Theresa Andrews

Ashley Manor Nursing Home - Southampton

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 10, 11 and 12 August 2015 and was unannounced.

Ashley Manor Nursing Home provides accommodation and nursing care for up to 45 older people. The home is in a rural location near Shedfield, and provides accommodation on three floors.

Ashley Manor Nursing Home had a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 16 September 2014, we asked the provider to take action to make improvements in

Summary of findings

respect of improving staffing levels, especially at night, carrying out quality monitoring checks and improving the quality of medical records and care plans. The provider submitted an action plan which stated that the home would be compliant by December 2014. We found that the provider had not carried out the required improvements.

The service placed people at risk due to the unsafe storage, handling and administration of medicines. Medicines Administration Records (MAR) charts were handwritten by the nurses and did not comply with National Institute for Clinical Excellence (NICE) Guidance. The provider could not be assured that the correct medicines for each person had been supplied.

Medicines were not stored safely. Controlled drugs were not kept safely. Controlled medicines have the potential for misuse and are therefore subject to the Misuse of Drugs Act 1971. The storage of these medicines did not comply with the Misuse of Drugs Act 1971. Medicines were not disposed of safely. We found medicines for disposal in open plastic baskets under the sink. There was a risk that people or staff could access these medicines inappropriately.

There were no guidelines in place explaining how people should receive medicines which were needed 'as required.' This meant there was a risk that people would not receive pain relief when they needed it.

Risks associated with people's care were not appropriately addressed and risk assessments were not in place for all known risks, to explain how the risk could be mitigated. People were at risk of unsafe care.

There were not sufficient numbers of staff to keep people safe and meet their needs and the provider had not complied with previous CQC requirements in respect of increasing staffing numbers. People waited for long periods of time for their call bells to be answered.

The use of agency staff was not safe. The registered manager did not know who would be sent from the agency and therefore there was no opportunity to check the person's training and experience to determine if they suitable prior to working in the home, or to ensure that the skills of the staff on duty were balanced in terms of meeting people's needs.

People living in the home told us they felt safe and staff showed an appropriate understanding of safeguarding and when they would report concerns. However, inappropriate treatment of a whistle blower meant that staff were afraid to raise concerns.

People were not protected by the prevention and control of infection. There were not enough housekeeping staff to keep the home clean and we observed that areas of the home, especially the kitchen were not clean. Commode bowls were not decontaminated effectively and some commodes were un-cleanable due to rust.

People's food and fluid charts were inadequate and an ineffective tool to appropriately monitor people's nutritional and fluid intake. Daily fluid charts showed that people were consistently drinking less than the 1000 – 1500ml identified as policy by the home. People were at risk of dehydration. The provider could not be assured that people were eating and drinking sufficient amounts to meet their needs. People's needs in relation diet and weight loss were not met. Care plans were not in place to address the people's weight loss.

Mealtimes were not a positive experience for people. We observed people were not treated with dignity and respect. Not everyone had a drink, unless they asked for one and spoons had not been laid for pudding. Once pudding had been served all the staff disappeared to have their break. People who wanted to be supported to use the toilet after lunch, had to wait until staff had had their break.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Where a person's capacity to make a specific decision is in doubt, a mental capacity assessment should be carried out. Mental capacity assessments were not appropriately carried out and no best interest decisions were recorded. Records showed the provider had no understanding of the principles of the MCA.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect

Summary of findings

the person from harm. We found that the registered manager did not understand when an application should be made and was not aware of a Supreme Court Judgement which widened and clarified the definition of the deprivation of liberty. This meant there was a risk that people were being illegally detained against their wishes.

Staff had not received sufficient training to meet people's needs. More than half the current permanent staff team had not received training in moving and handling, first aid, infection control and food hygiene. Nurses had not received medicine administration training and no competency checks were carried out. Not all staff received regular supervision meetings and appraisals to ensure they were adequately supported in their role. Staff were not adequately supported to carry out the duties they were employed to perform.

Healthcare professionals visited the home regularly. A local GP visited the home twice weekly in order to treat anyone who was unwell. It was not clear whether other community professionals such as a tissue viability nurse, diabetic nurse or mental health professional visited the home.

The home was not well maintained and not appropriate for people living with dementia. Colours were bland throughout, room numbers were nearly indistinguishable being in small black lettering on a dark blue plastic plate. There was nothing to distinguish one bedroom from another or bathrooms and toilets from other rooms. This would have made it difficult for people with dementia to navigate around the home.

The concept of person centred care was not evident in this home. Although we did observe some kindly treatment of people which was well meant, overall the care was institutionalised and representative of old fashioned and out dated practices. People were not treated with respect and dignity.

People were not offered choice. There was no choice of when to eat breakfast or what to eat for lunch. Some people made choices which were not respected.

Independence was not always supported in the home with two people reporting a loss of mobility due to a lack of support to regularly mobilise. Some relatives were happy with the care provided.

People did not receive personalised care which was responsive to their needs. Care plans were inaccurate, incomplete, unsafe and by room number demonstrating a complete lack of understanding of individualised person centred care. People's care and support needs were not met.

Handover procedures were inadequate to enable staff to appropriately meet people's needs. There was no information about who needed support to eat and drink and people's repositioning requirements, for those being nursed in bed, in order to prevent pressure ulcers. Information about the severity and complexity of people's illnesses was missing and there was no information about people's wounds and how they should be treated or their continence needs. There was no information about who was being treated for an infection or of people's dietary requirements. There was a lack of communication and guidance about anyone's care needs and therefore it was not possible for care staff to accurately meet people's needs.

People's social needs were not met. There was no evidence of any activities or social interaction in people's care plans. There was an activities plan on the wall in the hall but there were many days with no planned activities and none at the time of the inspection.

The provider did not promote a positive culture that was person-centred, open, inclusive and empowering. Due to the actions taken by the registered manager in pursuit of a whistle blower, staff felt afraid to raise any concerns. It was evident that the registered manager found it difficult to balance the demands of the provider with the needs of the staff.

