# Care UK Community Partnerships Ltd

# Mill View

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 23 February 2016 and was unannounced.

Mill View is a purpose built home providing residential and nursing care for up to 70 people, including people who live with dementia, mental health conditions and have general nursing needs. The service provides both long term and respite places and at the time of the inspection there were 62 people living at Mill View.

The service should have a registered manager however currently the person in charge is not registered. 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.

The previous inspection carried out on 29 November 2014 and 2 December 2014 identified a number of breaches of the regulations with regard to inadequate levels of staffing, poor record keeping, failures in meeting nutrition and hydration needs, lack of staff training and support and ineffective quality monitoring systems. The provider produced an action plan in April 2015 to tell us what they would do to meet the legal requirements.

We undertook a comprehensive inspection in February 2016 to check whether the required actions had been taken to address the breaches previously identified. This report covers our findings in relation to these requirements. Improvements had been made in some areas, however we found continuing breaches of regulation relating to staffing levels, nutrition and hydration, and good governance. Further areas for improvement were identified in relation to maintaining people's dignity, providing person centred care and ensuring people were supported to follow their interests.

It remained that there was not always sufficient staff to keep people safe and meet their needs. People, relatives and staff told us that there was not time to do more than provide basic care and our observations confirmed this. One person told us "The staff do their best but they are so busy, they are rushed off their feet most of the time." The provider had an active recruitment programme however their updated action plan confirmed 'We have been unable to significantly reduce the use of agency staff due to the high number of vacancies.' We saw that people were left unattended for what appeared to be long periods of time, people had to wait to have their care needs met and staff were often too busy to spend time talking to people other than when directly providing care.

People were still not always given sufficient support to eat and drink and risks of dehydration and malnutrition were not being appropriately monitored and managed. A visiting relative told us "No one's been in to see if they've had a drink." We saw that people who had been assessed as being at risk of dehydration were not having fluids offered consistently and records showed that their fluid intake was

unacceptably low. People were not always given sufficient support to eat. One person had lost a significant amount of weight and their care plan contained contradictory information regarding the support they needed with eating. This indicated that monitoring and management of risks associated with people's food and fluid intake was not robust and some people remained at risk of receiving poor nutrition and hydration.

People's care records were not always personalised and some did not give an accurate reflection of people's needs. One person said "I'm treated the same as the other people but my condition is different, sometimes the staff don't understand my behaviour." Although some care plans were detailed others contained very little information about people's life history and it was not possible to 'see the person' in the documentation in order to promote personalised care. Information specific to the person was sometimes missing or incomplete and this meant that people did not always receive support that was personalised and responsive to their needs and people were not always supported to follow their interests or to use local facilities. Relatives had concerns that people's dignity was not always supported for example with regard to maintaining people's privacy when supporting their continence and people's culture and beliefs were not always respected. The provider and person in charge had systems in place for monitoring quality and standards of service but these were not always effective. This meant that gaps in service delivery had not always been identified, for example with regard to gaps in people's records.

Some areas of practice had improved including support and training for staff and this was improving standards of care in some areas. For example staff had received training specific to their roles such as pressure damage awareness training and we saw good practice relating to this. Staff had a good understanding of the Mental Capacity Act and applied sound principles in seeking peoples' consent to care and treatment and in making best interest decisions where necessary. The person in charge had ensured the service was proactive in seeking authorisations for Deprivation of Liberty Safeguards. Staff demonstrated a good understanding of how to safeguard people and understood their responsibilities to report abuse.

Risks to people's safety were assessed and monitored. People's medicines were stored, managed and administered safely and people were supported to access health care services. One person told us, "If I am in pain I just ask for my tablets and they bring them there's no problem," and a relative said "If there's anything wrong they call in the GP."

The provider followed safe procedures for the recruitment of staff and people spoke highly of the caring nature of staff, comments included "They are really kind and do their best for me," and "The staff are all friendly and caring," and a relative told us "I had a member of staff nearly in tears because they weren't able to give people more time." We saw numerous positive interactions between staff and people that demonstrated a caring approach. People were supported to express their views and be actively involved in making decisions about their care as well as the running of the home. We observed the residents meeting and found that this was conducted in an inclusive manner with suitable adjustments made for people who were living with dementia and for people who had sensory needs.

The person in charge was committed to learning from people's experiences and encouraged people and relatives to give feedback and complain. People told us they knew how to complain and felt comfortable to do so. Relatives confirmed that the person in charge was approachable and took their concerns seriously. However a number of relatives said that their most pressing concern was with regard to staffing levels and they did not believe that the Provider was doing enough to address this issue.

People relatives and staff spoke highly of the person in charge. People said "She's a very nice person," and "She is approachable, she's often walking around talking to people, asking them how they are." Staff told us that they considered the culture at the home to be fair and open and said that they had confidence in the

person in charge. We saw that the person in charge was working hard to make improvements and had made some progress but that some improvements had yet to be implemented and embedded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

There were not enough staff to keep people safe and meet their needs at all times.

Medicines were stored, managed and administered safely

Safe recruitment practices were followed and staff were knowledgeable about signs of abuse and what action to take.

Risk assessments were in place to help keep people safe.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective

People were not always given sufficient support to eat and drink and risks of dehydration and malnutrition were not being appropriately monitored and managed.

Staff were supported with regular supervision and training opportunities relevant to their roles.

Consideration of people's mental capacity was consistent and staff had a good understanding of their responsibilities in making best interest decisions.

People had access to health care professionals to maintain their health.

### Is the service caring?

**Requires Improvement**

People told us staff were kind and caring

People's dignity was not always respected

People or their representatives were involved in planning their care

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive

People's care records were not always personalised and did not provide an accurate reflection of their needs.

People were not always supported to follow their interests and some people were isolated

People and relatives knew how to complain and the person in charge responded to complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led

The service has not had a registered manager since March 2015.

