Barchester Healthcare Homes Limited

Southgate Beaumont

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Southgate Beaumont is a 'care home'. The accommodation is purpose-adapted with passenger lift access to both residential floors, each of which have separate facilities. People living in this care home receive accommodation along with nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager, which 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 service is registered to provide accommodation for up to 52 people. There were 50 people using the service at the start of this inspection. The service specialises in the care of older people and is operated by a national care provider.

This was an unannounced comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs, and well-led.

At our last inspection of this service in March 2017, we found one breach of legal requirements. These was in respect of safe care and treatment, specifically for the management of wounds and pressure ulcers. The provider completed an action plan to show what they would do and by when to improve the rating of key question of 'Is it Safe?' to at least 'Good.' At this inspection, we found the necessary improvements had been made to addresses the previous regulatory breach.

At this inspection, most people using the service praised it, but a minority expressed broad or specific dissatisfactions to us that we looked into further. People's representatives were generally happy with the service and said they would recommend it, and community healthcare professionals provided positive feedback.

We found people's call bells were sometimes not answered in a timely manner. We also raised concerns about our observations of one person's continence care, which the provider investigated and concluded was not in keeping with the clinical standards expected of the service. Therefore, despite some positive feedback and observations about caring approaches at the service, people's dignity was not consistently respected as the approach of the service sometimes left people feeling uncared for.

Some people's feedback and our checks of how the service handled concerns and complaints led us to conclude that these were not always listened and responded to, to improve on care quality.

There were recent occasions when the numbers of care and nursing staff working in practice did not quite meet planned staffing levels. We also found that recruitment checks of new staff were not sufficiently robust

at ensuring they were safe to work with people using the service. These practices put people at unnecessary safety risk.

Where there was doubt that anyone had capacity to consent to aspects of the care and support the service proposed to provide them, the service did not always act in line with the principles of the Mental Capacity Act 2005 that helps to ensure actions are taken in people's best interests.

Providers and registered managers must notify CQC about certain changes, events and incidents that affect their service or the people who use it. However, we had not been notified about two people using the service in 2018 experiencing significant injuries. This meant we did not have full oversight of the risks associated with the service.

Systems were in place to ensure that ongoing learning took place in response to accidents. However, this was not always conveyed to people involved in the accident or their representative under Duty of Candour expectations.

There were many auditing processes at the service that fed into a service improvement plan that was kept under review. However, these processes had not identified and addressed the care delivery concerns we identified, which demonstrated weaknesses in effective governance at the service.

The service provided people with a broad range of mental and physical stimulation, and supported people to develop and maintain relationships that mattered to them.

Although there was some mixed feedback about the quality of food provision, we found the service supported people to eat and drink enough and maintain a balanced diet.

The service holistically assessed people's needs and care-delivery risks, and set up individualised care plans that were kept under review. This helped ensure people's specific needs, such as in terms of communication or end-of-life care, were met. The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

People were generally supported to maintain good health and access appropriate healthcare services. The service ensured the proper and safe use of medicines, and protected people from the risk of infection such as through keeping the premises clean and well-maintained. Parts of the service had benefitted from redecoration this year. Equipment and premises were regularly checked to ensure the environment was safe.

This is the first time the service has been rated Requires Improvement. We found seven breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. There were recent occasions when the numbers of care and nursing staff working did not meet planned staffing levels, which failed to ensure people's safety and welfare.

Recruitment checks of new staff were not sufficiently robust at ensuring they were safe to work with people using the service.

The service had systems and processes that aimed to safeguard people from abuse.

The service assessed and managed risks to people's individual safety and welfare. Equipment and premises were regularly checked to ensure the environment was safe.

The service ensured the proper and safe use of medicines. It protected people from the risk of infection such as through keeping the premises clean.

Systems were in place to ensure that ongoing learning took place in response to accidents. However, this was not always conveyed to people involved in the accident or their representative.

Is the service effective?

Requires Improvement

The service was not consistently effective. Where there was doubt that a person had capacity to consent to aspects of the care and support the service proposed to provide them, the service did not always act in line with the principles of the Mental Capacity Act 2005 that helps to ensure actions are taken in people's best interests.

The service holistically assessed people's needs, and set up individualised care plans that were kept under review, to help ensure people's specific needs were met.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

The service supported people to eat and drink enough and maintain a balanced diet.

The whole service worked in co-operation with other organisations to deliver effective care and support.