Everyone we spoke with said they either never or hardly ever saw the registered manager even by request. The lack of input from the provider and the lack of availability of the registered manager meant there was no visible leadership in the home.

There was no system of quality monitoring in the home. The provider had not carried out any audits checking the overall quality of the service provided and ensuring that appropriate improvements were made. The registered manager provided monthly reports to the provider. These reports evidenced that the registered manager had been

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making urgent requests for improvement since October 2014. The provider had taken no action. The lack of responsiveness of the provider meant people's safety was put at risk.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking further action in relation to this provider and will report on this when it's completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not stored, handled or administered safely.

People told us they felt safe although risk assessments were not accurate and did not include all known risks.

There were not enough staff on duty at all times to meet people's needs and this impacted on the care they received.

The home was dirty, and the lack of some key equipment represented an infection control risk.

Is the service effective?

Inadequate

The service was not effective.

People's food and fluid intake was not monitored to ensure people had sufficient fluid and dietary intake to meet their needs.

Staff had not received sufficient training to meet people's needs.

A local GP visited the home regularly. It was not clear whether other community professionals such as a tissue viability nurse, diabetic nurse or mental health professional visited the home.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 in obtaining valid consent and appropriate DoLS applications had not been made.

Is the service caring?

Inadequate

The service was not caring. Some kindly treatment of people was observed, however overall the care was institutionalised i.e the same for everyone rather than personalised.

People were not treated with dignity and respect.

People were not offered choice.

Independence was not encouraged or supported.

Is the service responsive?

Inadequate

The service was not responsive. People's individual needs were not met because the service had not responded appropriately to people's individual needs providing personalised care plans in response to identified risks and conditions.

A lack of meaningful activities meant that people were at risk of social isolation.

The service did not respond appropriately to concerns raised by relatives and people living in the home.

Is the service well-led?

Inadequate

The home was not well led. The provider did not promote a positive culture.

Summary of findings

The lack of input from the provider and the lack of availability of the registered manager meant there was no visible leadership in the home.

The provider and the registered manager did not demonstrate that they understood their legal responsibility to keep people safe.

There was no effective system of quality monitoring in place.

Ashley Manor Nursing Home - Southampton

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

This inspection took place on 10, 11 and 12 August 2015 and was unannounced. The inspection was carried out by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. Our specialist advisor was a specialist in the care of frail older people living with dementia.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service.

During our inspection we spoke with 11 people using the service and five people's relatives. We also spoke with the registered manager, two nurses, six care workers, two housekeeping staff, two chefs and the activities co-ordinator. We reviewed records relating to twelve people's care and support such as their care plans and risk assessments. Additionally medicines administration records for every person living in the home were reviewed and 21 people's daily care records.

Not all people were unable to tell us about their experiences due to their complex needs, therefore we used other methods to help us understand their experiences, including observation of their care and support.

Inadequate

Is the service safe?

Our findings

The service placed people at risk because they did not store, handle or administer people's medicines safely. Medicines Administration Records (MAR) charts were handwritten by the nurses using people's previous MAR and their medicines as supplied from the pharmacy. The pharmacy was within a GP surgery and the prescriptions went straight from the GP to the pharmacy. This meant that MAR charts were written without the provider having sight of the original prescription to check that the medicines that had been dispensed were those that had been prescribed. The home could not be assured that the correct medicines for each person had been supplied. National Institute for Clinical Excellence (NICE) Guidance (NICE, 2014) 1:11:13 states that 'Supplying pharmacies should produce MARs whenever possible and that care home providers should ensure a new hand written MAR is produced only in exceptional circumstances.' We saw that all MAR charts were hand written by nurses in the home. These should have been checked by two nurses in order to comply with NICE guidance. Medicine administration records were not safe because the provider could not be sure they were accurate or complete and did not comply with NICE guidance.

In addition, people's MAR charts did not include the quantity of medicines for a particular person. This meant it was not possible for the provider to accurately record stocks of medicines held for people. We found evidence of this in cupboards in the medicines room. Two cupboards were completely full; this stock was held in addition to stock held in medicines trolleys. Overstocking can lead to a deterioration or expiry of shelf life of the medicines held.

Medicines were not stored safely. In a cupboard, we found an unlabelled controlled medicine and other unlabelled strong sedatives in a plastic box. Controlled medicines have the potential for misuse and are therefore subject to the Misuse of Drugs Act 1971. The storage of these medicines did not comply with the Misuse of Drugs Act 1971 and they were removed from the premises by police officers on 11 August 2015. Other medicines which were removed by police included unlabelled packs of dispensed medicines and controlled drugs which had belonged to people who had passed away. These medicines were not stored safely.

Medicines were not disposed of safely. We found medicines for disposal in open plastic baskets under the sink. These medicines should have been kept in a tamper proof container whilst awaiting disposal. There was a risk that people or staff could access these medicines.

Medicines were not administered safely. We found seven people's MAR charts did not include a photograph of the person. Other people's photographs were black and white, grainy and of poor quality. It would have been difficult for anyone who didn't know the person, such as agency staff, to recognise the person from the photograph as a check to ensure they were administering medicines to the right person. We found gaps in MAR charts where medicine had not been given. One person was taking medicine in relation to their Parkinson's disease. This medicine is time critical, as it controls the symptoms of Parkinson's, and the person may have experienced increased symptoms due to the omission. Two other people were taking medicines which lowered their heart rate. A risk of this is that it can lower the person's heart rate to an unsafe extent and therefore nurses need to measure the person's pulse before the medicine is administered. One person did not have their pulse rate recorded. Therefore, nurses would not have known if it was safe to administer the medicine.

Some people needed their medicine 'as required' known as PRN medicine. There were no PRN care plans or protocols in place to provide staff with written guidance about how to determine whether the person needed PRN medicine, the reason it should be given, what the medicine should do and what to do if it were not effective. People with a cognitive impairment may not be able to express pain, but there were no pain assessments in place which would assist staff in determining if the person was in pain, and therefore in need of PRN pain relief. Some people were prescribed paracetamol and cocodamol as PRN medicines. These medicines both contain paracetamol but there were no controls in place to ensure these two medicines were not administered closely together.