Not all monitoring systems were effective in identifying gaps in the quality of care delivery. This is needed for the continuous improvement of the service.

The person in charge was committed to improving the quality of the service.

# Mill View

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 23 February 2016 and was unannounced. The inspection was carried out by three inspectors and a nurse specialist adviser.

Mill view was last inspected on 29 November and 2 December 2014 when we identified a number of breaches of regulations. The provider sent us an action plan that explained the measures they would take to ensure they met the Regulations. We undertook this inspection to check that improvements to meet legal requirements had been made.

Before the inspection we reviewed information that we held about the home. This included information shared with us by the local authority, previous inspection reports, safeguarding concerns that had been made and notifications that had been submitted. A notification is information about important events which the service is required to send us by law. We did not, on this occasion, ask the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements that they plan to make. We considered the action plan submitted by the provider following their previous inspection and recent concerns shared with us by relatives of people living at Mill View. This enabled us to ensure that we addressed potential areas of concern.

We observed care and spoke with people and their relatives, we interviewed nine staff and spoke with others during the course of the inspection. We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who cannot talk with us. We looked at 14 care records, staff rotas, five staff files, training records and supervision plans, medication administration records (MAR), weight charts, fluid and wound care records, quality feedback surveys, incident and accident reports, minutes of meetings and audits.

During the inspection we spoke with 12 people using the service, 10 relatives, the person in charge, two

nurses, five care staff, a team leader, and the chef. After the inspection we spoke to a health care professional who had involvement with the service to gain their views.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in December 2014 we found that the provider was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to provide safe care to people. The provider submitted an action plan in April 2015 that detailed how they would meet the legal requirement.

At this inspection we found that staffing levels remained a concern for people, their relatives and staff. One person told us "It gets very frustrating having to wait for staff to come and help you, I always have to wait because I need two staff to help me." Someone else said "The staff do their best but they are so busy, they are rushed off their feet most of the time, I don't like to bother them." Relatives of people living at Mill View told us that they had concerns for the safety of their family members, comments included, "There just aren't enough staff, people are left unsupervised and basic care doesn't get done," and "The number of staff is inadequate for the needs of people living here. A lot of the experienced staff have left, sometimes people are just left sitting for ages." We asked the person in charge if staff have left in recent months, they confirmed that the current vacancies are as a result of staff leaving for a variety of reasons.

The provider's action plan submitted in April 2015 stated that 'We are actively recruiting more staff thereby reducing agency staff.' However staff rotas over a number of months showed an increasing dependency on the use of agency staff to cover shifts rising from six shifts in June 2015 to 20 shifts in February 2016. The provider's updated action plan, dated 4 February 2016 confirmed that recruitment was ongoing and stated that 'We have been unable to significantly reduce the use of agency staff due to the high number of vacancies.' The person in charge said that although some people had been recruited they had not been suitable candidates and therefore a number of vacancies were still outstanding.

The person in charge told us that there was an active recruitment programme as there were still a significant number of vacant posts that amounted to 200 hours per week. This deficit, together with any sickness or leave was being covered with agency workers. Analysis of rotas showed staffing levels had reduced since last summer when there were two nurses, one team leader and between11-13 care workers on duty. Recent rotas showed two nurses, two-four team leaders and 7-11 care workers was the usual pattern. This showed that staff providing direct care to people had reduced from between 15-19 in June 2015 to between 12 and 17 in February 2016. Night duty staffing levels have remained consistent with I nurse and 7 care workers on night duty. Staff told us, and we observed, that there were a number of highly dependent people in the home who needed intensive support with their care needs.

We spoke with some of the permanent staff, the majority were also concerned about staffing levels saying, " We need more staff, we have a lot of agency staff here and relatives complain because we can only give basic care, there isn't time for anything else and things are getting worse," and "I have spoken to the manager about the lack of staffing and I know they understand, I've been told they will speak to their manager about getting more staff," and "The dependency tool says we have enough staff but we don't. It

just doesn't go into enough detail about when we need more staff at particular times. I have spoken to the manager and we hope to get more staff, particularly at teatime." Except for one person who was having one to one support throughout the day, we saw that staff had very limited time to spend on a one to one basis with people unless they were providing direct care. The care plan of one person living with dementia described how the person should be kept occupied to ensure his and others safety due to some behaviours that were challenging. A visiting relative told us that they were often left in a chair for hours at a time in the lounge. We observed that this person had been in the lounge with minimal interaction with staff both before the visitor arrived and after they had left. For a short time a member of staff attempted to interest the person in looking at a magazine but they were called away to assist an agency staff member and this activity was not resumed. The only other staff interactions seen with this person were during specific care tasks.

We asked the person in charge for their views about staffing levels. They told us that they believed there was adequate staffing to keep people safe and that interviews were happening that day to fill one of the vacant posts. They said that a dependency tool was used to determine the number of staff needed and this showed the home was in fact over staffed at present. However, staff told us that they did not believe that the dependency tool gave an accurate indication of the number of staff needed to meet peoples needs. Staff told us they had raised their concerns and the manager was looking to get more staff.

We looked at records of incidents and accidents and noted that these were reviewed by the person in charge. Analysis of the information for the period September to December 2015 showed that the number of incidents overall had increased significantly as had the number of altercations between people and other people or between people and staff as well as the number of unwitnessed falls. Incidents that occurred during the evening and at night had also increased. A relative told us "Staffing levels are so poor, particularly in the evening and at weekends, it worries me, and there are so many agency staff- they just don't get to know people well enough." We asked staff how they ensured that risks to people were managed without restricting people's freedom. One staff member said, "My priority is to keep people safe. There aren't enough staff on my floor and at the evening meal people can get frustrated because we don't always have enough staff to help them". Another staff member told us, "We try to keep the residents safe and to get them to do things for themselves but it's not easy because there aren't enough of us".