People were supported to maintain good health and access appropriate healthcare services.

The adaptation, design and decoration of premises supported people's individual needs to be met.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's dignity was not always respected as the approach of the service sometimes left people feeling uncared for. In particular, people's call bells were sometimes not answered in a timely manner.

People were supported to express their views and make their own decisions about their care and support. Their independence was promoted.

The service supported people to develop and maintain relationships that mattered to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. It did not always listen and respond to people's concerns and complaints, thereby improving on care quality.

The service provided people with a broad range of mental and physical stimulation.

The service supported the communication needs of people with a disability or sensory impairment.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Whilst there were many governance processes and audits in use at the service, these were not consistently effective as they had not identified the concerns and service shortfalls that we found.

There were two failures in 2018 to submit statutory notifications to the CQC about significant injuries to people using the service.

Records we requested were not always provided to us in a timely

manner. The service otherwise worked in partnership with other agencies to support care provision and development.

The provider had a clear vision and strategy to support staff to deliver high-quality care and support. It engaged with and involved stakeholders in the development of the service.

Southgate Beaumont

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 unannounced inspection took place on 28 August and 6 September 2018. It was undertaken by two inspectors, a specialist professional nurse advisor and two Experts by Experience, who spoke with people and visitors during the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted the local authority and various community healthcare professionals who have a role at the service, for their views on the service. We received one reply.

There were 50 people using the care home service at the start of our inspection visits. During the inspection we talked with 20 people living at the service, eight of their relatives and representatives, and two community healthcare professionals. We spoke with ten care staff, two nurses, a cook, two activities co-ordinators, the regional training manager, the deputy manager, the registered manager, and the senior regional director.

During our visits, we looked at selected areas of the premises including several people's rooms, and we observed the care and support people received in communal areas including at meals. We reviewed the care records for ten people living at the service to see if they were reflective of the care people received. We also looked at staff recruitment records for five members of staff. We reviewed some management records such

as for health and safety, accidents and incidents, complaints, staff rosters, and quality audits, to see how the service was run. We then requested further specific information about the management of the service from the registered manager following our visits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found action plans for one person at risk of skin complication were not being followed and timely intervention had not been made with another person with pressure ulcers. This meant the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made which addressed the breach as the service was safely meeting people's pressure care needs. People's potential for developing pressure ulcers was regularly assessed by using the Waterlow scale, a specific way of estimating the risk to an individual of developing a pressure ulcer.

Where two people had pressure damage, records showed they had been referred for specialist community professional input. Management plans were in place with evidence of wound assessments which included photographs, repositioning plans and use of appropriate equipment. They had access to 'as required' pain control medication. Two further cases reviewed indicated that the pressure damage previously acquired through hospital admission had successfully healed.

Records showed that where people required repositioning at specific intervals because they were at risk of pressure ulcers, this was being done. This matched what one person's representative told us, that their loved one was "checked every hour at night by staff, checked by staff during the day and has to be turned every four hours which they do, staff come in and check on him apart from the four hours, opposite office and listen out for him."

The service routinely carried out recruitment checks of prospective staff such as by checking identification, right to work in the UK, and Disclosure and Barring Scheme (DBS) disclosures. These disclosures are checks of police records and a list of people legally recorded as unsafe to provide care to adults. However, recruitment checks were not consistently robust at ensuring and recording that all necessary checks took place. This put people using the service at unnecessary safety risk.

Of the four new staff whose recruitment files we checked, two indicated that references from previous care providers had not been acquired or reasonably sought before they began employment. The reference for a third file stated they would not re-employ the person, but there was no record made explaining how that had been taken into account in the employment of the person. All three files failed to record exploration of the applicants not providing the requested five years' employment history, nor the seven-year employment gap for one of the applicants. One file did not record reasons for the applicant leaving previous care employment; another lacked an interview record and the third lacked evidence of a care qualification that the person declared on their application form. This all demonstrated that new staff were not fully vetted before being allowed to work with people using the service.

There were recruitment check forms at the front of the files of each staff member we saw. However, these were all partially filled in, indicating they were not being used robustly to ensure all appropriate recruitment

checks had taken place.

The registered manager told us employment histories were explored, but agreed there was no record available in the files we looked at in support of that.