The unsafe storage, administration and disposal of medicines were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Care plans included risk assessment tools to assess people's individual risks such as the risk of malnutrition. However it was not clear that all identified risks were being addressed and that assessments were regularly reviewed

and updated in relation to people's changing needs. Some risks to people had not been addressed. People at risk of choking, did not have a risk assessments in place to mitigate the identified risk. Some people had a history of urinary tract infections (UTI) which meant they were at risk of repeated infections. There was no risk assessment in relation to this. There were no risk assessments in relation to the use of bed rails which were in use in the home for home some people. One person had had a recent fall but their falls risk assessment had not been updated. The provider was unable to demonstrate that they had identified and addressed all known risks in relation to people living in the home.

The failure to identify and mitigate risks to people was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

The provider had not complied with previous CQC requirements in respect of staffing. During our inspection on 16 September 2014, we identified there was a short fall of nurses working the night shift. In response the provider told us that they would increase nurses on night duty from one to two. However, 11 months later evidence shows that only one nurse worked a night duty between September 2014 and August 2015. This was a continuing breach of this regulation.

There were not sufficient numbers of staff to keep people safe and meet their needs. The provider had used 'Staffing guideline for Nursing Homes Version 1.5 17/06/2009' as a resource to calculate staffing numbers. However the provider has not followed the guideline when allocating staff. The guideline says three nurses and five care workers should work a morning shift, whereas in Ashley Manor Nursing Home two nurses and nine care workers worked the morning shift. For a night shift the guideline states that two nurses and two care workers should be on duty, however at Ashley Manor Nursing Home one nurse and three workers were on duty at night. For both day and night shift this appears to be in excess of the guidance however that guidance also states that the ratio of nurses to people should be 35%. The provider diluted this ratio with only 18% nurses to people on a morning shift and 25% nurses to people on a night shift. The reduction in the use of qualified staff had a direct impact on people's care affecting their quality of life. There was a lack of risk assessments, care planning and medicines management, which were the responsibility of nursing staff.

There were not enough staff on duty to meet people's needs. During our inspection, call bells were heard to be ringing constantly. The registered manager told us that the target for staff to answer call bells was five minutes. Call bell print outs showed that in the course of just one day this target had been exceeded 19 times with waiting times for people recorded at between seven and 24 minutes, most people waited about 13 minutes. People told us that they waited a long time for call bells to be answered. One person said "Bells go on for a very long time before you get assistance. Three weeks ago, I cut my arm; it was bleeding, so I rang the bell to get a dressing. I waited 25 minutes, then I went to find someone. The other day the lady in the next room had been ringing for half an hour, so I went to look for someone for her – I looked all around the ground floor, it was deserted. I went to the offices and the lounge, I called out – nothing. I couldn't find anyone." Another person told us, when asked about call bell response times "It depends on the time of day, but usually you have to wait – when you need the loo, it's very difficult." Most people we spoke with were unhappy with call bells response times.

The call bell response time was made slower by the allocation of pairs of staff to certain room numbers to provide people's care. Staff only answered call bells for the rooms they were allocated to. If the allocated staff were busy, another member of staff would not answer the call bell and the person would have to wait until the allocated member of staff was available. Nurse's time was also not used effectively as they also provided personal care and were therefore not providing nursing care to people.

Staff told us there were not always enough staff. One member of staff said "If one member of staff is off everything is thrown out and it filters down all day, if two are off that is demoralising. Normally we have agency." When asked what things would not get done when the home was short staffed, they said "Laundry baskets and it would be hands, face and bottom wash, not a full wash." Another member of staff said "If we say there are not enough staff to the manager, she says 'get on with it,' she is not approachable. There have been four in the afternoons and it can be really stretched." Evidence from staff showed the number of staff displayed on the rota were not always

the number on shift and that if staff were absent, these absences were not always covered. Nurses told us there were not enough nurses on duty. One nurse, when asked why they had not disposed of medicines appropriately said "We have to do our jobs because there is not enough carers, we end up rushing through, then providing personal care for hours and then we have to do all the nursing jobs, it is really hard and not fair but I will get into trouble if you tell the manager." The nurse who told us this was visibly tearful and upset.

The lack of staffing was not limited to staff providing care to people. Domestic staff told us that they were only able to provide a cursory clean. One member of staff, who told us they were in ill health, was on duty on 10 August 2015. Another member of staff was unwell but their shift had not been covered. The member of staff on duty said "I'm just doing the basics today; we need four housekeeping staff to get this place back up to scratch. I just do everything as best I can. The buzzers are going all the time in the morning, sometimes I help the carers to feed people, I do the drinks round in the morning." The member of staff worked from eight in the morning to two in the afternoon and during this time they carried out a drinks round and helped care staff. There were not enough staff to keep the home clean and safe for people.

The lack of nurses and the shortage of care and domestic staff meant there were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Recruitment and induction practices for permanent staff were safe and relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The use of agency staff was not safe. When agency staff were required the registered manager made a request to the agency. The agency sent whoever was available on the day and the registered manager did not know the name of the person until they arrived. There was no opportunity for the registered manager to check the person's training and experience to determine if they suitable prior to working in the home. The profile sheets provided by the agency about the person did not state whether the member of staff had a work permit to work in the UK. The provider could not be assured that the member of staff was legally permitted to work in the UK or that they had suitable qualifications and experience to meet the needs of people. Additionally, the registered manager could not ensure the right skills mix of staff to meet people's needs.

The lack of safe recruitment procedures in relation to the use of agency staff was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Fit and proper persons employed.

People living in the home told us they felt safe and staff showed an appropriate understanding of safeguarding and when they would report concerns. One member of staff said "I would look for bruises and marks." Another member of staff told us they had raised a safeguarding concern in the past and this had been investigated.

