M & C Taylforth Properties Ltd

Rossendale Nursing Home

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 comprehensive inspection was unannounced, which meant the provider did not know we were going to visit the home. It was conducted on 14 and 15 June 2016.

The Rossendale Nursing Home is registered to provide personal and nursing care for up to 27 adults, including those who are living with dementia. The home is a detached Victorian property situated in a residential area and within easy reach of shops and local amenities. A small number of double rooms are available for those who wish to share facilities. Communal areas consist of three lounges and a separate dining room. Parking spaces are limited, but on road parking is permitted in the surrounding area.

The last comprehensive inspection of this service was conducted on 25 January 2016, when improvements were identified as being required in relation to cleanliness and infection control, safety, the management of medicines and monitoring the quality of service provided. These shortfalls were incorporated in the planning of this inspection.

At this inspection we identified numerous areas where improvements needed to be made, which are detailed within each relevant section of the report.

People who lived at Rossendale Nursing Home were not adequately safeguarded from abuse and therefore their safety was not always protected. The recruitment practices adopted by the home were not sufficiently robust, to ensure all employees were fit to work with this vulnerable client group.

We identified several areas of the home which presented potential risks to those who lived at Rossendale and therefore people were not always protected from harm.

There seemed to be sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home. However, people told us that there had been shortfalls in the staffing levels, but these had recently been increased. Records showed that there was a high level of agency staff used in order to maintain the current staffing levels.

The staff team had received training in safeguarding adults and whistle-blowing procedures. However, refresher training was overdue for a good number of staff members. Some records we saw, which related to people's monies were poorly kept and did not sufficiently protect individual's finances.

The management of medicines was, in general satisfactory. We identified a small number of areas, which could have been better. We made a recommendation that medicines procedures continue to be reviewed and improved in line with the NICE guidance 'Managing Medicines in Care Homes.'

Some areas of the home could have been cleaner and more hygienic. Infection control practices could have been better. This constituted a continuing breach of regulation.

The risk assessment in relation to fire safety was not always being followed in day to day practice and the Personal Emergency Evacuations Plans (PEEPs) needed to be updated. We have made a recommendation about this.

Care plans did not always reflect people's assessed needs and some information provided was vague and not specific to the care and treatment of those who lived at the home. This did not give the staff team clear guidance about how individual needs were to be best met.

Some care files reflected people's preferences and what they liked to do and needs assessments had been conducted before people moved into the home.

Deprivation of Liberty Safeguard (DoLS) applications had been submitted, in line with the requirements of the Mental Capacity Act. Records showed that people's mental capacity had been considered. However, the Mental Capacity Assessments were not always decision specific. Formal consent had not been obtained from the relevant people before care and support was provided.

The management of meals could have been better organised and people who required assistance could have been better supported.

The majority of staff we spoke with had a good understanding of the support people required and were able to discuss their needs. The staff team were well supported by the manager of the home, through the provision of information and supervision.

Complaints were, in general being well managed. Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings.

The provider had not always forwarded the required notifications to CQC. We identified two incidents, which should have been referred under safeguarding procedures, but had not been. The system for assessing and monitoring the quality and safety of the service provided was not effective. This did not allow for shortfalls to be identified and improvements to be made.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, premises and equipment, good governance, staffing and fit and proper persons employed.

We are taking enforcement action against the service and will report on that when it is complete. As the overall rating for this service is now inadequate, the Care Quality Commission (CQC) have placed the home into special measures and further enforcement action has been taken. Our guidance states that services rated as inadequate overall will be placed straight into special measures. We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore, we have introduced special measures. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must

improve the quality of care they provide or we will seek to cancel their registration.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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?

Inadequate

This service was not safe

At the time of this inspection there were sufficient staff deployed to meet the needs of those who lived at Rossendale Nursing Home. Staffing levels had recently been increased, in response to concerns raised by community professionals. However, a high level of agency staff were being utilised in order to sustain the higher staffing levels.

The recruitment practices adopted by the home were not sufficiently robust, in order to protect people from harm. Areas of risk had not always been identified and safeguarding incidents had not always been appropriately reported. It was evident that staff were struggling to manage and support one person who lived at the home, which had resulted in a number of physical assaults on other people who lived there.

Medications were, in general being well managed.

The emergency plans implemented at Rossendale could have been better. The premises were not safe throughout and infection control legislation and guidance was not being followed in day to day practice.

Is the service effective?

Inadequate

This service was not effective.

The staff team had not all received refresher training in some mandatory learning modules and therefore these were overdue. Staff had not been provided with specific training to meet the needs of those who challenged the service. There was no documented evidence to show that new staff members received a formal and structured induction programme on commencement of employment. Records showed that staff were supervised.

We established that mental capacity assessments had been conducted before an application was made to deprive someone of their liberty, for their own safety, or the safety of others. However, these were not decision specific. Staff members we

spoke with did not fully understand the legal implications of the Mental Capacity Act or associated regulations.

Consent had not been obtained prior to care and treatment being delivered.

People's nutritional requirements were not being consistently met. Feedback we received in relation to the food served varied.

Is the service caring?

Requires Improvement

This service was not consistently caring.

People felt that, in general staff were kind and caring, but some felt that people were not given choices. However, people's privacy and dignity was not consistently promoted.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

Staff did not always communicate with those they supported and there were missed opportunities to interact with people who lived at the home.

Is the service responsive?

Requires Improvement

This service was not always responsive.

An assessment of people's needs was done before a placement was arranged. Written plans of care did not always reflect people's needs and these could have been more informative. Advice from supporting professionals had not always been followed and risk assessments were not clear.

Activities were not being provided regularly. People we spoke with told us they would know how to make a complaint should they need to do so and staff were confident in knowing how to deal with any concerns raised.

Is the service well-led?

Inadequate

This service was not well-led.

