.

Improving care quality in response to complaints or concerns

• Improvements were needed to the provider's management of complaints. There was a complaints management system in place, however not all complaints had been recorded. Where complaints had been investigated it was not clear whether these had been responded to.
• People told us they felt able to raise complaints with staff. One person told us, "There's nothing to grumble about, if there is we just mention it and the (staff) sort it, no bother".

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were identified, recorded and highlighted in their care plans. These needs were shared appropriately with others.
• Some people were supported with their communication needs by the provision of whiteboards and by the use of some technology, such as 'Alexa'.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure effective oversight. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The service had deteriorated since the last inspection. This meant the provider had failed to address the issues found at the last inspection, and the provider's governance systems had failed to improved the quality of care delivered.
• Good governance arrangements were not in place. The provider had a schedule of checks and audits. These had been completed by the previous registered manager and verified by the previous regional manager. However, these checks had not identified any of the issues found during our inspection, so they were not effective at identifying issues with the safety and quality of the service.
• There were discrepancies in the recording of accidents, incidents, safeguarding notifications and statutory notifications. This meant the provider's governance systems had failed to ensure effective consistency of reporting.

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate the provider's governance systems were effective. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A new regional manager had recently identified concerns with the quality of the service and had started to take action. The regional manager undertook weekly visits to the service.
• A registered manager was not in post as the previous manager had left two weeks before the inspection. An interim manager was in post and a replacement manager had been recruited, pending a start date.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• Required improvements identified at our last inspection visit had not taken place. This meant people's outcomes had not improved.
• People told us they did not know who the manager was. A staff member told us, "It's chaotic with all the new managers. I haven't met [interim manager] yet." Another said, "Whole system need to change and the way it is organised."

Continuous learning and improving care
• Feedback from people, relatives and staff had not been used to improve care.
• It was not clear how staff were engaged in improving care or sharing their learning or experience. Most staff had not had the opportunity to attend regular meetings nor had they had other opportunities to share their learning or experience.
• Although the home displayed details of staff champions for aspects of care such as dignity and infection prevention and control, there was no evidence this had improved care. For example, the dining experience remained poor, and PPE was worn and stored incorrectly.
• Where people had requested a change in the frequency of fresh face towels and flannels being provided, this had been requested at two consecutive residents' meetings. This showed their care had not improved following the first residents' meeting.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The service explained their open-door policy for people, relatives and staff. However, a staff member said, "We never saw the [registered] manager, I hope the new one is different."
• Regular meetings took place for people. These discussed what people wanted to see and do in the home. However, we identified people had made repeated requests each month, for example, for fresh flannels every day. The meetings were not effective as people's feedback had not been acted upon.
• Some staff meetings took place, however these were not regular. Staff told us, "I can't remember the last staff meeting." The regional manager told us the interim manager had made plans to include all staff in future meetings.
• Surveys had taken place. However the actions from these were out of date and more up-to-date feedback had not been sought.

Working in partnership with others
• The provider group had regular manager support groups and internal management meetings were held, which looked across each of the services and provided regular updates on best practice and care legislation.
• The home had developed links with the local District Nurses and GP surgery.
• Following the inspection we signposted the home to the local Infection Prevention and Control team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1) (b) (c) People did not always receive care which met their needs or reflected their preferences. 9 (3) (a) The provider had failed to ensure a collaborative assessment of people's needs and preferences always took place.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) The provider had failed to ensure people received care in a safe way. 12 (2) (b) The provider had failed to do all that is reasonably practicable to mitigate risks to people. 12 (2) (h) The provider had failed to review the risk of, and take effective action, to prevent and control infection.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) The provider had failed to ensure systems and processes were operated effectively to ensure people care was delivered safely. 17 (2) (a) The provider had failed to ensure effective assessment, monitoring and quality improvement of the quality and safety of the care provided. 17 (2) (b) The provider had failed to mitigate the risks to people's health and safety. 17 (2) (c) The provider had failed to maintain an accurate and contemporaneous record for each service user.

The enforcement action we took:

We issued a Warning Notice