The provider did not have an appropriate response to whistle blowing. It is in the public interest that the law protects whistleblowers so that they can speak out if they find malpractice in an organisation. Blowing the whistle is more formally known as 'making a disclosure in the public interest' so it is important whistleblowers can do so knowing that they are protected from losing their job or being victimised as a result of what they have made public. The provider had a whistle blowing policy stating that 'If any staff member reasonably believes that offences have been committed he/she will be able to raise their concern without fear of victimisation or dismissal.' The policy goes on to state 'The government has made it clear that any employer attempting to silence reasonably based concerns may be subject to a complaint or action in the Employment Tribunal.' This policy was reviewed and updated in January 2015. Following a number of whistle blowing concerns raised to CQC, which were investigated by social services, the registered manager told us she held a staff meeting in which she openly discussed the whistle blower and the concerns raised. The registered manager also sent a letter to all staff which stated 'At the moment the person is protected under the whistle blowing anonymity clause, but social services have assured me that if it happens again they will disclose the name to me. If this happens again the person involved will be subject to our disciplinary procedures with regard to gross misconduct." The letter contravenes both the provider's policy and legislation. A

member of staff who had received the letter told us "It felt silencing." People were not safeguarded because staff felt unable to raise concerns with the provider or registered manager.

Staff were discouraged from raising concerns; this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safeguarding service users from abuse and improper treatment.

People were not protected by the prevention and control of infection. There were not enough housekeeping staff to keep the home clean and shifts were not covered if a member of staff was ill. The carpet on the ground floor was damaged and stained and there was a malodour in the main lounge. Housekeeping staff told us they only had time to do a cursory clean and this was demonstrated by a review of communal areas in the home. There were no cleaning schedules for staff to record and check cleaning although the registered manager did carry out checks of people's rooms on a rotational basis. Commodes in people's rooms were observed to be dirty and rusty. The rusty areas were un-cleanable. Seat pad cushions were dirty and split representing an infection control risk.

There were bed pan washers on the ground and first floor but only the one on the ground floor was in working order. Staff cleaning commode bowls on the first floor had to carry contaminated commode bowls through the home and downstairs before they could be decontaminated. This represented an infection control risk. Records show that the registered manager had been asking the provider to have the machines repaired since October 2014. The repairs had not been carried out for ten months.

Cleanliness of the kitchen was the responsibility of kitchen staff. A stand-alone fan in the kitchen was filthy with large clumps of dust mixed with grease and the extractor fan was dirty. Records showed the registered manager had been asking the provider to repair the extractor fan in the kitchen, which was not working properly and could not be cleaned properly since October 2014, but nothing had been done. Areas of the kitchen were 'grubby' in that older equipment such as plastic storage drawers were cracked and did not look clean. Tiling was old and did not look clean; areas around the cooker and deep fat fryer were not clean.

There were daily and weekly cleaning schedules in place for the kitchen staff, however there were gaps in signatures to confirm this cleaning had been carried out. For example, daily cleaning rotas were not complete for a weekend in August and two days in July 2015. There were also gaps in the weekly deep clean schedules. The provider could not be assured that cleaning had been carried out. We were not asked to wear personal protective equipment (PPE) upon entering the kitchen and there were no plastic aprons available for staff. There was a supply of plastic gloves and we saw the two chefs wearing these. There was a risk of cross infection from people's clothes upon entering the kitchen from the home.

The lack of cleanliness in the home, dirty commodes and broken bed pan washer were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Three of the five wheelchairs in use by people during lunchtime did not have foot plates. We drew the registered manager's attention to this. Foot plates allow the person's feet to be raised from the floor when the wheelchair is in motion. Without these there is a danger that people's feet will become entangled in the wheels causing injury.

The laundry was well managed by a dedicated laundry worker. All soiled laundry was separated into red bags. Bed linen was collected by an outside company twice weekly. The laundry worker explained they kept soiled clothes separately in red bags and these were washed on a 'red bag' wash in designated machines. We saw this in operation. The laundry worker confirmed that care staff changed linen and clothing as it became soiled during the day. There were separate cleaning products for the laundry and the area was clean and tidy. There was a separate sink for hand washing.

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Inadequate

Is the service effective?

Our findings

Food and fluid charts were inadequately completed. Monitoring charts were in place for everyone, however, these charts were ineffective as a tool to appropriately monitor people's nutritional and fluid intake. This was because food charts recorded only minimal information such as 'breakfast given'; there was no indication of whether people actually ate it or what the breakfast included. We could not be sure of the accuracy of records as one person told us "They write down what we eat and drink, but often it's lies." There was not an accurate record of people's nutritional intake. For people identified as 'at risk' of malnutrition, this key element of care was not delivered and those people remained at risk of malnutrition. The fluid charts did not include a target, were not totalled and were not monitored to ensure people had sufficient fluid intake. We looked at daily fluid charts for 21 out of the 40 people using the service for the period from 7 August 2015 to 10 August 2015. These records showed that not one person had consistently drunk in line with the provider's policy of 1000mls to 1500mls per day. Some people were drinking as little as 100mls per day. People were at risk of dehydration. Symptoms of dehydration can range from mild to life threatening. The symptoms of dehydration can include increased thirst, dry mouth, weakness, dizziness, confusion and palpations. Some people may not have been able to verbalise how they felt due to the complexity of their illnesses. People who were known to be at risk of dehydration did not have those risks identified and addressed through risk assessment and care planning. One person's 'eating and drinking' care plan had not been updated since August 2013 and did not mention any risk of dehydration although staff told us the person often refused to drink and was at risk of dehydration. The provider could not be assured people were eating and drinking sufficient amounts to meet their needs.

People's needs in relation diet and weight loss were not met. One person had lost 7.2kg between March 2015 and July 2015 and was at risk of malnutrition. There had been no referral to a dietician, who would have made nutritional recommendations for the person, such as fortified food. The person was being given a pureed diet, but there was no reference to this in their care plan, so it was not clear why this was being given. The registered manager told us she had made the decision because the person had not been eating. Some notes suggested the person may have been having a dietary supplement; however, there was no reference to the person's diet in their care plan. One person had lost 14kg in four months, they had not been referred to a dietician and their 'eating' care plan did not identify any issues. There was no care plan and no actions taken to address the person's significant weight loss. People were at risk of malnutrition and weight loss.