The service had a quality assurance system in place. However, this was not effective, as concerns we identified during our inspection had not been picked up through internal monitoring systems and the recording of checks in some cases was very poor. Meetings for residents and their relatives were held, as well

as for the staff team.

Staff spoken with had a good understanding of their roles. They were confident in reporting any concerns and they felt well supported by the manager of the service. People who lived at Rossendale and their relatives had completed satisfaction surveys. This allowed people the opportunity to periodically comment about the service provided. However, there was no evidence available to show that action had been taken following concerns raised by relatives of those who lived at the home.

Staff morale was very low because of changes which had been made in relation to training and bank holidays, without any consultation with the staff team. It was evident that the Registered Provider and Registered Manager did not work well together and therefore the service was not well-led.

Rossendale 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. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

There had been some concerns raised about the staffing levels at the home. An evidence gathering visit had been conducted on 25 April 2016 by the lead inspector for the service, which led to this inspection. Following the visit by the lead inspector a meeting had also taken place between the Commission, the Registered Provider and representatives from the Local Authority and Clinical Commissioning Group (CCG) to discuss concerns. This had led to a voluntary embargo on new admissions by the Registered Provider along with formal suspension on admissions by the commissioners. This unannounced inspection was carried out on 14 and 15 June 2016 by two Adult Social Care inspectors from the Care Quality Commission (CQC), who were accompanied by 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.

At the time of our inspection of this location there were 22 people who lived at Rossendale Nursing Home. We spoke with fourteen of them and six family members. We also spoke with eight members of staff and the manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we 'pathway tracked' the care of six people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and safety were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records, quality monitoring systems and the personnel records of four staff members.

During the inspection we conducted a SOFI (Short Observational Focussed Inspection). A SOFI helps us to observe the level of staff interaction provided for a small group of people over short pre-set time frames.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents,

injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Rossendale Nursing Home. We asked eleven community professionals for their feedback and we received two responses, whose comments are included within this report.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe living at Rossendale Nursing Home. One person said, "We're all safe aren't we?" Another responded by saying, "Yes, the security, everybody moans we can't get out, but that's for a purpose." A relative commented, "Reasonably so, varying levels of residents are more mobile, so there's been a heightened level of activity." Another relative told us, "I watch everything and he seems alright. He's very secure." One female resident told us that she didn't like the men at the home.

A community professional wrote on their feedback, 'I have not witnessed unkindness or inappropriate behaviour from the staff towards the residents, but I would have no hesitation in reporting anything untoward to the manager or the owner, in the absolute confidence that it would be dealt with appropriately.' Some relatives told us they had concerns about those residents who displayed challenging behaviour, providing us with various examples.

Records demonstrated that the registered manager was able to recognise abuse and systems were in place for reporting any safeguarding concerns to the relevant authorities. However, we found that two recent safeguarding incidents had not been referred through the appropriate channels.

We looked at training records and found that safeguarding certification had expired for ten members of staff. This meant that staff who worked with the vulnerable people who lived at Rossendale were not appropriately trained in this area.

We looked at records relating to incidents of abuse within the home. We found that there had been a high number of incidents between people who used the service that had resulted in physical assaults, which was a concern.

One member of staff we spoke with told us, "I don't feel people are safe here. They are very vulnerable, because of that resident who has challenging behaviour." We made a safeguarding referral following our inspection, as we had identified concerns about the management of one particular persistent perpetrator.

During our inspection we established that the provider was appointee for two people who lived at the home, because they did not have anyone to act on their behalf. An appointee is responsible for ensuring that any benefits awarded are spent in the best interests of the individual to whom they belong.

We asked for the financial records of these people and were told that they were not kept at the home, nor were any of their personal allowance monies, but that the provider was responsible for this. We subsequently requested the records to be forwarded to us. The records we saw were poorly kept. Weekly entries of benefits, such as pensions had been recorded. However, we noted large amounts being deducted for hairdressing and chiropody. This was not shown as being paid weekly or monthly, at the time these services were provided. There were no signatures for any transactions. The column headings did not correspond with the amounts entered. For example, the column headed 'Balance' contained the weekly credits from the Department of Works and Pensions. There was no evidence that these records had been

audited, but this would have been difficult as there were no running totals or balances carried forward. There were no monies on site for these two people to access and we were told that there was no pretty cash available at the home. It was established that a joint bank account had been opened by the provider on behalf of these two individuals, which was not appropriate. We raised a safeguarding alert on behalf of these two people, who lived at the home.

We found that the provider had not safeguarded people from abuse and improper treatment. This was a breach of Regulation 13 (1)(2)(3)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there were some people who used the service with very complex needs, which not all staff were properly trained to support. Risk assessments in relation to some of these people were incomplete and their care plans did not always contain full details about certain aspects of their behaviour and the potential risks to other people. This meant that staff may not have had all the necessary information to support these people in a safe manner and those who used the service were not always protected from abuse.

During a tour of the home we observed a number of identifiable risks within the environment. These included two windows on upper floors of the home that were not restricted. We found a lock on a toilet door on the top floor of the home, which was unsafe and many doors within the home slammed shut in a manner that could have caused injury to people who used the service.

Several pieces of broken furniture were observed, which included a wardrobe that was insecure and dangerous. We did see one resident in the lounge collapse a folding card table and nearly trap his fingers. A relative shouted, "Be careful!"

In a number of communal areas, potentially hazardous items such as disposable razors, creams and various toiletries were seen to be accessible to people who used the service. We also observed a cleaning trolley containing bleach and other cleaning fluids left unattended for several minutes in one of the communal areas. In several people's bedrooms we saw that call bells were out of reach or had no leads to enable people to summon help whilst they were in bed.