At the end of our second visit, we asked the management team to provide us with evidence of addressing or mitigating these concerns. We also requested a copy of the provider's recruitment policy. At the time of drafting this report, nothing further had been provided. The above evidence is therefore a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five people we spoke with expressed some dissatisfaction with staffing deployment, whereas no-one praised the service for this. The comments included, "Short staff at night; during the day just sometimes there is not enough staff on the floor", "Not enough staff, I got back to square one, they are not looking after my health" and "Shortage of staff, when I came here quite a few, but a lot have left." People's representatives were more measured, with comments ranging between, "Generally enough staff; can be very busy" and "I would say they need a few more."

Whilst some staff were satisfied with staffing levels, four staff members also expressed concerns with staffing deployment. One told us, "There is often a shortage of staff and Barchester do not allow agency staff. This has been a particular problem regarding nurses recently." A second said, "The care team is often short staffed; I have witnessed one nurse on night duty for 51 residents, and Barchester never call the agency. Usually we do not have enough carers on shift either, I have seen three carers on a floor of 32 residents." A third told us that a weakness is that the service is "short of staff sometimes." A few staff mentioned that people with greater care needs moving into the service but no change to staffing levels.

The management team told us of deploying three nurses during the day plus nine care staff, then two nurses and four care staff at night. This was based on providing more staff than the provider's staffing dependency tool, based on the collective needs of people using the service, dictated. However, we identified situations where staff allocation records for two weeks in August showed planned staffing levels were not consistently adhered to. The registered manager confirmed this was the case in some instances, but stated allocation records had not been updated in others, although no other evidence in support of that was supplied on request. Therefore, across those two weeks, the service was operating with two instead of three nurses during the day for 37.5 hours out of a maximum of 168. This meant they were one nurse short 22% of the time during the day.

The management team told us many staff now started work at 07:00 rather than 08:00 as currently many people using the service liked to get up earlier. However, we identified that this meant many care staff were leaving at 19:00, reducing care staffing levels to as little as two until the four care staff arrived at 20:00 for the night shift. The two care staff scenario occurred five times in a two-week period in August 2018. The management team took immediate action to cover that hour when we highlighted the concern to them; however, this may not have occurred without our intervention.

One member of staff indicated that there had been instances where staff had worked back-to-back shifts (both day and night). They felt this meant that those staff were sometimes tired and short-tempered. Our checks of staffing deployment found back-to-back day and night shifts occasionally occurred amongst care staff, including a few 36-hour shifts (day then night then day). The registered manager told us that where cover was needed at short notice, shifts were offered to willing staff who may therefore work long hours but who would know the service and people's needs well. However, they acknowledged this was not ideal.

In summary, our checks showed the service was not consistently ensuring that staffing levels were upheld. Combined with the views of people using the service and staff above, and the time sometimes taken to answer call bells as explained under 'Is It Caring?', this demonstrates insufficient deployment of staff to ensure people's safety and welfare. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems and processes that aimed to safeguard people from abuse. Training records showed all care staff were up-to-date on safeguarding training. It was covered prominently during the initial induction training of new staff. Our discussions with staff showed they understood the different forms and potential signs of abuse, and their broader role in keeping people safe. They recognised the need to report any abuse concerns to the management team, and were aware of organisations such as CQC or the local authority for escalating concerns.

When the service showed us a summary list of safeguarding cases for the year, it omitted a matter the local authority raised with them about allowing a dependent person to be sent alone to a hospital appointment. The June Clinical Governance Meeting minutes, under the safeguarding heading, did not refer to this ongoing case. This indicated weaknesses in the service's safeguarding procedures.

The management team told us they now made sure there were advance arrangements where anyone needed support to attend a hospital appointment. This meant either checking with the person's representatives to ensure that support, or charging for a staff member to attend.

The above case was considered within the service's safeguarding file. However, that file had no information on the safeguarding process followed in response to someone using the service developing a grade three pressure ulcer at the service, despite that case being part of the safeguarding summary list. This also undermined the effective operation of the service's safeguarding procedures.

The service ensured the proper and safe use of medicines. People were satisfied with how the service helped them manage their medicines. For example, one person told us they could get pain relief medicine "more or less right away." We saw that nursing staff had protected time to ensure that they were able to focus on administering people's medicines. They spent time with people when they were taking their medicines to ensure that they were comfortable and properly supported.

There was safe storage of people's medicines. Each floor had a separate clinical room where medicines were securely stored and kept at appropriate temperatures. Medicines trolleys were seen to be kept secure during medicines rounds.

The service administered all medicines from their original packets. After each administration the medicines were counted. This meant that each person's medicines were audited daily, to help ensure they were offered as prescribed.