Throughout the inspection we observed staff to be busy with little time to spend just being with people. A shift leader appeared to be under particular pressure as they were seen to be directing staff as well as providing care to people. One staff member said, "It's difficult with so many agency staff, they don't always know what to do and we have to help them as well." We saw that people were having to wait for care workers to be free to attend to their needs, for example one person who needed to be moved with two care workers using a hoist, waited more than half an hour for care workers to move them from their wheelchair to a comfortable chair after lunch. They told us this was not unusual and that they got frustrated having to wait for two staff to be available to help. A member of staff confirmed that they found it difficult to fit everyone in, saying "When people need to be hoisted, sometimes five times in a day, it's difficult for staff to always be available."

We saw that people were left unattended for what appeared to be long periods of time, one person was seen to be sitting in a chair in the hallway most of the day, they occasionally slept for a short while or went for a brief walk along the corridor. We looked at this person's care plan and it stated that they 'Like to be in the communal area to chat with staff and other residents.' Other than brief passing comments we saw little staff interaction with this person all day and staff were not chatting or encouraging interaction between this person and the other people living at Mill View.

Some people were left in their rooms with food or drinks placed in front of them even though their care plan

indicated that they needed extra support to eat and drink. There were some periods when people were left with no staff support in communal areas, for example in the early evening there were ten people sitting in the lounge area, the television was left on but there were no staff present until the evening medicines were administered 25 minutes later. This was concerning as some people were living with dementia and had been seen to display some behaviour that was challenging to others earlier in the day. We noted that the care plan for one person stated ' (person's name) may become aggressive to people around him.' Other people were unable to move without support and some had restricted mobility making them at increased risk of falls.

There was not always sufficient staff to keep people safe and meet their needs. This meant that the provider had failed to implement the improvements detailed in their action plan and therefore this remains a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines safely. Medicines were stored securely and there were daily checks to ensure the fridge and room temperatures were within recommended ranges to help keep medicines safe for use. There was a medicines policy and the member of staff administering medicines was aware of this. There were clearly printed Medication Administration Record (MAR) charts each with photo identification and details of any known allergies. We observed medicines being administered and found that the care worker was competent and confident in the role. They wore a tabard to indicate that they were administering medicines and not be interrupted but they were by the telephone/bleep on a number of occasions. Some people required PRN (as required) medicines and there was a clear protocol in place including a medication plan for each PRN medicine to monitor its effectiveness. A person told us "If I am in pain I just ask for my tablets and they bring them there's no problem." Care records included consideration of people's consent to have medicines administered and one person managed their own medicines. This showed that the provider was supporting people to be as independent as possible.

Staff members we spoke with had undertaken adult safeguarding training within the last year. They had a good understanding of safeguarding procedures and were clear about what they should do if they suspected abuse. One staff member told us, "I would go to one of the nurses or the manager if necessary". Another staff member said, "I would let you (the Care Quality Commission) know if the manger didn't deal with it. They would though". Staff confirmed the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. We noted that the person in charge had ensured there was information about safeguarding in several areas of the home, they explained that this was to ensure that agency staff also knew which phone numbers to call as they may be less familiar with local safeguarding arrangements. A relative told us " I have no fears of any mistreatment or anything like that here."

Appropriate recruitment checks were undertaken before staff began work. We examined staff files containing recruitment information for five staff members. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people. There were also copies of other relevant documentation including character references, Nursing and Midwifery Council registration details and Home Office residence permits in staff files. The person in charge told us that a number of people volunteer at Mill View and DBS checks are also undertaken before they can start.

Care records for people contained a range of risk assessments that were signed as being reviewed on a monthly basis. For example risks associated with skin integrity and pressure care were found to be clear and detailed including photographs of the relevant area and clear instructions for staff in the care of the wound. We noted one example where a person was identified as being at high risk of developing pressure wounds

due to poor mobility and nutritional risks. Their record contained both nutritional and skin integrity risk assessments with action plans in place including pressure relieving aids and guidance for staff in turning the person frequently. Other risks to people were also identified and plans were in place including manual handling risk assessments. One example included detailed guidance for staff in the use of a full body hoist and sling.

Risks associated with the building were also recorded, for example the central heating system had been broken for a number of weeks and the provider had brought in a number of free standing heaters for people's bedrooms and there were risk assessments in people's records for the use of these heaters. The person in charge told us that the heating issues were now resolved and we noted that the home was warm on the day of the inspection. A lift was being repaired on the day of the inspection and we noted that safety measures were in place to protect people during this process.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in December 2014 we found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because people were not always protected from the risks of malnutrition or dehydration. People who required a soft of pureed diet were not provided with a choice of suitable and nutritious food that protected them from the risk of choking. Where people were at risk of dehydration fluid charts were in place but had not been completed consistently, this meant that the registered manager was unable to demonstrate that people had received sufficient fluids to meet their needs. An action plan was submitted by the provider in April 2015 that detailed how they would meet the legal requirement.

At this inspection we found that there had been some improvements in the provision of soft and pureed diets however concerns remained regarding some people's fluid intake and how they were supported to eat their food. The provider had received support during the summer of 2015 from the Integrated Response Team (IRT) who provide advice, training and information to local care homes. IRT had facilitated training in a range of areas including Food for Life training and they had advised the person in charge about areas for improvement including nutrition in the home. This had resulted in some improvements, including more availability of nourishing drink options such as milkshakes and smoothies. The chef told us that he was awaiting delivery of a new food processor that would enable improved quality of pureed foods and other modified texture meals.