Environmental risk assessments lacked sufficient detail. For example, risk assessments for loss of heating, loss of electricity and gas leaks did not include keeping people warm, alternative lighting, the provision of food, moving people away from the source of the gas leak or closing doors and opening windows. Similarly the risk assessments for loss of utility supplies or inoperable fire alarm system did not provide guidance about obtaining water supplies, the provision of personal care, and increased checks of the home.

We found the provider had failed to ensure that the environment was safe. This was a breach of Regulation 12 (1)(2) (a) (b) & (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an infection control policy and associated procedures in place, which had been reviewed in December 2015. However, we found that the procedures did not fully reflect practice within the home. We were advised by the registered manager and several staff members that they did not have access to a sluice facility on a day-to- day basis, but the procedures did not reflect this or provide guidance in how to work around this issue. In addition, the service's infection control procedures stated that all laundry staff would be provided with training in this area, but on the day of our inspection, a new staff member who had not received any infection control training was working in the laundry department.

The registered manager was the appointed lead for infection control at the service. We saw, that following concerns raised by external professionals about the cleanliness of the home, the registered manager was working with advice from a community professional with expertise in the area, to improve infection control standards.

We carried out a tour of the home and noted some areas and equipment to be visibly unclean. Some areas of the home were very dirty and were clearly in need of a deep clean. We also saw equipment, such as bed side bumpers, which were visibly stained and impossible to clean effectively, as they were ripped. An old commode chair in one room was in a very dirty condition and in need of replacing.

An infection control audit had taken place in April 2016. However, in viewing this audit we saw that it had not been carried out effectively. For example, the audit stated that all areas within the home were in a good state of repair and properly cleanable, but we saw several vanity units, which were being used by those who lived at the home, which were broken and had exposed porous chipboard, which could not be properly cleaned. Similarly, worn and rotting grout was identified on a number of bedroom sink facilities, which could not be cleaned properly.

There were cleaning schedules in place, which should have been signed off on a daily basis. However, those we viewed were only signed sporadically. The standards of cleanliness observed in some areas indicated the schedules were not being followed on a day to day basis.

Clinical waste facilities were available. However, we viewed two bathrooms where there were no clinical waste bags in place. We were also made aware of some concerns relating to the removal of clinical waste. We were advised that in recent weeks, clinical waste had been overflowing at the back of the home, but that this had now been collected. The registered manager explained that she did not have a copy of the clinical waste contract. This was subsequently sent to CQC by the provider.

The training matrix showed that not all staff had completed training in the control of infection. This meant that some staff were not appropriately trained in this area.

We found that the provider had failed to ensure that good infection control practices were being followed. This was a continued breach of Regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we looked at the personnel records of four people who had worked at Rossendale for varying periods of time. We found that safe recruitment practices designed to help protect the safety and wellbeing of people who used the service were not consistently being followed.

Providers are required to carry out a range of background checks for prospective staff members before they commence their employment. Such checks include previous employment references, employment history and photographic identification. A DBS (Disclosure and Barring Service) check is also required before commencement of employment. This enables the provider to determine if prospective employees have any criminal convictions or have been deemed unfit to work with vulnerable people. Whilst we found there was a DBS on all the staff records we viewed, we found that other information was missing.

For example, we checked the file of one staff member who was working in the home on the day of our inspection. We found there had been no references taken up for this person and no employment history was available. Two other staff members' files did not contain any photographic identification. Several files we viewed did not contain any evidence to demonstrate they had received induction training at the start of

their employment.

We found the provider had not ensured that robust recruitment practices were adopted by the home. This was a breach of Regulation 19 (1)(2)(3)&(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were advised by the local authority safeguarding team that there had recently been a number of medicine errors reported to them by the service. These had included some people who used the service being given incorrect medicines or not receiving their prescribed medicines. During our inspection we assessed the management of medicines.

The safeguarding team had agreed an improvement plan with the registered manager, which was being implemented at the time of our inspection. The registered manager was able to demonstrate that increased audits of medicines and associated records now took place and were effective in identifying any errors. Another aspect of the improvement plan was that of updating training for all staff involved in medicines administration. Records showed that all relevant staff had undertaken the training. However, the provider was still to successfully complete the course. We were advised that the provider would not be involved in medicines administration until this was addressed.

We looked at records associated with medicines administration and viewed stocks of medicines within the home. We found that most medicines, including controlled drugs, were stored in a secure and appropriate manner. However, during a tour of the home we found a number of creams and ointments stored within people's bedrooms and in some communal bathrooms.

Medicines records were found to be in general, satisfactory. All the records viewed contained a photograph of the relevant person to help reduce the risk of identification errors. Important information such as any allergies the person had was also included.

Whilst the majority of medicines administration records (MARs) were completed to a satisfactory standard we noted a small number of issues, which included hand written entries on the MARs not being witnessed or countersigned, and a small number of unexplained omissions.

Records relating to the administration of topical applications such as creams or ointments required further detail. For example, we viewed the records of one person prescribed a potent hydrocortisone cream, which stated 'use as directed'. This was also the instruction on the box of the cream. Therefore, there were no clear instructions for staff as to how and whereabouts on the person's body this should be applied.

Some people who used the service were prescribed medicines on an 'as required' basis. We found that where this was the case, there was additional information for staff about when the 'as required' medicines should be offered. This helped to ensure people received their medicines when they needed them.

When viewing records we became aware that one person had run out of an eye preparation two days earlier, which should have been administered on a daily basis. Staff had identified the issue and were taking measures to obtain new stock. However this should have been identified and dealt with before the stock ran out, so the person did not have a break in their treatment.

We were told by some relatives of incidents where medicines would have been given to the wrong person, should a family member not have intervened.

It is recommended that medicines procedures continue to be reviewed and improved in line with the NICE guidance 'Managing Medicines in Care Homes.'