There were appropriate systems in place for managing controlled drugs (CDs). Medicines classed as CDs have specific storage and administration procedures because they have a higher potential for abuse. Records showed that two staff signed when CDs were administered. Weekly audits accurately reflected the use of CDs within the service.

Where people had been prescribed topical creams or lotions, charts were kept separately in people's rooms and staff completed them when creams had been applied. We found these charts were signed with no omissions, indicating people received topical cream support as prescribed.

We saw monthly medicines audits taking place. The registered manager duly signed off the action plans arising from the audits as completed. Our checks found that these plans had been completed as required.

We found the service was protecting people by the prevention and control of infection. People and their representatives were satisfied with the cleanliness of the service, saying for example, "The cleaning is good" and "Her room is clean." We found the premises including people's rooms to be clean and tidy. The service had a dedicated domestic staff team plus numerous cleaning schedules and checklists that needed to be completed for infection control standards. People had an allocated space in the laundry room for their cleaned clothes and bed linen. Soiled and unsoiled items were kept separate.

The service achieved a four-star 'good' food hygiene rating from a June 2018 inspection of food safety processes in the kitchen. We checked the kitchen area and did not identify any cleanliness or food hygiene concerns. Food hygiene standards were discussed at inter-departmental meetings.

Recent clinical governance meetings included attention towards infection control standards. It was evident that staff could raise concerns about infection control practices that influenced this.

There were systems in place to ensure designated staff at the service undertook safety checks regularly. These included for bed-rails, pressure-relieving mattresses, hot water temperatures, window restrictors, and a range of fire safety checks. There was a rolling program of checking safety risks in people's rooms, for example, that call bells were working. Records showed this helped concerns to be identified and reported.

There were professional inspection certificates in place where appropriate, for example, for lifts and lifting equipment, the fire alarm system, fire extinguishers, emergency lighting, electrical devices, and the water systems in respect of Legionella risk.

The service assessed and managed individual risks to people, to balance their safety with their freedom. There were a variety of risk assessments and subsequent care plans in place to recognise people who may need further support to keep them safe. For example, care plans guided staff on how to minimise the risk of falls for each person, based on regularly reviewed falls risk assessments. There were risk assessments for where people had bed rails to help keep them safe in bed. For one person we saw that an hourly check had been put in place to help ensure that they did not trap themselves in the bed rails.

We found risk assessments to not be consistently in place for people prescribed high risk medicines. These medicines can have significant side effects if not administered correctly. For example, one person was taking Warfarin, a medicine used to prevent harmful blood clots. There was no guidance in place for care staff to ensure that they could recognise if the person was experiencing side effects and understand if action needed to be taken. At our second visit, the management team showed us an appropriate risk assessment had been set up.

The service learnt lessons and made improvements when things went wrong. There continued to be procedures in place to ensure any accidents or incidents involving people using the service were recorded and action taken. The records paid attention to what happened, possible causes, and what treatment was provided. There was analysis of what further action was now needed, and reports were signed off by the registered manager.

The management team told us of ensuring the learning from incidents was conveyed at staff meetings, to help ensure everyone was aware and took ownership for making improvements. Daily nurses' meetings and monthly review meetings of clinical governance also supported this process.

We saw one person who needed thickened liquids was provided with un-thickened soup for lunch. Staff brought it to the person's relative and asked if it needed thickening. Following our visit, the management team checked on this matter and found that the involved staff member had not followed the protocols for this person. We saw a record of developmental supervision for that person, to help ensure the safety concern did not reoccur, and we were told they would be attending dysphagia training again. The service's actions were minimising the risk of reoccurrence.

A Duty of Candour file showed that where people were involved in significant injuries or safeguarding cases whilst using the service, investigations and learning took place to minimise the risk of reoccurrence. However, written communications to the person or their representative did not apologise or candidly explain all relevant facts of how significant injuries occurred. This did not follow the open and transparent principles of the Duty of Candour.

Requires Improvement

Is the service effective?

Our findings

We asked 20 people if they would recommend the service. 13 clearly stated they would, but four said they would not and others were unsure. Comments ranged from "It's marvellous" to "It could be better" but most people said it was "pretty good." People's representatives were generally happy with the service and said they would recommend it. One said, "Generally the Beaumont is a quality care environment."