Mealtimes were not a positive experience for people. Lunch on 10 August 2015 was a bleak occasion. Everyone was given a blue plastic apron to wear. Two television sets which were in the lounge area of the room were set to the same channel producing an echo which made the dining area sound very noisy. There was nothing to create a relaxing ambience for people and very little interaction between staff and people except that directly associated with the food being served. Two people were being supported appropriately by staff to eat their lunch in the lounge area of the room. Staff sat next to the two people and supported them to eat with encouragement. Not everyone had a drink, unless they asked for one and spoons had not been laid for pudding. Once pudding had been served all the staff disappeared to have their break. People who wanted to be supported to use the toilet after lunch, had to wait until staff had had their half hour break. There were seven people in the dining room at this time.

People's dietary needs, allergies, required assistance, meal size, likes and dislikes were recorded on individual sheets in the kitchen, so the chef would be able to serve food appropriately. Whilst individual needs were catered for in terms of meal consistency, there was no choice of meal for people. The menu on 11 August 2015 was pasty and salad or the vegetarian option was vegetable kiev. Menus were not listed by ingredients to identify allergens. On 13 December 2014 new legislation came into force requiring providers of food to provide allergy information in relation to unpackaged food. This legislation ensures that food which may contain substances linked to food allergies and intolerance are identified in prepared food. Two chefs were on duty at the time of the inspection and neither had had specific training in relation to nutrition, fortified food or allergens. One of the chefs had previously been a care worker and said they had had some nutrition training in their role as a care worker but not as a chef. The chefs told us they catered for diabetic diets by using sugar substitutes although best practice is that people who have diabetes

should receive a normal diet with smaller portions of carbohydrates and should have their blood glucose levels closely monitored. The provider was not following best practice guidance in relation to diabetic diets.

Inadequate monitoring of food and fluids, the lack of risk assessments and care plans in relation to weight loss and those at risk nutritionally. The failure to provide a choice of nutritionally balanced food was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Meeting nutritional and hydration needs.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Where a person's capacity to make a specific decision is in doubt, a mental capacity assessment should be carried out. If it is determined that the person does not have capacity, a decision in the person's best interests should be recorded. Mental capacity assessments had either not been carried out at all for people with a cognitive impairment or they had been inaccurately carried out. In most cases we found a piece of paper within people's care plans stating '(the person) has no capacity so care plans written in their best interest.' This was a statement not an appropriate assessment of the person's mental capacity. A best interest decision had not been appropriately recorded including all parties relevant to the decision. Records showed the provider had no understanding of the principles of the MCA.

The incident log included 72 incidents recorded since 1 May 2015. Of these 32 were in relation to people refusing to take their medicines. In these situations we would expect to see a mental capacity assessment to determine whether the person had capacity to understand the implications of their decision and a referral to a GP, or an explanation of their refusal. We found only one person had a mental capacity assessment in relation to medicine refusal. The assessment had not been concluded and no best interest decision had been recorded, including all interested parties such as relatives and a pharmacist. The person had been prescribed five different medicines which were regularly refused yet no action was taken in the person's best interest.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found the registered manager did not understand when an application should be made and was not aware of a Supreme Court Judgement which widened and clarified the definition of the deprivation of liberty. No applications had been made despite our observation that people were deprived of their liberty. There was a risk that people were being illegally detained against their wishes. Care records showed one person had taken to walking outside even though staff considered it was unsafe for the person to do so. The registered manager sent a letter to the person's relative saying that the person could not understand the risk and 'therefore we will not be held responsible should (the person) walk outside unaccompanied.' This showed a lack of understanding of DoLS. The provider is legally responsible for the safety of all people living in the home. This person was at risk due to their lack of capacity to understand the risks of walking outside. The provider had not used their legal powers to prevent the person from leaving and to ensure their safety.

Staff told us they did not understand the terms 'mental capacity' and 'deprivation of liberty.' Records showed they had not received any training. The registered manager told us she had received training in the requirements of the MCA but had not received an update since the supreme court judgement in March 2014. She said she had not received any training in relation to deprivation of liberty. The registered manager had not complied with requirements in relation to mental capacity and DoLS in order to keep people safe.

The failure to comply with the MCA and the DoLS standards was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Need for consent.

Staff had not received sufficient training to meet people's needs. There were 43 members of staff. Of these 19 had either not completed moving and handling training or had completed it but an update was required, 36 had not completed first aid training and 35 had not completed infection control training. Food hygiene training had not been completed or updated by 34 people and 20 people had not completed safeguarding training. Staff told us training was not routinely completed. Nurses had not

Is the service effective?

received medicine administration training and no competency checks were carried out. One nurse said "We have mandatory training but it's the optional training the provider needs to fork out for and doesn't, for example, syringe driver training, wound care, palliative care and dementia, not just basic awareness." The impact on people in relation to lack of training was reflected in the care we observed whilst in the home.

Not all staff received regular supervision meetings and appraisals to ensure they were adequately supported in their role. One nurse told us she had a supervision meeting with the registered manager roughly every three months, however a member of care staff told us they had had no supervision meetings, no appraisal and no confirmation of employment following their initial probationary period. A new member of staff who had been working in the home for six weeks said they had not had any supervision meetings during that time and had not yet completed moving and handling training. One member of staff who had been in post since November 2014 did not understand what was meant by supervision meeting and appraisal. Staff were not adequately supported to carry out the duties they were employed to perform.