Fire safety policies were in place at the home and regular fire drills were conducted within a risk management framework. Although the fire risk assessment was detailed, it was not being followed in day to day practice, as it stated, 'Corridors are kept free from apparatus and clutter.' However we saw a large locked tool box blocking part of a corridor. PEEPs (Personal Emergency Evacuation Plans) were in place, but these were very brief and lacked sufficient information. We made a recommendation that the fire risk assessment is followed in day to day practice and the PEEPs should be updated and retained in a central file for easy access to emergency services, should evacuation be needed.

Accident records were completed appropriately and were retained in accordance with data protection, so that personal information was kept in a confidential manner.

There seemed to be sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home. However, people told us that there had been shortfalls in the staffing levels, but these had recently been increased. Records showed that there was a high level of agency staff used in order to maintain the current staffing levels. We checked the duty rotas and calculated that 22 agency staff were used in a selected four week period.

When asked about staffing levels one person we spoke with said, "There's a very good ratio [of staff]." Another commented, "I think the problem is they have other things to do. They've no time to spend with the residents to do anything with them." And a third told us, "I think they [the staff] understand about de-escalation techniques. I've witnessed an altercation between two male residents and staff intervened to avoid confrontation. Three months ago I had grave concerns about reducing levels [of staff]. I felt all the residents were vulnerable particularly at night time. Then the staffing levels increased, but over the last two weeks a number of staff have left or are leaving. This affects the level of care. The manager does not create a high turn-over of staff; it is interference from the provider. The manager and staff are really trying, but they don't get enough support. "

One community professional we spoke with told us, "It is chaotic at times. The staff are always rushed off their feet. They are often short staffed and they do use a lot of agency staff. The provider is cutting costs."

Two relatives said they were concerned about staffing levels, and they commented on the use of agency staff. However, not all the relatives saw this as a problem. The registered manager advised us that staffing levels had recently been increased. This was following an exercise during which the dependency needs of all the people who used the service had been assessed and staffing levels had been determined in line with the assessments. However, this had been as a result of requests from outside agencies that had previously had concerns about staffing levels, which the provider had reduced, despite concerns from staff that this would mean the home was not safe.

Following the dependency assessments the calculated establishment hours had been consistently provided in accordance with the rotas we viewed. However, it was noted that a substantial use of agency staff had been necessary to achieve this.

People we spoke with told us they were relieved about the increase in staffing levels. However, some people expressed anxieties that the staffing levels may be decreased by the provider in the future.

Inadequate

Is the service effective?

Our findings

One relative commented, "The weekend chef is superb, they get cakes in the afternoon, but they haven't had any for a few weeks. The biscuits tend to be bland." Another told us, "She had a really bad cough. I had to ask the nurse to phone the doctor. The doctor came the next day and gave her a prescription. On the whole they get fed, watered and changed and everything's charted and the sheet (chart) is tucked behind their pillow."

We asked people we spoke with if there were many changes in the staff teams. One person who lived at the home said, "They're pretty much the same." A relative told us, "There are still some here, but the rest come and go." Another family member commented, "I like all the staff. There are no problems at all at the moment."

People told us that staff asked permission before carrying out care. A relative said, "They respect his dignity, I'm positive about the home. The manager and her staff are very caring. They explain things to him."

During the course of our inspection we 'pathway' tracked the care and support of six people who lived at Rossendale Nursing Home.

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. The application procedures for this in care homes and hospitals are 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 were being met.

On a number of care plans we viewed, there was no recorded consent to any aspect of care from the person or their legal representative. One care file stated, 'It is up to family and staff to act in service user's best interests.' However, there was no evidence available to demonstrate that best interest meetings had been held on behalf of this individual. This meant it was unclear whether the person agreed with their care plan and had consented to the care and treatment provided.

We found that the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided. This was in breach of regulation 11 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found one good example of a decision specific mental capacity assessment in relation to a person receiving their medicines covertly (hidden in food). We saw that there had been due consideration paid to the person's capacity to consent to taking their medicines and a best interest decision had been agreed. This process had included the person's family, other relevant professionals and an advocate.

Mental capacity assessments were in place on people's care plans. However, in all but one example, these were generic, which did not relate to specific decisions in accordance with legislation and good practice guidance. We found the registered manager had taken the correct steps to apply for DoLS where appropriate and was awaiting the outcome of some of these applications. However, in cases where DoLS approvals had been granted there was no reference in the plans of care in relation to restrictive practices and how these should be best managed. Staff members we spoke with did not fully understand the legal implications of the mental capacity act or associated regulations.

We have made a recommendation that Mental Capacity Assessments should be decision specific and reference should be made in care plans to any restrictive practices and how these are to be managed. This would help staff members to grasp a better understanding of the Mental Capacity Act and associated regulations.

We looked at the arrangements for oral care for one person. We found there was no information in their care plan about any support they may require for their dental health. When speaking with the person, we could see she was in need of dental care. We also found evidence that this person experienced dental pain. Her medication records showed she was written up for pain relief for dental pain. We spoke with the registered manager about the dental care of this person. We were told that the individual's daughter had said she was resistive to dental care. However, there was no evidence available to show that avenues had been explored since admission two years previously or that best interest decision meetings had been held. We referred this matter to the local authority safeguarding team.

We found that the provider had not always ensured that risks to people's health and safety whilst receiving care and treatment had been assessed and had not always done everything reasonably practicable to mitigate such risks. This was in breach of regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we assessed the management of meals. We received mixed comments about the quality of food served. These included: "It's alright"; "I don't like it"; "Its good food" and "I'm a vegetarian and there's always something to eat."

We established that the menus were decided by the manager of the home and a member of kitchen staff. There was no evidence available to demonstrate that these were developed with the input of the people who lived at the home. The chef was not aware of the budget and he did not have a list of people's food preferences.