Some visitors told us that they chose to come every day to support their relative to eat because they had concerns that people were not being supported with their food and fluids. Their comments included, "The standard of the pureed food varies, I can always tell which chef is on, the regular chef is good but it's a bit hit and miss, I have to come every meal time because it's too much of a risk. I sometimes have to mix a little milk in to get the consistency right. "Another person said, "I come every day to help at meal time because I don't think the staff would be able to take the time, there are so many people that need help," and "It's a difficult process, I'm not confident in staff feeding (person's name) because the consistency of the puree has to be right and I'm not confident staff would recognise if it was not correct and I'm not confident staff would manage their feeding. It would be ok if the staff stayed and they got to know people but there's a high turnover- mostly agency staff." We raised these issues with the person in charge who said that people and relatives should have no concerns about the consistency of the food because the chef had been trained, staff worked closely with dieticians and speech and language therapists (SALTs) and the staff were confident and competent to undertake these tasks. There were 18 people at the home who required a soft or pureed diet. Care plans relating to soft diets provided variable guidance to staff. One care plan simply stated that the person 'required a fork mashed diet ' with no other guidance. Another was more detailed describing positioning prior to supporting them to eat , starting with a thickened drink and then offering a teaspoon of pureed food, guidance included checking for lumps or bits of food that might cause choking and allowing ample time to swallow food.

There were inconsistencies in how drinks were offered and recording of this. IRT had made some

suggestions about improving fluid monitoring for people who were at risk of dehydration. This included ensuring that staff took action to increase fluids where it was noted that a person was not achieving their target fluid intake. At this inspection we found that this was an area of practice that was not yet embedded or sustained. We observed one person who had been assessed as at risk of dehydration and who needed additional support with food and fluids. Staff told us that they were able to identify people who required additional support easily because there was a red mat and file visible in their room which indicated that they required extra support. Despite this system a visiting relative told us "No one's been in to see if they've had a drink." There was an open bottle containing a fortified drink on the side, about three quarters full. Staff had recorded in the daily record '2 or 3 sips of ensure and 100ml apple juice.' This was the only recording for that day and this record was seen at 17.30pm. The care plan noted ' At risk of dehydration, staff to be aware needs plenty of drinks during the day.' Records for the previous six days showed fluids recorded between 250ml to a maximum of 750 ml. These amounts are deemed to be inadequate. Guidance from the British Dietetic Association (BDA) recommends average adequate intakes of water from drinks for woman are 1600ml per day and for men 2000 ml per day. Individual requirements may increase in warm, dry conditions such as a centrally heated home.

Another observation involved a person who was receiving all care in bed. The care plan detailed their need for assistance with food and fluids and identified high risks of developing pressure wounds, high risks of choking and medium nutritional risks. The person required a pureed diet and the care plan specified that staff should ' Offer drinks regularly with every meal, between meals and every time staff go in.' We noted that the person's mouth looked dry and checked the fluid intake record calculating a total of 650ml over 15 hours. The previous day had also recorded a low intake of 500ml in total. This is a quarter of the recommended intake and showed that staff had not been ensuring that this person received sufficient fluids. There was no indication on the care plan that this person had been assessed as needing a lesser amount of fluids and no recorded explanation as to why they had a low intake in this time. The fluid chart did not showing a running total so it was not immediately clear what their total fluid intake had been and there was no specified target for their intake. This made it difficult for staff to make a quick assessment about whether more fluids should be offered and to pass this information to colleagues.

A third person was seen to be alone in their bedroom with a meal and drink placed on a table in front of them. This scenario had been noted at lunch time when they were seen to be picking at their food without the use of cutlery. At supper time they were clearly struggling to manage without assistance and their food and drink had fallen into their lap. They were seen to be in distress and coughing so the inspector asked if they could call a staff member for assistance. The staff member stated that this person was able to eat and drink independently and did not need assistance however they agreed to speak to the nurse on duty about a reassessment of needs. The care plan did indicate that they were able to eat independently, however this was contradicted by other information in the care record which stated 'Requires assistance to be fed.' There was also a malnutrition risk assessment that indicated that this person was at high risk of malnutrition and the handover sheet reported that this person was to have fluids monitored. In the previous days the fluid chart showed totals over 24 hours of 200ml, 400ml and on the day of the inspection 700ml. According to the BDA guidelines these amounts are inadequate. We checked the weight chart for this person and found that in the last 12 months their weight had dropped by around 7kg.There was no evidence that this was a planned or acceptable weight loss. Their Body Mass Index (BMI) showed that this person was now seriously underweight for their height. Although the care plan indicated they were at risk of malnutrition it was not clear what action was being taken to support this person with their weight loss.

This shows that people were not being given sufficient support to eat and drink and risks of dehydration and malnutrition were not being appropriately monitored and managed. This meant that the provider had failed to implement the improvements detailed in their action plan and therefore this remains a breach of

regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed their food and we observed that people who were eating in the dining area where chatting and relaxed and appeared to be enjoying their meals and the social atmosphere. One person said "The food's fine, considering they are feeding the masses here, its ok." Tables were set nicely with menus showing a choice of two main courses. We saw staff were showing people two plates of food so they could choose their meal. This showed an awareness of good practice for people living with dementia who may find that seeing and smelling the food in front of them helps them to make a choice or to remember what they previously choose.

Staff said that people could choose something else if they didn't want the menu choice. We saw one person having fried eggs for lunch as they had not wanted either of the menu options. There was fresh fruit and a range of cold drinks in the lounge area for people to help themselves to if they were able to. People were offered a choice of drinks during the morning and afternoon. There was also a vending machine on the first floor offering drinks, a café area where people could have snacks and a small shop selling sweets. The provider employed a hostess to serve meals, but staff told us that they were not available at every meal time and that meant care workers undertook this task. Relatives told us that sometimes people were not offered a tea or coffee if the hostess was not in because care staff were too busy. We asked the person in charge about this, they told us that in March the home would be back to having three hostesses and two activity co-ordinators who could also help at meal times.