We found the service was not always working within the principles of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A recent review by the provider's quality improvement team identified some applicable people had not had DoLS applications made and that mental capacity assessments had not been consistently used where needed. A subsequent regional director visit indicated good work to progress the DoLS applications. The deputy manager told us which people using the service had a DoLS in place, but said that she needed to update the oversight record of this on the clinical record. They and the registered manager were not aware of any conditions on people's DoLS. The updated oversight document we were subsequently sent did not check for this. However, the first person's DoLS we checked had a condition that the service had to abide by. This indicated the service was not monitoring that it was complying with any DoLS conditions, which was contrary to the principles of the MCA.

People's care records did not consistently demonstrate the principles of the Mental Capacity Act 2005 were being followed. We checked the care files of three people using bed-rails to help avert the risk of falls. Their bed-rail risk assessments all stated they lacked capacity for the decision to use bed-rails but there was no record of assessing this or of best interest decision processes being followed. Two had capacity assessments for overall care and treatment at the service, but subsequent best interest processes had not been completed. Two lacked a copy of the DoLS that was in place for them or reference to the DoLS within their care plan. The third person's file had the DoLS in place but no reference on their care plan to how this impacted on their care, particularly in respect to the condition on their DoLS that the care service was required to act on.

The above evidence demonstrates failures to ensure care and treatment was being provided in accordance with the MCA. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. A community professional told us of comprehensive and

individualised assessments of the needs of new people using the service. They felt the service had improved its processes so people whose needs could not be met were not offered the opportunity to move in.

People's records showed that a needs assessment was completed before they moved into the service. The assessment looked at the person's medical history, and their current and on-going care needs including for continence, skin care, and moving and handling. The assessment looked at the person as a whole, including their background, family and emotional wellbeing. The assessment helped to create a basis for the person's individual care plans

The deputy manager told us, "We have 'resident of the day' [on each floor] which means that each person is reviewed monthly." People's care records showed that monthly reviews of care, including people's care plans and risk assessments, were being completed and were generally up-to-date.

The whole service worked in co-operation with other organisations to deliver effective care and support. Community professionals told us this was the case. One explained that there was always a well-informed nurse present when they had appointments with people using the service. Another spoke of receiving appropriate referrals and that staff were welcoming and interested in their work in support of people's care and treatment. People's care records showed evidence of specialist community professional referrals and input where indicated, for example, for dietitian and audiology support.

When people were transferred between services or to hospital the service had a 'transfer form'. This documented, for example, the person's physical wellbeing at the time of transfer, whether the person had specific equipment they used such as a PEG, and any pressure ulcers or skin conditions. This ensured that the receiving service was aware of any physical conditions that the person might have and would be able to address them accordingly.

The service supported people to access healthcare services and receive ongoing healthcare support. People told us they could see a GP when needed. Their comments included, "Doctor will come if I need; I haven't needed her that much, but have seen her when around", "You tell the nurse what is wrong and they put your name down to see the doctor" and "Now they are checking on me regularly; GP visits ones a week, it's a big advantage." People's representatives also fed-back positively, for example, "They've very on the ball; health issues but they respond, for example, around hospital and physio."

We saw clinical governance meeting records that covered key areas of health risk such as weight change, falls, pressure ulcers and unplanned hospital admissions. The deputy manager explained the meetings were also used to help identify and address patterns and concerns.

One staff member's photo was on display in the entrance area as 'employee of the month.' The registered manager explained they had acted promptly to provide one person with resuscitation, which records indicated saved the person's life.

People provided us with mixed comments on food and drink at the service. Positive comments included, "Nice food, two big meals a day, you can get yourself a cake and a drink" and "The grub's good." One person was happy with the food but unhappy that they sometimes had to wait half an hour to be served. Another person said, "The food is not as good as it was, sometimes is good but mostly not. Sometimes the meals are 25 minutes late." Wholly dissatisfied comments included, "I'm fed up of the menu, quality varies depending on who is on duty. Far off the standard that they are aiming to" and "I fill in the menu but it's a waste of time, I never get what I want."

People's representatives provided similarly mixed views. One relative said, "Food is of a high quality" and praised that their family member received good support to eat more. However, another told us, "I hear a lot of complaints about the meals."

The chef told us of feedback from the last meeting with people using the service. Consequently, more meals involving pasta were being prepared, for example. The registered manager added that people were now being asked each day, rather than weekly, on choice of the meals. She added that there was enough cooked to enable people to change their minds when meals were served.