One relative gave us an example where an alternative pureed died had been provided, because soup was not available. We saw people being served a pureed lunch. This was all mixed up together and no-one knew what it was, so we asked the chef. This did not enable people to enjoy the different flavours of food served and did not offer those needing pureed meals the same opportunities, as those receiving normal diets.

Another visitor told us that on one recent occasion a visitor had eaten breakfast at 11am followed by lunch at 12md. A relative told us, "He eats all the food and if he doesn't like it he'll tell them [the staff] and they'll change it."

Another person was sitting at a dining table alone eating his lunch. He was struggling, as the sweet bowl was moving around the table whilst he tried to get some food on his spoon. This may have been prevented by use of a none-slip place mat or the assistance from staff. A member of staff was sitting at the next table, but did not react to this situation. An inspector went to help, but the sweet bowl fell off the table and on to the floor. A member of staff picked the half full bowl up and removed it. The individual was not offered any more sweet.

We observed care workers sitting on the arms of people's chairs, whilst assisting them with their lunches. We saw another member of staff assisting one person to eat whilst standing over them. This was not very dignified or person centred. One person's lunch was left in front of her and covered over for ten minutes before someone went to remove the cover. This individual was shouting, "I want my dinner" over and over again. Some care staff were chatting pleasantly with people whilst assisting them with their lunch. However, one did not speak to the person they were assisting throughout the activity.

We found that the provider had not always ensured that people's nutritional needs were being met. This was in breach of regulation 14 (1)(2)(a)(b) (4)(a)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutritional risk assessments were in place in all the care plans we viewed. These assessments were designed to identify those at risk of poor nutrition or de-hydration and included measures to help maintain people's safety.

We viewed the plan of one person who has lost a significant amount of weight during a long hospital stay. We saw that staff had identified this issue on their return to the home and had taken steps to support them effectively. The person had started to gain weight as a result.

We viewed the care plan of another person who was identified as high risk of poor nutrition. We saw that amongst other measures, this person's weight was monitored on a weekly basis to ensure it remained stable.

We saw that people could have whatever they wanted for breakfast and some chose to have bacon, sausage, beans and eggs. Breakfast was served whenever people wanted it. However, lunch was served at 12:00 and tea, which was the cooked meal was served between 16:00 and 16:30. The chef wasn't aware of any residents having food allergies. Fresh fruit was available, but it was kept in the larder and people had to request a piece of fresh fruit, if they wanted one.

We did observe one person being offered an alternative lunch option, as he refused the menu selection. A family member told us, "[Name removed] does have a good appetite. There were issues raised at lunchtime, as the sandwiches weren't sufficient. I don't think he got a choice [of filling]. They [the staff] selected them for him. There's no choice at teatime." However, one of the inspection team ate lunch with those in the dining room, where there were plenty of sandwiches of both brown and white bread available, with a choice of three different fillings and people were asked which ones they would prefer.

We noted that some bedrooms were individualised with personal property and we established that new flooring had been laid in all bedrooms, with the exception of two, which were to be completed very soon after our visit. However, during a tour of the building we found some areas to be in need of improvement. Parts of the home were shabby and in need of upgrading and modernising. We noted in some people's bedrooms, broken furniture and ill-fitting curtains that did not close properly.

Furniture such as chairs were in some cases seen to be in very poor condition and we saw several chests of drawers missing handles and in a poor state. In the top floor bathroom, old broken chairs were stored making this a very unpleasant environment. A number of people's bedrooms did not have their name on the doors or anything to help them recognise their own room.

In several bedrooms we found that call bells were not in reach due to their position in accordance with the positioning of the person's bed.

We found that the provider had failed to ensure people who used the service had access to comfortable, well maintained accommodation. This was a breach of Regulation 15(1) (c)(e) of the Health and Social Care Act (Regulated Activities) 2008 Regulations 2014.

We viewed rotas to assess staffing levels and the skill mix of staff. We found that there had been a significant amount of agency staff used in recent months. In one four week period we calculated a total of 22 agency staff, who had worked shifts at the home. We discussed this with the registered manager who acknowledged the high use of agency staff. This could result in a lack of consistency and those who used the service receiving their care from staff who did not understand people's needs well. One relative told us, "There's generally three agency staff on during the day."

Some people who used the service had some complex needs that could be a risk to themselves, people providing care and other people who used the service. We found that not all staff who worked at the home had received training in supporting people with this level of need.

We found that the provider had not always ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. This was a breach of Regulation 18(1) (2)(a) of the Health and Social Care Act (Regulated Activities) 2008 Regulations 2014.

The care plans we viewed contained some information about people's health care needs. In several we found Hospital Passports designed to ensure important information could be passed over to hospital staff in the event of a person's admission to hospital.

Some examples were found of close joint working with professionals, such as workers from the Community Mental Health Team and GPs. One visiting community professional wrote on their feedback, 'In the past I have found the manager and nurse, who I have mainly dealt with to be approachable and to listen to suggestions. Often however the staff want someone's behaviour 'fixing.' This leads to a very medication orientated approach with token consideration of other (non-drug) strategies. The environment is noisy and is likely to contribute to increased agitation in this client group. Further, the layout of the building isn't particularly conducive to best management of people with behaviour that challenges. Over the last six months there appears to have been a significant increase in staff turnover. The home has on occasion appeared under-staffed. Previously I have been called in on an urgent basis but have been given completely different narratives with regards to someone's presentation; resulting in the need for subsequent visits.'

Everyone we spoke with said the staff understood the needs of the residents well and nobody had any concerns about the competence of the staff team. Relatives of those who lacked capacity said they were involved in the decision making process.

One community professional wrote on their feedback, 'Staff are always willing to assist me when a resident might need extra reassurance. I have witnessed the more experienced staff encourage newer members of the team when they are in the early stages of their training.'

Requires Improvement

Is the service caring?