We saw staff assisting people with their meals in a discreet way, offering drinks and additional gravy where needed. One staff member recognised that a person needed fork mash-able food and we observed them mash the food in front of the person with their consent. This enabled the person to see the individual elements of the meal as it was being softened. Some people were not in the main dining area, staff said this was because they had large wheel chairs and they had their meals brought to them. We noted that they had to wait a considerable amount of time after everyone else had been served, for example one person was seen to wait for 35 minutes for their meal. They appeared to be frustrated and was heard to say "I only want some soup, why is it so difficult?" Staff gave reassurances that the soup was just coming. We observed that staff were busy supporting a number of people with their meals in the dining area and this appeared to be the reason that people sitting in the lounge area were served last.

The chef demonstrated that they had a good knowledge of individual needs and preferences. Catering requirements forms were in place to indicate people's preferences, religious requirements, any allergies, portion size preferences and any special dietary needs. For example if pureed food was required the form specified this together with the desired consistency. One person had a separate menu as she preferred plain food, the chef explained that he would prepare a plain version of the menu choice to reflect her choice.

At the last inspection in December 2014 we found that the provider was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured that suitable arrangements were in place for staff training and appraisal. An action plan had been submitted by the provider that detailed how they would meet the legal requirement by the end of April 2015.

At this inspection we found that the provider had followed their action plan, improvements had been made and sustained, therefore this breach has been addressed. We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "I spent two weeks shadowing someone. I was never left alone and I felt really well supported". Skills for Life Care Certificate

training was undertaken by all new staff. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. We looked at staff records and the supervision planner for 2015. Supervision sessions and yearly staff appraisals for all staff had been undertaken or planned, in line with the provider's policy. The staff we spoke with were satisfied with the process and felt it gave them the opportunity to discuss matters of importance to them.

There was a wide range of training available and all permanent staff were able to access training in subjects relevant to the care needs of the people they were supporting. These were available either as on-line learning or formal teaching sessions and included dementia awareness. We noted that these courses had been completed by between 86%-98% of care staff within the allotted time span. Some staff had undertaken other relevant training. For example the Integrated Response Team (IRT) had facilitated pressure damage awareness training delivered to 10 care workers in June 2015. We spoke with one person and their relative about their experience when they developed a pressure wound, the relative said, "They(staff) got onto it, they kept a regular eye on it." their care plan included a skin integrity risk assessment, a report on the wound including a photograph and evidence of involvement with the tissue viability nurse. The care plan included instructions for staff to ensure repositioning every two to three hours, recorded on a repositioning chart. Staff demonstrated a good understanding of managing skin integrity and the need to seek support quickly if they noticed a change in the person's skin. This shows that the pressure damage training had been effective.

Some relatives we spoke with had concerns about staff training, particularly in relation to the agency staff. One relative said, "As far as I can work out they (agency staff) have no understanding of dementia care" and " I don't think the agency staff have much training at all, some of them appear to be really inexperienced and they don't always know what to do when things get a bit heated between residents. " We asked the person in charge about their expectations in terms of training for agency workers. They said that the agency was responsible for ensuring people had basic training such as manual handling training and that they had found the agency to be reliable. They tried to use the same agency to maintain consistency of staff and if they were concerned that agency staff did not have the skills and experience to be competent in their role then they asked the agency not to send them again. We saw evidence that this had happened on a number of occasions.

We observed staff providing care and support to people, we saw a mixture of standards. For example we saw a number of people being supported to transfer to and from wheelchairs by use of a hoist. Staff were seen to manage this process efficiently with confidence and care, people were not always relaxed but staff recognised this and gave lots of reassurance during the procedure. We also saw people being supported to walk a short distance with support from two care workers. The process of assisting the person to stand and walk was well managed and humour was used to give them reassurance with a care worker saying "Shall we dance now?" the person was smiling and laughing in response. Another example was seen where an agency worker was taking a plated meal to someone's room, the person had decided to walk along the corridor but was very unsteady on their feet and the agency worker was clearly unsure of how best to manage this situation. The inspector suggested they bring a chair to the person to prevent them from falling whilst support was sought from another member of staff.

One person who was living with dementia was seen on their hands and knees picking at the carpet. A staff member recognised that this was because the pattern of the carpet was not dementia friendly and the person thought there were things on the floor that needed to be picked up. Whilst this was a good observation for the staff member they did not try and interest the person in a more meaningful activity and instead left them to carry on. This showed that whilst some staff were able to demonstrate that they had the skills and competence to care for people others were less effective, predominantly it appeared to be the

agency workers who were less confident in their role.

We looked at the provider's system for the communication of information concerning people's care between staff members. We were shown copies of the personal information handover forms which were used and circulated to all staff. They contained information such as people's mobility levels, care needs and dietary requirements, in addition to information concerning the management of behaviours that challenge. We noted other information, such as matters related to visiting professionals and changes in medication were also included. These gave a useful snapshot of the person's current wellbeing and care needs. We saw that staff were proactive in communicating with health care professionals, for example where a person had been identified as having some pressure damage to their skin, their care record showed that this was communicated effectively and support and advice was sought in a timely way from the tissue viability nurse.

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA) (2005). All of the staff we spoke with had undertaken recent training in this area. All had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We saw evidence of this in peoples files, for example one file noted 'Declines to be turned at night. She has the Mental Capacity to decide. We have explained the risks of developing pressure ulcers, but she still declines.'

Some staff members could tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. DoLS is part of the Mental Capacity Act. The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. One staff member told us, "We know that we are to assume people have mental capacity unless proven otherwise". Another staff member told us, "It's about acting in their best interests. We have to restrict people as little as possible".