The lack of adequate training and support was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Healthcare professionals visited the home regularly. A local GP visited the home twice weekly in order to treat anyone who was unwell and made extra visits if there was an emergency. During our inspection an optician, physiotherapist and speech and language therapist (SALT) visited the home. There was no access to an NHS physiotherapist, so those people unable to afford the service would not have been able to access this service. It was not clear whether other community professionals such as a tissue viability nurse, diabetic nurse or mental health professional visited the home. We did not see records in relation to these services in the records we reviewed. There were no records of a dentist visiting the home, although the registered manager said this could be arranged in an emergency. This was not seen as a routine service to maintain people's dental health. One person said "There's a manner about that manager. She doesn't seem to think that medical issues are her problem; I wanted her to get the GP to look at my wife's hands, which had developed a tremor – she said she wouldn't call him unless it was a new symptom, which obviously she thought it wasn't." Although healthcare professionals visited the home, not everyone had access to the services they needed or wanted.

The home was not well maintained and not appropriate for people living with dementia. Colours were bland throughout, room numbers were nearly indistinguishable being in small black lettering on a dark blue plastic plate. There was nothing to distinguish one bedroom from another or bathrooms and toilets from other rooms. Rooms were not personalised to the individual and there was no reminiscence material. The lounge area was not well laid out with a row of armchairs in the middle of the room, meaning people sitting in those chairs would have sat with their backs to other people in the room. There were two television sets in the lounge area and both were set to subtitles. This took no account of the people who did not need subtitles or those who disliked them. A recently added conservatory was used as storage area for wheelchairs and zimmer frames, and not as a sitting area.

Inadequate

Is the service caring?

Our findings

Person centred care was not evident in this home. Although we did observe some kindly treatment of people which was well meant, overall the care was institutionalised and representative of old fashioned and out dated practices. People were not treated with respect and dignity. People told us they were given excuses for not having their needs met such as 'You'll have to wait,' 'I'm a bit busy,' 'That's not my job.' People told us they waited long periods of time for their call bells to be answered and some people had had undignified accidents whilst waiting long periods of time to be assisted to the toilet. After lunch people were made to wait until staff had had their lunch break, which they took altogether, before being supported to the toilet. People said that 'toilet' lists were made by staff and you had to be on the 'right list' in order to be supported to the toilet. Three different people said they asked to be assisted to the toilet and were told "You're not on my list." One lady told us she was not sure when staff made the 'lists'; I'd like to know who my carer is, or I don't know who to ask to go to the loo – or they'll just leave you." Another person said "You really need to go when they want you to, or you wait." One person told us that his wife was no longer assisted onto the commode but was given an incontinence pad and told "Go in that."

People were not offered choice. For example, breakfast was always served at the same time and always in people's rooms. There was no option to get up for breakfast or to have breakfast at a different time. There was no choice of food at lunchtime. During lunch time everyone was given a blue plastic apron to wear. Lunch was presented as a functional activity rather than a pleasant midday activity where people interacted and chatted in a calm environment. Some people had their lunch served on trays in their room. We noticed that plates did not have covers on them so food would have arrived cold. One person told us "Lots of people are discontented here." Another person said "I'm lucky, I'm quite independent at the moment. But I've told my daughter, that should I get to the stage where I need proper nursing care, to find somewhere else for me." People were left in wheelchairs for long periods of time rather than being hoisted into armchairs which would have been more comfortable for them. One person said that after lunch, when his wife has been sat in a wheelchair for two hours, her neck starts to ache. He said he asked staff to hoist her onto the bed and was told "No." We asked people whether their opinions had been sought about the service they received, for example the type of food. No one we spoke with could remember being asked anything. There was evidence that a relatives meeting had been held in June 2015 but there was no evidence that anyone had ever attended a residents meeting and been asked for their input about the service.

Where people had made a choice, this was not respected. For example, one person asked for a cup of tea, but was given coffee. They told us this was a very common error. Another person told us they were asked in the afternoons what they would like for their supper. They told us they nearly always received something different to that which they had chosen. On the one occasion they mentioned it to the member of staff who brought supper they was told "Well, it's not my fault – I'm only bringing it." The person went on to say "Nothing's ever anyone's fault." One person observed to us "They (the staff) do acknowledge they're over worked, but they seem to be busy doing the less important things – do you know, they change everyone's sheets every day. That seems unnecessary. At the same time they don't have an accurate picture of one's needs – it seems a bit upside down!" Another person told us they slept badly and were often awake in the night but were afraid to ask for a cup of tea.

The lack of dignity and respect for people and the lack of choice were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Dignity and respect.

There was no evidence that people had been involved in developing their plan of care, although the registered manager told us some people had been involved in some parts of care planning. It could not be demonstrated which parts these were. People had not signed to agree to their plan of care and reviews generally documented 'no change' indicating that no discussion had taken place with the person about any changes. It was unlikely that nobody's care plan changed at all month on month and therefore staff were not paying due consideration to people's individualised needs during the review process. There were no personal histories documented within people's care plans and it was unclear how staff got to know people on a personal level, especially those with limited communication skills. One person did have a picture of them in a racing car in their care plan but we did not see any other examples of this type of personalisation. There

Inadequate

Is the service caring?

were no likes and dislikes recorded in people's care plans. One person had been living in the home for eight years and during that time nothing about them as a person had been recorded in their care plan. People were not treated as individuals.

Independence was not supported in the home with two people reporting a loss of mobility due to a lack of support to regularly mobilise. One person said "I came in after I had a stroke. In hospital, I had been walking, with help, it kept my legs going – but here, nobody will let me walk. I'm trying to keep my legs exercised by waggling them like this, in case I ever get a chance to try again." Another person told us his wife was always flat in bed and he was worried her legs would no longer take her weight.

Some relatives were happy with the care provided. One relative said "Mum's been here a year; she is safe, content, doesn't complain. They do need more staff – there's always call bells going – especially just after lunch, when they go for their break altogether. They usually come if I ask them too."

Inadequate

Is the service responsive?

Our findings

During our inspection many people complained to us about the care they received in the home. One person told us "Lots of people here are discontented."

People did not receive personalised care which was responsive to their needs. During our inspection there was an emergency incident which was not responded to appropriately by staff. It was understood from the GP that the person was at the end of their life, however there was no end of life care plan indicating how the person would like to be cared for at the end of their life. This person's needs were not being met.