Our findings

One relative we spoke with stated, "I realise there are issues, but the care we have seen the residents get in this home is second to none. I cannot rate the permanent staff well enough. They are wonderful. The staff are doing as much as they can over and beyond, to meet Dad's needs, but I am frustrated that the system in general is not reacting fast enough to meet his needs."

People told us that staff asked permission before carrying out care. Another relative said, "They respect his dignity, I'm positive about the home. The manager and her staff are very caring. They explain things to him."

We asked those who lived at the home how the staff treated them and if they were kind. The responses we received included: "They're [the staff] alright. They're not cruel"; "They're quite good. We get well looked after." And "First class. They are kind."

Relatives we spoke with told us, "The care's magnificent", "They're [the staff] really nice and they listen. They work hard and try their best under very difficult circumstances" and "I consider them to be very caring. They try to keep spirits up, but morale's been very low."

When asked about choices, one relative commented, "[Name removed] is just brought into this lounge. Sometimes she's in the conservatory, but there are no chairs for visitors in there." Another relative told us, "He's placed wherever staff put him. I noticed as I went into the two lounges and the conservatory throughout the day, there were very little staff there. I walked through the dining room after lunch and there was a care worker perched against a table listening to the radio. I didn't see staff interacting with residents unless they were doing something for them."

The plans of care we saw incorporated the importance of respecting people's privacy and dignity, particularly during the provision of personal care. We observed people receiving support throughout the day. We saw that staff interacted with people in a pleasant and kind manner and approached them with dignity and respect. However, we saw some opportunities for meaningful interaction were missed. For example, one care worker was observed assisting someone to eat their meal on a one to one basis, but they did not attempt to talk with the person throughout the time they were assisting them.

We observed another person who appeared to be anxious about ensuring windows and doors were secure. They spent much time checking on this. Most staff attempted to discourage this person, which was not reassuring the individual. However, on one occasion a member of the nursing team was seen to engage with the person in a more positive way. Rather than discourage the person the nurse spent some time checking doors and windows with him and reassuring him whilst doing so.
Another person was seen to be engaged with moving some chairs about the home. Again, staff constantly discouraged the person, rather than spend time with them supporting them to engage in the activity safely.

There was one person shouting "help" at regular intervals throughout the day. When we mentioned this to a staff member we were told, "She's always doing that." We did not see any staff members attempting to

comfort her. We saw one gentleman, who was getting agitated and appeared to need the toilet, but no staff members noted this, so we brought it to the attention of a member of staff, who assisted him to the toilet. He was much more settled on his return.

We asked relatives if staff were discreet when discussing care with them. One said, "They [the staff] don't take you away. They just say it where you are" and another told us, "It can be either, private or public."

We asked visitors if they were made welcome to the home by staff. One said, "Not at mealtimes", another told us, "To a certain extent. We've had the door shut in our faces a few times. We've been told we can't come in at 13:20; we have to wait until 13.30. We can't visit in the evenings. You are expected to tell them you are visiting. If I come early, I am told that I have to come back. I don't drive, I walk here." And "There are restrictions during mealtimes; I have been given permission to attend at teatime." We found this arrangement to lack a person centred approach. However, the provider subsequently told us that relatives are advised that mealtimes are protected and therefore there may be a delay in the door being answered, but that visitors are not refused access to the home.

One person was given a bowl of ice cream. There was no clothes protection provided. The individual was spilling the ice cream down his clothes and wheelchair and scooping it back up off his clothing. Assistance from staff was not provided. This was undignified and there was no way of knowing if this person had eaten sufficient at that meal time.

During a tour of the home we noted in the majority of people's bedrooms, large written notices on the walls. These were very noticeable due to their size and the fact they were written in multi coloured marker pens. The signs contained information about the occupant, which in some cases was very personal. For example, information about their continence needs and eating abilities. These were also displayed in the shared bedrooms. We also saw one sign that referred to giving one person a 'dolly'. The nature of this information and the way it was displayed did not support people's privacy or dignity.

We viewed a selection of shared rooms. In one shared room we noted the absence of a privacy screen. We spoke with a staff member who was unsure why there was no screen in the bedroom. One was later brought and we were told it had been removed for cleaning. However, it was of concern that a privacy screen had not been readily available.

A community professional we spoke with expressed concerns with us about a situation whereby the provider had given notice for one person who had lived at the home for many years, to leave. We established that this was accurate information. When we looked into the situation it was apparent that the needs of the person were being adequately met. The community professional advised us that the decision to request the person leave the home was purely financial and that the provider had stated the person was not 'financially viable.' We were also concerned to learn that no discussions had taken place with the family of the person in question.

We found that the provider had not always ensured that people were treated with dignity and respect. This was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with were complimentary about the care staff and felt they did a good job. However, some relatives commented that there was no time for staff to sit and interact with the residents, although people felt that their loved ones were treated with dignity and respect. People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf

of those needing support to make decisions.

One community professional wrote on their feedback, 'I can only comment on what I see and hear on my visits, but it always seems that residents are treated with respect and humanity. The staff talk to them, make little jokes, encourage them to enjoy a biscuit or treat with their tea or coffee. The atmosphere feels upbeat and I enjoy my visits. I have witnessed people enjoying carol singing and royal wedding parties, as well as the day to day routine. People's wishes are respected. The residents always look well cared for. The staff know them well and treat each person as the individual they are.'

Requires Improvement

Is the service responsive?

Our findings

When asked about making complaints, one relative we spoke with told us, "I can approach her [the manager] and discuss things; whether it would be dealt with is a different matter. Sometimes I get excuses to genuine concerns; she can pass it on but it wouldn't be dealt with." Another said, "We've had a few meetings. Sometimes things change for a while and then it slips back again." Another said, "Definitely [able to raise concerns]. I've got a good relationship with the manager and staff. She listens and has an open door policy." And a third commented, "Yes I'd see [name removed] right away. They're very helpful." However, one person who lived at the home told us, "If it's to do with the home, I think it's better not to [complain]." People we spoke with told us they thought the registered manager would do her best to address any concerns raised.