We examined the care plan for someone who required close supervision and support, which constituted a deprivation of their liberty. The provider had acted appropriately, having requested a Deprivation of Liberty Safeguards (DoLS) assessment and authorisation following mental capacity assessment. We also noted people or their representative's consent had been sought in a variety of areas. These included whether they wished to manage their medicines independently or to be involved in care planning and reviews. The relatives we spoke with told us they were able to discuss their family member's care at any point with the manager.

People were supported to have access to health care services. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included speech and language therapists, local authority DoLS Teams and Older People Community Mental Health Teams, GP's, district nurses and dieticians. We noted that advice and guidance given by these professionals was followed and documented. A relative told us "They know I come in and monitor each day. If there's anything wrong they call in the GP." A person told us "I had a bad spell. I've got a pace maker fitted and saw the GP here about it when I arrived."

Requires Improvement

# Is the service caring?

## Our findings

People and their relatives had mixed views about the staff team. Most people told us that they were happy and felt that staff were kind and caring in their approach. Comments included " The care staff are good, they are really kind and do their best for me," and " The staff are all friendly and caring, " and "The girls are nice. They are lovely. It's not an easy job but they are all so sweet." Comments from some relatives were less positive "There are good staff but often they don't stay," and "There are simply too many agency staff, they don't get to know people and it's just a job for them, it's our loved ones that suffer." One relative said "Care has improved and is getting better, sometimes you still see staff sitting in the lounge but it's a question of time and nursing dementia is quite hard work. I had a member of staff nearly in tears because they weren't able to give people more time."

Some relatives told us that dignity and privacy was not always respected, examples they gave included, people being left without support with their continence due to time pressures on staff and staff not knocking before entering rooms. We were told that one person had their continence pad changed in front of another resident, the person in charge has given assurances that this incident was fully investigated and action was taken to ensure such an event could not occur again.

One visitor told us that her relative had been taken to a Christian service conducted at the home, this had caused confusion and upset because they were of a different religion. The person in charge told us that staff were aware of the persons religion and took them along to the service as they felt they would enjoy it as a social event. The person in charge said that staff had tried unsuccessfully to secure the services of a minister of this person's faith and following a full investigation into the incident actions had been taken to prevent any reoccurrence.

We asked staff how they maintained people's dignity and privacy. One staff member said, "We treat them as we would want to be treated," another said "I think we always try to put people first and treat them well," and a third staff member said "We all try our best but sometimes we are busy and it becomes about getting the basics done and not much else." We noted that there was no specific dignity training offered to staff, however the person in charge told us that dignity and respect were key elements of other training that had been undertaken. During the course of the inspection we observed that a person who had spilled some food at lunchtime was still wearing the same clothes in the evening, this did not preserve their dignity. This is an area of practice that needs to improve.

We observed positive interactions between staff and people that demonstrated a caring approach. For example staff recognised when someone was distressed and quickly acted to reassure them, saying " Don't worry, it will be lunchtime soon, shall we see what they've got for us today?" whilst kneeling next to their chair to gain eye contact and gently touching the person's arm. We saw one care worker sitting in the sunshine and chatting with the person they were supporting. This person was receiving one to one support on the day of the inspection. Another care worker responded quickly when someone was asking about his wife, saying "She's doing really well, you don't have to worry about her." This appeared to reduce the person's anxiety. We observed a number of altercations between residents where staff were quick to

intercede and diffuse the situation, using distraction and separation to calm people and prevent an incident. People appeared relaxed and comfortable in the company of the staff and staff listened and spoke to them appropriately.

Most of the electronic care plans we looked at contained both life histories and social care assessments. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships, for example, people's previous occupations and hobbies. One person told us that they had been involved in developing their care plan and this was evident in the document that stated ' (Name) likes to stick to a routine. Prefers small portions of food, a clean room and a happy cheerful faces, always make sure the TV remote control is within reach.' However some of the care plans contained very little information about people's life history and it was not possible to 'see the person' in the documentation. We asked a member of staff about this and they said that they were not always able to find the information about people's backgrounds to complete their "life story" section.

We observed a residents meeting where people were actively encouraged to express their views and be involved in making decisions about the home. The meeting was attended by 13 residents and was chaired by a resident. Prior to the meeting we saw staff encouraging people to attend. Some of those that attended needed additional support during the meeting and this was sensitively provided. One person living with dementia took more time to process the discussion and interjected with responses after the discussion had moved onto the next topic. However, their point of view was welcomed and reasonable adjustments were made to receive his input. For example, after discussion had moved on from catering they said, "It's very nice, very good. I've no complaints." Another person living with dementia returned to a point they wanted to make throughout the meeting. Their idea, for time each week to remember those people who had died, was adopted and acknowledged each time it was raised again. Minutes from the previous meeting were handed out at the time with the agenda for this meeting. One resident complained the type on the meeting minutes was too small to read and staff went away and produced a large type version, this showed that staff were responsive to requests and to the individual needs of people. The chair had control throughout the meeting and made sure that everyone had their say. She checked in to make sure everyone that used them had their hearing aids in.so that they could follow proceedings.

People were supported to have an advocate to make decisions and Independent Mental Capacity Assessors (IMCAs) had been involved in some decisions that were made in the best interests of people who lacked mental capacity. Other best interest meetings had included representatives or family members for people who lacked capacity.

Much of the environment at Mill View was designed to support the needs of people living with dementia. There was a tree with pleasant seating arrangement in the main reception area and a traditional sign post with arrows pointing the direction of the café, the lifts, the shop etc to help orientate around the building. People had memory boxes beside their bedroom door to help them to recognise their own room, most of these were in use and contained photographs and memorabilia that was relevant to the individual. All of these environmental elements were designed to support people's dignity and independence. We saw that people's records were kept securely in locked offices.

There were no restrictions for relatives or friends visiting and staff told us they welcomed input from relatives. However one relative told us "When I first came I would be greeted by name and the staff had time to sit and chat. It only happens now if I'm here when staff are helping with their supper."