One person was living with Parkinson's disease. There was a note in their care plan on 9 August 2015 stating 'Due to deterioration in Parkinson's (the person's) mobility has decreased.' It did not state how their mobility had changed or give instructions to staff about how to meet the person's changing needs. A Parkinson's nurse last visited the person on 7 February 2014. Parkinson's nurses are a free and knowledgeable resource and would have been able to provide guidance about how to support the person appropriately as their condition developed. The person's care plan was dated June 2013 and staff had initialled since that date to say 'no change.' It was evident that the person's condition had deteriorated and the care plan did not meet their current needs.

At least four people were living with diabetes. One person's care plan did not identify that they were diabetic and there were no individualised diabetic care plans, explaining to staff haw to appropriately manage their condition. The registered manager told us that another person was "Borderline" which was why there was no diabetic care plan in place. This would have made the need for a care plan more important because appropriate care and support can help the person remain free from diabetes for the longest possible time. People with diabetes did not have their care and support needs met.

From a review of care plans, there were numerous examples of a lack of understanding and knowledge of care planning resulting in gaps in care planning which would have impacted significantly on people's care. At the time of the inspection eight people were being nursed in bed. These people were at higher risk of developing pressure ulcers. There were no risk assessments around this risk or care plans advising staff how to care for the person. There were no repositioning charts. Staff would not have been able to tell how long people had been lying in one position and when they needed repositioning to mitigate the risk of developing pressure ulcers. One person's care plan stated they needed support to eat but did not detail what support they required. Although many people moved to the home at the end of their life, there was a complete lack of end of life care planning. Some care plans stated that weight must be monitored but there was not a weight monitoring chart in place for people. Another person received their nutrition and hydration through a percutaneous endoscopic gastrostomy (PEG) but there was no guidance in the person's care plan about how to clean around the PEG and dress the area. Another person had been given a patch containing morphine as pain relief, even though the person's care plan stated they were allergic to morphine. The next day we noticed the patch had been removed but the person was agitated, indicating they may have been in pain. Alternative pain relief had not been given. One person entered the lounge on the last day of our inspection with a fresh skin tear which had not been dressed. Care plans were inaccurate, incomplete, unsafe and by room number demonstrating a complete lack of understanding of individualised person centred care. People's care and support needs were not met.

It was not possible to determine how staff were made aware of people's specific needs and how they were updated about people's changing needs. We were told a handover meeting was held every day however when we arrived at 8am staff were providing care to people and no handover had taken place. The handover took place about three quarters of an hour after our arrival. The information sheet which was used to facilitate this process contained a list of people's names and room numbers. It lacked accurate and key details about people's care and treatment. For example, there was no information about who needed support to eat and drink and people's repositioning requirements, for those being nursed in bed, in order to prevent pressure ulcers. Information about the severity and complexity of people's illnesses was missing and there was no information about people's wounds and how they should be treated or their continence needs. There was no information about who was being treated for an infection or of people's dietary requirements. The handover process discussed people's weekend visitors and activities they had undertaken at the weekend such as

Inadequate

Is the service responsive?

watching a film on television. There was no clinical information imparted and no discussion at all about people's individual care and support needs. Staff did not ask any appropriate questions. Staff were not able to use information on the handover sheet in a meaningful way to respond to people's needs. Care staff told us they did not read care plans and agency staff would have had no opportunity to read care plans. There were no summaries of people's care needs in their room or hospital 'grab sheets.' A hospital 'grab sheet' gives key information about people's needs which can be taken with someone should they be admitted to hospital in an emergency. There was a complete lack of communication and guidance about anyone's care needs and therefore it was not possible for care staff to accurately meet people's needs. One person told us that staff were not aware of their care needs.

People needed topical creams applied as part of their personal care. There no body maps showing where cream needed to be applied and no care plans in place giving instructions about how and when to apply the cream. There were no records demonstrating that people needing topical creams had had these applied. It was not possible to determine whether people requiring topical creams had had these administered appropriately. Therefore there was a risk that people did not receive these creams in response to their assessed need.

As we walked around the building we noticed people with their call bell out of reach. Some had just been hung up out of reach but others were entangled with cable for the controller to adjust the bed and clearly had not been in use for some time. There was nothing in people's care plans saying they were unable to use a call bell and no risk assessments or mitigating action that would need to be taken if this were the case, such as half hourly checks.

The lack of appropriate care planning and delivery of care were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Person-centred care.

People's social needs were not met. There was no evidence of any activities or social interaction in people's care plans.

There was an activities plan on the wall in the hall but there were many days with no planned activities and none at the time of the inspection. One person told us that entertainers came in from 'time to time' but there was no evidence of other stimulating activities such as armchair exercise, quizzes, bingo or crafts. One person said "The staff sometimes start something like a game, but it doesn't last long." We asked people when staff had last done this but no one could remember. We spoke with the activities co-ordinator who had recently received training. She told us she had asked people what activities they would like to do. However, no trips had been arranged and there were no proper planned activities taking into account people's individual likes and dislikes such as those people who liked to spend most of their time in their room and may benefit from one to one activities. We observed one person sat in their room, gazing into space, doing nothing. There were no meaningful activities for people.

The registered manager told us that no written complaints had been received. However, during our inspection people told us about the care they received in the home. One person told us they had not complained because they believed the complaints procedure involved "Sending a letter to head office, and it could take a week." We found the complaints procedure pinned to a notice board but people said they were not aware of the procedure and it had not been communicated to people in other ways such as a booklet on admission followed up by discussion at residents and relatives meetings. A survey of relatives and residents had been carried out and one relative had complained about a smell of urine, bland food and inadequate activities. The registered manager had sent a letter responding to these concerns, however these issues were evident during our inspection, therefore responsive action had not been taken. People's concerns and complaints were not encouraged. There was not clear open communication between people, staff and the registered manager meaning that the registered manager was unaware of people's concerns and complaints.

Inadequate

Is the service well-led?