The service's main dining room was welcoming and tables had been set with linen tablecloths and glasses. We saw that people were provided with a choice of two main options for the three-course home-cooked lunch. We saw specific meals prepared based on people's needs and choices, for example, a salad with strawberries. There was a plentiful supply of fresh foods available in the kitchen.

A community professional told us people's food and drinks charts were well maintained, and so people's weights were properly monitored. We saw that nutrition assessments had been carried out on all the care plans reviewed. The needs of specific people at risk of malnutrition were discussed at each clinical governance meeting, to help ensure appropriate responses such as weekly weight checks, fortified diets and dietitian input. Minutes of a recent nutrition meeting, involving nurses, catering and care staff, helped to ensure communication between staff of different roles. For example, on people's food preferences and where unplanned weight loss was occurring.

The chef told us of a recent week themed around hydration. This involved different ways of encouraging fluid intake, for example, through smoothies, fresh fruit, fruit pots and ice lollies.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. Most people and their representatives told us of staff being capable, for example, "Staff are very good", "They understand enough of the conditions of the patients" and "All the nursing I get has been excellent." A community professional told us of experienced nursing staff at the service which helped ensure people receive good care and treatment. We found that nursing staff were up-to-date with their nursing registrations, and knew people's individual needs well.

Staff told us of receiving sufficient training for their care roles, much of which was classroom-based. Some praised the training and its impact on care provision, including, "Training is very good and frequent" and "Training provided, always happy to answer my question, all tools provided to do my quality job."

The provider's designated trainer told us of running week-long training sessions at the service each fortnight. Staff could also attend their sessions at one of the provider's other services nearby if needed. This process ensured new staff received prompt training, and established staff received updated training periodically. The classroom-based training included topics on health and safety, person-centred care, dementia, and customer care. There were also some online courses that new staff had to complete soon after starting work, mainly on safety matters such as fire and food safety, and falls prevention, but key points from these were part of the classroom training. There was also a practical assessment of competency for safely hoisting people. This ensured new staff completed a national training program on essential care standards within the standard 12-week framework. We saw individual staff records in support of this.

Oversight records showed care and nursing staff received developmental supervision regularly, and that there were annual appraisals, in addition to the training support provided.

The adaptation, design and decoration of premises supported people's individual needs to be met. People were satisfied with the décor and accessibility of the premises and their rooms. One person said, "My bed's comfy." Another told us of people using the extensive garden when it was warm. A third person explained that a strength of the service is the "ambiance of the place, includes building and grounds." A representative praised that the building was "well furnished, appointed and maintained"

The management team informed us there had been redecoration of the communal areas. Before our visits, they had notified us of the redecoration work, its potential impact on people using the service, and how they had been consulted about this to minimise impact. The senior regional director told us of further plans to upgrade the kitchenettes and more people's rooms.

Requires Improvement

Is the service caring?

Our findings

During our visit we mainly heard and saw staff treating people kindly. For example, when leaving someone in their room, a staff member made sure the person was comfortable before saying they were going. Another staff member offered to cut up someone's meal and bring alternatives when the person refused what was served. Nursing staff engaged well with people when offering them their medicines. People and visitors were warmly greeted throughout the service.

However, people gave mixed feedback about how caring the service was. Positive comments included, "They've all been very kind to me", "The staff is excellent, very nice, very caring" and "We have a laugh." However, seven people provided mild to serious negative comments. This included mixed views such as "Staff are good but some are lazy, some can't be bothered" and "There's some fantastic staff and some who shouldn't be in the job," citing one staff member's refusal to help them sit up. Some comments were entirely critical, including, "The staff is coming to my room only to bring my food, they don't talk to me" and "They are a bit rough and bossy, very ignorant and unpleasant; I needed help and she paced straight by me without helping me."

People's representatives generally told us of a caring service through comments such as, "Staff pop to see her in quite regularly, especially at night; very caring staff" and "Caring, attentive and compassionate staff; evidence of genuine concern for the residents who are treated with respect and dignity." However, two representatives provided mixed feedback about the approach of some staff. One said, "You do get the odd one who does not smile as my relative responds to smiles." The other cited some staff saying things like "What do you want?" when answering call bells, which they felt put people off from asking for help.

When we read these comments to the management team, they told us these were a surprise as they were not aware of this amount of concern, but that the views would need to be taken on board and acted on. They said there was no specific training provided on dignity in care but it formed part of the safeguarding and customer care training that all staff received. 'Distressed reactions' training also included practical training on matters such as supporting people to eat, which helped staff understand how it felt to be dependent on staff support.