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in December 2014 we found that the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because records, information and documents in relation to the care and treatment of people had not been maintained. There were gaps in the monitoring records and care plans did not always reflect people's current needs. An action plan was submitted by the provider in April 2015 that detailed how they would meet the legal requirement.

Many of the issues identified at the previous inspection had been addressed, however at this inspection new areas of concern were identified. The provider had implemented an electronic system to ensure reviews are completed for each person. In addition care records relating to people who had been identified as at risk of developing pressure damage had improved since the last inspection. Staff had attended a number of training sessions facilitated by the Integrated Response Team (IRT) to increase their knowledge of pressure damage, nutrition and bladder and bowel awareness. A health care professional from IRT told us that they had returned after six months to review progress and felt that the staff had benefited from the training and noted there were no current issues regarding pressure damage. Despite this positive feedback there were some areas of practice in relation to personalised care that needed to improve.

One person said that they did not feel that their care plan reflected their mental health needs and that staff did not always understand the complexities of the condition because they were more used to dealing with people with dementia. They said "I'm treated the same as the other people but my condition is different, sometimes the staff don't understand my behaviour." The person's relatives also expressed concern that staff understanding of mental health was not sufficient to recognise if the condition was deteriorating and said they were concerned that individual needs were not met in this regard. Their observations were that their relative was "Going downhill." The care plan did clearly state the person's mental health diagnosis however there was not specific guidance to support their mental health needs, including of the signs that would indicate a worsening of the condition. This meant that the care plan did not accurately reflect the person's needs and they were at risk of receiving care that was not responsive to their mental health needs.

Care provided was not always responsive to people's needs. For example, the care plan of one person living with dementia described how the person should be kept occupied to ensure they and others safety as they had some behaviours that were challenging. A visiting relative told us that they were often left in a chair for hours at a time in the lounge. We observed that this person had been in the lounge with minimal interaction with staff both before the visitor arrived and after they had left. For a short time a member of staff attempted to interest the person in looking at a magazine but they were called away and this activity was not resumed. The only other staff interactions seen with this person were during specific care tasks.

Care plans did not always reflect people's culture and beliefs. For example, there was minimal information in care plans regarding people's faith. In one example the front of the care plan noted that the person had specific religious beliefs. This was mentioned in their life history section and in the detail for end of life plans however there was no other mention of the significance (or not) of this person's faith or what staff should be

aware of to respect this. One electronic care plan contained different information to the paper file with regard to relationships that were important to the person. This could mean that important information is not communicated effectively to someone that was important to the person. Despite having a good level of detail, care plans were not all personalised and this meant that care provided was not always responsive to people's needs. This meant that the provider had failed to maintain accurate, complete and contemporaneous records and this is a breach of regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their representatives had contributed to care planning and many care plans were detailed and recorded people's preferences and interests. For example a relative told us "They always ask me if I want to go through the forms and place comments." One person said "I used to love knitting but I can't do it now because of my arthritis, I like to watch TV now, it keeps me occupied." The care plan confirmed this information and included guidance for staff to 'Ensure the TV remote control is to hand,' as well as other information including 'Dislikes puzzles and prefers small portions.' We noted that staff were aware of this information and that the lunch time meal did include a smaller portion.

People and relatives we spoke with had mixed views about whether people received personalised care. Some relatives expressed concerns, comments included "They sit in the lounge for hours at a time, there's so little interaction," and "Staff don't have time to sit with people and talk so they don't get to know people." Other people had different views, one person told us, "The staff are all lovely, they respect my wishes, if I don't want to get up early I can have a lie in. It's up to me." A relative commented "We have got an excellent key worker, they pop in for a chat even if they are working in another part of the home. Staff do get to know people's routines."

There was a range of activities that people could be involved in. There were two activities co-ordinators and they spoke with us about the programme on offer which operated seven days per week. One explained that the activities programme had changed and was now "More resident-led, based upon what we know people like to do, for example the music therapy group." People were able to choose what activities they took part in and suggest other activities they would like to complete. On the day of the inspection we observed a bowling activity attended by 18 people. One person told us they they particularly enjoyed this activity saying "I used to be in a bowls club, it's nice to do this again." We saw that staff used gentle encouragement to include people and gave plenty of time for people to be involved. There were refreshments available at the interval and people were seen to be enjoying the social activity.

We asked how people were supported to avoid becoming isolated. Staff told us that there were a number of activities that were extended to include people who were at risk of becoming isolated, this included visits from dogs and ponies who were taken upstairs to ensure everyone had a chance to be involved if they wanted to. There were also opportunities for people to have some individual time, for example talking about their interests, one example given was of someone who had been an award winning gardener and liked to talk about orchids. One to one time was available but this only happened for limited periods during the week, staff told us this was usually one morning and one afternoon. On the day of the inspection people were being encouraged and supported to attend the resident's meeting and the bowling activity. We saw a staff member gently encouraging someone to attend saying "Do you fancy a game of bowls? " they replied "Yes why not, I've nothing better to do!" However we also observed that there were a number of people who appeared to be isolated in their rooms with little access to staff interactions. It was clear that care staff on duty had little time to spend with people other than when supporting them with their care needs.

Some relatives said they were concerned about the lack of opportunity for people to access the local facilities. We asked about the opportunities for people to be supported to go out. Staff told us that the home

had use of a mini-bus but that it was only available once a fortnight when they can take six or eight people out at a time. Staff told us it was more difficult for people who were not able to walk unaided as they required more staff to support them when out of the home. People told us they would like to go out more often, one person said "I go out but only if my family can take me," another said "I would love to go to a football match again but I don't think that can happen because there's not enough staff." The care plan for this person had no mention of their interest in football. People were not always supported to follow their interests or to use local facilities, this is an area of practice that needs improvement.