Our findings

The provider did not promote a positive culture that was person-centred, open, inclusive and empowering. Due to the actions taken by the registered manager in pursuit of a whistle blower staff felt afraid to raise any concerns. One member of staff said the registered manager was "Not approachable" and another said "The manager just doesn't care about staff." One member of staff said "Staff get on well together but they are not open with the manager." However there was some mixed feedback as another member of staff thought it was a "Happy ship." The registered manager told us she discussed everything with everyone although went on to say she might not tell the whole truth. There was a 'them and us' disjoint between the provider, the registered manager and the staff. The registered manager told us the provider visited the home about once a week, however the staff said they did not see the provider during these visits as they dealt only with the registered manager. It was evident that the registered manager found it difficult to balance the demands of the provider with the needs of the staff. Beneath the registered manager there was no clear staffing structure as all care staff were juniors i.e. there were no senior care staff which could support better managed communications between care workers and management.

No staff were aware of the visions and value of the provider. This included the registered manager. The registered manager said she would guess at what she thought these might be and suggested 'A person centred approach accommodating people's individual needs' however, a person centred approach was not evident in this service. When we asked another member of staff whether they were aware of the vision and values, they said "Sort of – they do try to treat everyone as individuals." Another staff member said that vision and values had not been discussed. Staff were not able to work together towards clear goals designed to continually improve the service because it was not clear whether there were any goals dedicated to the future of the home.

The registered manager told us she worked shifts 'on the floor' however evidence from people was contradicted this. Everyone we spoke with said they either never or hardly ever saw the registered manager even by request. One person said "No, we don't see her – she's got her own job to do." Another person told us "You have to ask to see her, sometimes she comes to see us, sometimes not. She didn't see us at all until we'd been here a fortnight." When asked, a visiting relative, told us they did not know who the registered manager was. The lack of input from the provider and the lack of availability of the registered manager meant there was no visible leadership in the home. The lack of leadership impacted directly on people's care.

Due to serious concerns about the service we asked the provider for an urgent action plan by 19 August 2015 to address our concerns through section 64 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The plan produced demonstrated that neither the provider or the registered manager recognised their legal responsibility to keep people safe and provide care in line with the requirements of the Act. The plan included excuses for poor care planning and a memorandum to staff to improve practices. There was no acknowledgement that both the provider and the registered manager needed to be an integral part of ensuring profound changes were made to the care provided for people.

There was no system of quality monitoring in the home. There were no audits around medicines, infection control and health and safety. Had there been a system of audits in place and had they been completed in detail they would have picked up the areas of concern identified in the inspection. For example, a sample of people's handwashing had been checked and there was a ticked sheet to show this. Medicine administration records (MARs) were randomly checked and again a list of charts and ticks verified this. In some cases this had identified gaps in MAR charts. The only recorded action was 'Nurse informed.' No appropriate action was recorded as taken to investigate this, assess the impact on the person or take any mitigating action. Bedrooms were also checked through a 'tick box' form. There were no action plans as a result of the checks and nothing to suggest that any improvements had been made.

The provider had not carried out any audits checking the overall quality of the service provided and ensuring that appropriate improvements were made. The registered manager provided monthly reports to the provider. These reports evidenced that the registered manager had been making urgent requests for improvements since October 2014. Requests included the cleaning of the extractor fan, the lack of operational sluice machines, holes in the ceiling,

Inadequate

Is the service well-led?

a cleaning machine for arm chairs and the updating of the health and safety policy. These had been identified in the reports as urgent for ten months yet the provider had taken no action. The provider did not have a service improvement plan. The lack of responsiveness of the provider meant people's safety was put at risk. The lack of quality monitoring was identified as a breach during our inspection in September 2014 and therefore this was a continuing breach.

The quality of MAR charts and care plans was also identified as a breach in record keeping during our inspection in September 2014. No action had been taken to address this failing and therefore it remained a continuing breach.

The lack of governance in the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance.

This section is primarily information for the provider

Enforcement actions

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

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 How the regulation was not being met: The care and treatment of services users was not appropriate, did not meet their needs or reflect their preferences. The registered person did not carry out collaboratively with the relevant person, an assessment of their needs and preferences for care and treatment. They did not design care and treatment with a view to achieving service users' preferences ensuring their needs were met. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b)

The enforcement action we took:
As a result of our findings, CQC have issued a Notice of Decision to cancel the registration of the manager.

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 How the regulation was not being met: Service users were not treated with dignity and respect. The registered person did not support the autonomy, independence or involvement in the community of service users. Regulation 10 (1) (2) (b)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

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 How the regulation was not being met: Where a person lacked capacity to give consent the registered person did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

This section is primarily information for the provider

Enforcement actions

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 How the regulation was not being met: Care and treatment was not provided in a safe way for service users. The registered person did not assess the risks to the health and safety of service users receiving care and treatment, do all that is reasonably practicable to mitigate any such risks, ensure that person providing care or treatment have the qualifications, competence, skills and experience to do so safely, ensure the proper and safe management of medicines, assess the risk of and preventing, detecting and controlling the spread of infections. Regulation 12 (1) (2) (a) (b) (c) (g) (h)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

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 How the regulation was not being met: Service users were no protected from abuse and improper treatment because systems were not established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1) (3)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

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 How the regulation was not being met: The nutritional and hydration needs of service users were not met. Service users were not in receipt of suitable and nutritious food and hydration which is adequate to sustain life and good health Regulation 14 (1) (2) (a) (b) (4) (a)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

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 How the regulation was not being met: Systems or processes were not established to assess, monitor and improve the quality and safety of the services provided. A complete accurate and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to care and treatment provided was not kept. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

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 How the regulation was not being met: There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. Staff did not received appropriate support, training, supervision or appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Recruitment procedures were not established to ensure that person employed were of good character and had the qualifications, competence, skills and experience necessary to perform their work. Regulation 19 (1) (a) (b) (c) (2) (a)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As a result of our findings, CQC has issued a Notice of Decision to remove the manager's registration.