We noted that some staff knocked very quietly on people's doors before asking if they could come in. In one case, we had to alert the person as they had not heard the knock.

During the afternoon of our first visit, we found someone soaked in urine on a chair in their room. Staff told us the person had been refusing personal care support that day. Their care plan confirmed they may refuse support but that staff should go back to check. However, the plan contained no guidance for staff on how best to work with the person if refusing care. This demonstrated failures to treat the person with dignity and respect. We brought this to the attention of the management team, who agreed to raise a safeguarding alert about the incident.

We were subsequently sent a detailed investigation report into the above incident, as undertaken by an

independent manager working for the provider. The report identified service shortfalls. This included that despite the support refusals, "incontinence management was not in keeping with the clinical standards expected of the team." It also confirmed the care planning shortfalls. The report also made recommendations for improvement that were stated as already being implemented. On our second day of visiting, we were shown that the person's care plan had been updated to guide staff more specifically on how to respond if the person was refusing personal care.

We also found people were not consistently treated with dignity and respect because call bells were not always answered quickly. Although some people were satisfied with how quickly they were responded to, seven people told us of waiting too long for call bells to be responded to. Their comments included, "When I need help and press the bell they never come", "It takes time, I have spoken to some other residents who are wheelchair bound or bed bound it can take 20 minutes to half an hour" and "It took them 20 minutes to help me." Another person said it was "sometimes okay" but cited waiting an hour for pain relief one night recently. They added they had to sometimes escalate the urgency of the call by pressing the call bell three times. Call bell records showed they had done this four times across two recent consecutive days, with overall response times always being at least 12 minutes.

During the visit, we generally saw staff responding quickly to call bell activations. They told us they were reminded to respond quickly such as in staff meetings, and showed us pagers they carried which alerted them to where call bells were being rung from. However, when we set off the alarm in a toilet during the morning, we found two care staff in the corridor nearby did not attend as they were dealing with a delivery of boxes. This was despite carrying pagers.

When we checked call bell response times for the ten days leading up to our first visit, we found 24% of activations had not been responded to within the service's call bell policy standard of six minutes. 12% took more than 10 minutes for a response. From that data we found peak delayed responses occurred between 8 and 10am, and again in the early evening. We also checked the longest response times. This showed one person's call at night was not responded to for over three hours, despite them elevating it to an emergency response. Another call bell just before 7am took over an hour to respond to, despite similar elevations of urgency. A third took over 50 minutes in similar circumstances on a different morning. These responses were well beyond the service's stated six-minute response expectation.

The registered manager showed us recent records of triggering the call bell and observing what response there was from staff. This had resulted in pager responses being altered to better identify which communal room the bell was being alerted from. They also showed us that some call bell response time checks took place based on the data available from the system. However, we noted whilst these identified some occasions when responses took a long time, there were no specific records to show how these were investigated. This was contrary to the service's call bell policy statement that, "Unacceptable response times above six minutes are to be investigated with the care team responsible and ensure that this is not repeated." The registered manager told us instead of immediate responses to try to fix matters, and of various problems with ensuring the system and equipment worked effectively. She acknowledged that "six minutes to someone lying in bed is like an hour."

The above evidence demonstrates failures in systems and practices to ensure people are treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service ensured people's independence was respected and promoted. The design of the building helped people to be independent. For example, most doors were held open using devices that would

release in the event of the fire alarm activating. This helped people to move around safely. We saw that everyone had access to their call bell if needed, and no one told us of it not being made available to them. One person told us they could access whatever they needed from the bed through grab-aid. We saw staff supporting people to be as independent as they wanted to be. For example, one person was using an inhaler themselves but with staff present to support if needed.

The service paid attention to ensuring people's personal information was securely kept. People's records were kept in locked offices. Staff meeting minutes reminded staff of the need to look after people's personal information.

The local training officer informed us new staff received training on equality and diversity on the first day of their induction. This emphasised the importance of treating people without discrimination.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. One person told us, "When I first came here staff did not know my history, but some of the staff listened to me and learned all about me, my medical history." A staff member told us that a strength of the service was that "we enable residents to make choices about their care." The registered manager told us letters were sent to people's representatives inviting them to a meeting to review the care of the person. We saw evidence of involvement by people and their representatives signing review meeting records. The action plan for the results of the last survey showed further work was taking place to better involve people in their care decisions through the service's key worker systems.