We asked people how they spent their time. One person told us, "I colour, crayon and paint." We did see this person enjoying this activity. She helped herself to the things she needed. Another resident said, "You just do what you want". And a third commented, "I watch a lot of television. I'm not really bored. The thing that keeps me going is that I'll be going home shortly."

We were advised by a number of people that the activities coordinator had been removed from their role and was now working in a different role. We were advised that this decision had been made by the provider on the basis of finances. People expressed concerns about this role no longer being filled. One staff member commented, "I think there will be more incidents between residents because people won't be occupied." Some of the relatives we spoke with were concerned about the lack of activities.

Relatives described activities in the following ways, "Nothing; whenever I come this is it; sitting in a chair. They love the musical entertainment, but it's only every three months; there's no stimulation." And, "Just sitting. I've raised that there weren't any activities. Music for health comes in once a month and the entertainer comes in every three months, that's funded through raffles etc. The CQC recommended an activity coordinator, but it doesn't exist. The staff don't have time to sit with residents or play games with them. The activity coordinator was finished after a month; she didn't have anything to work with." However, another relative said, "In the conservatory they have loads of activities, but he's not an activity person."

At the time of our inspection people who were in the communal areas of the home were just sitting there with no stimulation. In the afternoon one person sitting in the conservatory was holding a cuddly toy.

We have made a recommendation that activities are provided in accordance with people's wishes and interests.

During the course of our inspection we 'pathway' tracked the care of six people who lived at Rossendale Nursing Home.

The care plans we viewed contained evidence that a pre-admission assessment had been carried out prior to a person being offered a place at the home and relatives we spoke with confirmed this information was

accurate. However, in one case we found that the information about one person's complex behavioural needs was not clear and that risks associated with their behaviour had not been fully considered when making a decision to admit them. The registered manager advised us she had not been given the full facts when carrying out this pre-admission assessment.

We pathway tracked the care of this person. We saw there were a high number of incidents involving the person, which had impacted on other people who used the service. The service had rightly raised safeguarding alerts and attempted to involve other professionals in the person's care.

However, the person's high risk behaviours were not fully described or risk assessed in their care plan. There was some limited information for staff about strategies to support the person in challenging circumstances, but these required more detail. We observed staff at times having difficulty when supporting this person. We raised concerns about this person's care with the local authority safeguarding team.

We viewed the care plan of another person. We saw from reading their daily records that they had sometimes grabbed, scratched and bitten staff during personal care interventions. There was no reference to this behaviour in their care plan. No risk assessments had been completed and there was no guidance for staff about how to maintain safety for the individual or the staff team. Risk assessments seen lacked information and guidance for staff about how identified risks should be managed.

Further gaps in care plans were found. In some examples, large parts of people's social histories were not completed. For one person there was no information about their preferred activities and hobbies, even though external professionals had advised this was an important part of their care. However, we did see one example where there was a good level of information about the person's history and a one page profile detailing their likes, dislikes and preferred daily routines. For example, which programmes they liked to watch on television and which gender of care worker they would prefer to assist them. However, the plans of care often lacked specific details. For example, the care plan for one person under 'Eating and drinking' stated, '[Name removed] needs supervision and assistance', but there was no explanation of how this support should be provided. This person was at very high risk of developing pressure wounds. However, the plan of care did not include any guidance for staff in relation to positional changes or specific pressure relieving equipment needed. It just stated, 'Apply cream, as prescribed to skin', but which cream and the area of the body were not recorded. Another entry stated, '[Name removed] has problems with continence' and 'Maintain hydration', but there was no guidance available for staff to show how these areas should be managed.

We found the registered person had not always ensured that the plans of care had been designed to reflect individual needs. This was in breach of regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked relatives if they were given the opportunity to be involved in their loved ones' care plan reviews. One told us this was done every month, whilst another said the reviews were done 'now and again' and this person added, "They'll [the staff] show me what they've done. I have to sign it and give it back, but nothing is discussed." Another commented, "I haven't been involved previously, but I'm going to be now. It's the first one I'm going to attend; I asked the manager yesterday. The best interest lady said the care plan had been revised and I wasn't aware of it. I feel his needs have changed and want to discuss this with the manager." We noted that most of the care records we saw outlined people's likes, dislikes and preferences.

People we spoke with said they felt they could raise concerns, if they needed to do so and relatives told us they would be comfortable in making a complaint and thought it would be acted upon.

We saw there was a complaints procedure in place which provided contact details of various agencies included the Care Quality Commission and local authority. In discussion we were advised this procedure was only available in a standard format.

There was a record of the complaints received and action taken as a result. In general, the records were clear and we saw the registered manager had responded in a positive manner to complaints raised. Where relevant the registered manager had outlined to the complainant, any lessons learned and what action they intended to take as a result which was considered to be good practice. However, there was one complaint recorded which did not include any clear actions and the outcome of the complaint was not clear. This was a complaint which had been made to the provider in the registered manager's absence.

We recommended that the registered manager ensures all complaints are recorded and considers other formats such as large print so that the complaints procedure is more accessible.

Inadequate

Is the service well-led?

Our findings

We asked visitors about the frequency of residents' and relatives' meetings. We were told: "Occasionally, but there isn't much information given to you about when they are. There are no facilities for people who work, as they are in the afternoons and we don't get any feedback from them"; "Yes about every two months. I raise concerns, but things don't always change. I feel there's no investment in bricks and mortar. The tables the residents have to use are not fit for purpose. Last week a table collapsed and the plate of food went on the floor. Some table tops come off. One fell on my foot. Other tables have swivel tops and tip up when pressure is put on." And, "I've been twice [to meetings]. They listen, but there's no change. Everything's alright."