There was a complaints procedure in place and the person in charge told us that she welcomed complaints as an opportunity to learn and improve the service. People and relatives told us that they felt comfortable to raise issues and complaints with the person in charge. People's comments included, "I've never had to complain but I would speak to whoever is willing to help me with it," and "The manager is approachable and honest." Relatives told us that they had raised complaints and they were acted on, one example given was of someone who never had their hearing aid in when the family visited. The relative told us that they had complained about this and that now staff ensure the person wears them.

The person in charge told us that they were committed to improving the quality of the service and that they saw the complaints process as integral to this, explaining that they valued feedback from people living at the home, their relatives and visiting professionals to drive improvements. During the residents meeting we noted that a person had raised a complaint regarding dining room conditions and the person in charge had acknowledged the issue immediately and promised action to rectify the situation.

Some relatives had raised similar complaints so the person in charge had arranged to meet with them regularly as a group to try and address the issues they raised. The person in charge was concerned to ensure that relationships with relatives were maintained and recognised that they remained unhappy with some aspects of the home. An action plan had been compiled following the relatives meeting to ensure that issues raised were addressed. One example showed that relatives had raised concerns about support for people at meal times and the actions included recruitment of a hostess to assist care staff. We saw that these posts had been filled. Other examples included maintenance issues where the person in charge updated relatives on progress and actions they had taken. However relatives told us that they remained dissatisfied with the provider's response to their concerns regarding staffing levels and we saw that this had been a consistent theme at relatives' meetings.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection in December 2014 we found that the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have an effective system to regularly assess and monitor the quality of the services provided in carrying on all the regulated activity. The provider submitted an action plan in April 2015 that detailed how they would meet the legal requirement.

At this inspection we found that the provider had implemented a number of actions and improvements had been made in some areas, however there were continued issues in some areas of quality monitoring. A number of monitoring systems were in place and new ways of working had been introduced. However, there continued to be some failures particularly in identifying gaps in records. For example, despite the introduction of a new system for monitoring fluids for people who were at risk of dehydration, recording was inconsistent and this had not been recognised by managers. This meant that the person in charge could not be assured that people had received adequate fluids.

There was a system in place that indicated when people were due for a review or re-assessment of their care needs, however the system was a quantitative guide and did not provide assurance of the quality of the review to ensure that the care plan had been updated effectively, for example in response to a change in needs. This meant that although people had care plans that were reviewed within timescales the content did not always reflect people's needs.

There was a monitoring system in place to capture information from incidents and accidents, these were routinely signed off by the person in charge and analysis took place to determine if there were patterns emerging. This showed that there had been a 39% increase in the number of incidents and accidents between September 2015 and December 2015. The number of unwitnessed falls had doubled in this time and the number of incidents and accidents happening in the evening or at night had also increased by 36%. It was not clear what conclusions had been reached regarding the reasons for the increasing number of incidents and accidents nor what action had been taken to reduce risks to people.

Although there were monitoring systems in place they were not always effective in regularly assessing and improving the quality and safety of the service. This meant that the provider had failed to implement the improvements detailed in their action plan and therefore this remains a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service should have a registered manager, however the home has been without a registered manager since March 2015. The person in charge applied to become registered with CQC in June 2015 but due to an administrative error the registration has not been completed. The person in charge has now reapplied and their application is currently in progress.

People, relatives and staff spoke highly of the person in charge, people's comments included, "She is

approachable and better with the staff," and "She's a very nice person." Staff told us that they had confidence in the manager, one said, " The manager is great," another said," I think it's well led- we are a good team and I think we provide good care." Relatives told us they found her to be open, honest and approachable. One relative said, "It's improved here, largely due to the manager."

The person in charge was seen to be supporting an open culture at the home, they had instigated regular meetings with people and relatives and described how they welcomed the opportunity to get feedback and to work with them to develop the service. For example the recruitment of new staff was described as a priority and they had asked people living at Mill View to assist in the recruitment process, specifically with the interviews.

The staff had developed good links with the local community, we saw that a range of relevant health care professionals regularly visited the home and the activities co-ordinators were active in developing links with local groups such a craft group and entertainers . The person in charge said that a number of volunteers were also working with people at Mill View to enhance their quality of life, for example one volunteer was helping in the garden and would support people if they wanted to join in with some gardening activities.

The person in charge undertook a 'daily walk about', they explained that they used this time to talk to people and staff and to observe care being delivered. They also undertook spot checks to ensure that the service is delivered effectively and this included checks during the night. They felt this enabled them to have a clear view of the quality of care provided within the home. When staff had described feeling pressured the person in charge said that they took action to support them, examples included employing an additional hostess to support staff at tea-time, maintaining staffing levels despite having vacant rooms and increasing the number of agency staff as necessary.

The person in charge was committed to improving the service and gave examples of where they were aware that improvements were needed, such as with care plans, where the process for care planning was under review. We saw that a range of work had been undertaken during the last 12 months to make improvements to the quality of care delivery but some areas had yet to be properly embedded within the staff team. The person in charge presented an open and honest assessment of the current standards within the home, describing the staff team as hardworking and well-motivated but recognised that where agency staff were used on a regular basis there were additional pressures for the permanent staff team. They said that they felt confident that the current recruitment process would resolve these issues and that the service would continue to improve.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured that there were effective systems in place to monitor and improve the quality and safety of the services provided.<br><br>The provider had not ensured that all care plans were accurate and personalised and this meant that care provided was not always responsive to people's needs. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider had failed to ensure that people were being given sufficient support to eat and drink and risks of dehydration and malnutrition were not being appropriately monitored and managed. |

**The enforcement action we took:**

warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff to keep people safe and meet their needs. |

**The enforcement action we took:**

warning notice