We asked relatives if they could express their views and if they were kept up to date about developments in the home. Comments we received included: "No"; "Occasionally they do surveys"; "Yes, but they've not consulted us about activities or menus. I've raised issues about the standard of food on three or four occasions"; "I wouldn't say so. Last week the owner painted the toilet doors red. We weren't advised about it. Three toilets weren't usable and some residents were covered in paint." And, "Yes, about a lot of agency staff."

The relatives we spoke with were complimentary about the registered manager, describing her as approachable and they told us that she had a visible presence within the home. One relative said the manager had discussed the last Care Quality Commission report at a meeting. Staff members we spoke with described a feeling of low morale at the home. We were told that there had recently been some changes to working terms and conditions that some staff members felt were unfair. In addition, some staff spoken with felt dissatisfied with the arrangements for training.

Although people described the registered manager as very supportive, several people we spoke with including staff members, relatives and community professionals, commented they did not find the provider to be supportive.

The service had been subject to a local authority Quality Improvement Programme (QIP) in the weeks prior to the inspection. A community professional told us she felt the provider had not engaged well with the QIP. They went on to tell us that action plans for improvement submitted by the provider had been haphazard and that the provider had failed to implement recommendations. One professional said, "The provider has a distinct lack of understanding of regulations and her role in monitoring safety and quality." New admissions to this home have been suspended through the QIP process, until significant improvements have been made.

External professionals involved in the QIP process had identified that the registered manager required some support and had recommended the provider appoint a deputy manager. However this had not been actioned and the registered manager was not aware of any plans to appoint a deputy manager in the foreseeable future.

One community professional wrote on their feedback, 'There are staff members who have worked at Rossendale for a long time; they seem to work well as a team and they make me feel part of that team.' Another wrote, 'When it comes to leadership, I am always confident that the manager and the nurse in charge know exactly the health and well-being status of the residents. They will contact me outside routine visits if a resident has a problem, so that it can be addressed as soon as possible.'
Some staff we spoke with told us they did not always feel listened to. One described a recent occasion when staffing levels had been cut by the provider, despite staff expressing concerns that this would result in an unsafe service. The decision was later reversed following the intervention of community professionals, but not as a result of the concerns raised.

A relative we spoke with told us they had recently attended a relative's meeting during which the provider was due to attend and address people's concerns. We were told that during the meeting relatives had put their concerns to the provider, but did not receive answers, as the provider left the meeting to take a phone call and did not return.

We were told by several people that some toilet doors had recently been painted red, for easy recognition, in line with dementia care environments guidance. However, this work was carried out during the day, when people who were living with dementia had access to these areas. This resulted in several people getting red paint on their clothing and on their skin. This could have been organised in a better way.

The care workers did not seem to have any direction from senior staff members. It was evident that staff morale was very low and that the registered manager and registered provider were having difficulty in working together in order to drive standards at the home up and therefore the home was not well-led.

The provider compiled reports following her visits to the home. However, the quality of these was very poor and provided very little information. For example, the most recent report six months earlier showed that three people were interviewed. The summary of their views on the quality of care simply stated, 'Happy'. The number of relatives interviewed was shown as two and their views simply stated, 'No concerns.' However most of the form was blank with pre-set questions being unanswered. The previous report was a little more detailed, but still lacked significant information and no action plan had been generated from the concerns raised by relatives.

We saw there were a range of written policies and procedures within the home such as, health and safety, whistleblowing, safeguarding adults, infection control, and discipline and grievance. However, these were not being followed in day to day practice. The registered manager had not always forwarded the required notifications to CQC, as and when required.

Records showed that the registered manager conducted regular tours of the building, in order to identify any maintenance work needed. However, these had not picked up some of the shortfalls we identified during our inspection.

During the inspection we identified a number of breaches of regulations including several relating to the health and safety of people who used the service. We noted that many of these issues had not been identified by the registered manager or provider. This demonstrated that the systems for monitoring safety and quality across the service were not effective.

Records showed that not all systems within the home had been appropriately serviced, in accordance with the manufacturers' recommendations. Therefore, there was no guarantee that the electrical installation and gas boiler were fit for use. There was no electrical installation certificate available, which was a continuous

breach of regulation and the gas safety certificate had expired three months previously.

We found the registered person had not implemented effective systems to assess, monitor and improve the quality and safety of the services provided This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that surveys for those who lived at the home and their relatives had been conducted during the year prior to our inspection. This helped the management team to seek people's views about various aspects of life at Rossendale Nursing Home. Most responses we saw were positive.

Records showed that residents and relatives meetings were held. This allowed people the opportunity to discuss various topics in an open forum, should they wish to do so. We saw the minutes of several of these meetings.

Meetings were held for the staff team, so that any important information could be disseminated throughout the workforce. This enabled those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes. We saw that in one of these meetings staffing levels were discussed and how an increase in staff was having financial implications for the business.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found the registered person had not always ensured that the plans of care had been designed to reflect individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found that the provider had not always ensured that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent We found that the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found the provider had failed to ensure that the environment was safe. We found that the provider had not always ensured that risks to people's health and safety whilst receiving care and treatment had been assessed and had not always done everything

reasonable practicable to mitigate such risks.

We found that the provider had failed to ensure that good infection control practices were being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the provider had not safeguarded people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found that the provider had not always ensured that people's nutritional needs were being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We found that the provider had failed to ensure people who used the service had access to comfortable, well maintained accommodation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found the registered person had not implemented effective systems to assess, monitor and improve the quality and safety of the services provided

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Diagnostic and screening procedures Treatment of disease, disorder or injury	We found the provider had not ensured that robust recruitment practices were adopted by the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the provider had not always ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.