The service supported people to develop and maintain relationships that mattered to them. People told us their visitors were welcomed. Comments included, "My daughter visits me almost every day and take me out in my wheelchair", "I have friends that come to see me" and "They do make an effort to get to know regular visitors." Some people also appreciated the company of others using the service, for example, "I'm very happy to go downstairs, they take me there and I can meet people, nice people." A relative concurred with this, telling us, "Residents are nice and people talk." We saw visitors being welcomed into the service at all times of day.

One person and someone else's representative told us of difficulties receiving phone calls in the evening. The person told us, "After 5 o'clock no one can ring in as no one is on reception. Sometimes passing staff might pick up the phone but messages are not always passed on." In response, the management team told us of recognising this and looking into different phone systems based on monitoring performance data on how phone calls into the service were being responded to.

A staff member told us a strength of the service was that "relatives can maintain contact with friends and their local community." Records showed that improvements had been made to internet access in the service. This had enabled one person and their family abroad to communicate through Skype.

The service communicated well with people's representatives. One such visitor told us, "They do tell me what goes on as I am here all the time." Another spoke of staff always being approachable.

Requires Improvement

Is the service responsive?

Our findings

The service had systems in place for receiving and acting on complaints. Staff were aware of how to manage complaints through specific training that all staff attended. We noted the provider's website advertised how its complaints procedure worked, which helped demonstrate an openness to accepting and resolving matters.

People's representatives told us concerns and complaints were well-handled. One relative said, "If anything is not right I tell staff and they listen to me." Another told us the registered manager dealt with their concern "exceptionally well, gave us immediate and unreserved apologies, undertook a thorough investigation keeping us informed about it, and provided us with conclusions and action plans."

However, people had mixed views about how easy it was to have their concerns or complaints properly responded to. Some people made positive comments such as, "I am very happy here, I have nothing to grumble about" and "I don't know how to complain but I'll find out if I need to." In contrast, five people commented negatively about their experiences of complaining. Comments included, "I had a very nasty time after I complained" and "My chair is not comfortable, I've told them but nothing has been done."

One person gave us permission to share some of their current concerns with the management team, and stated they felt they had already complained about the service. However, there was no record of this in the service's complaints file. When we checked the person's care file, there was no obvious sense of dissatisfaction relating to aspects of their care. For example, the most recent monthly review of their care indicated the person was "happy." Records were not capturing the person's dissatisfaction and the service's responses. The management team informed us of various actions already taken to address older concerns this person had raised, but agreed records needed rectifying to accurately reflect the person's views and the service's responses.

People's mixed views on concerns and complaints did not match the provider's complaints policy expectations. The policy stated, "Any person who has expressed a concern or complaint should be able to say: "I felt confident to speak up and making my complaint was simple. I felt listened to and understood. I felt that my concern /complaint made a difference"."

There was no index or summary of complaints within the service's complaints file. Complaints were filed by month, although one recent complaint was instead filed at the back of the folder. The file showed full responses were generally made to complainants in due course, and the service accepted and apologised where appropriate. However, there was no audit trail to show what the complaint was, how it had been resolved, and what actions were being taken to ensure lessons were learnt. Whilst formal complaints were recorded on the provider's computer systems to enable response oversight such as for making sure matters were dealt with promptly, there were no trend-analysis systems formally in place. This did not help to identify people's mixed views on care that we found. This was being looked into further by the provider.

We received information a few months before the inspection indicating a complaint had not been

responded to. When we raised this with the registered manager, they told us the complaint had been investigated and believed a response had been sent to the complainant, however on checking they found the response had not been sent. This demonstrated a failure to effectively handle and respond to a complaint.

The registered manager told us in respect of the above complaint, "Going forwards we have taken the decision to follow all letters/emails responses to complaints with a phone call to confirm that these have been received." We could not check that was now occurring as there had been no new formal complaints. However, we asked for evidence of disseminating the lessons learnt from this complaint. At the time of drafting this report, 19 days later, nothing had been provided, which demonstrates a failure to take necessary and proportionate action in response to a complaint.
The above evidence is therefore a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were individualised care plans in place for each person that included information on most aspects of their physical and welfare support needs and preferences. The plans guided staff on how to provide personalised support to people that met their needs. For example, one person's moving and handling care plan noted that the person needed to be gently told exactly what staff were doing and to focus on the specific activity that was being done so that the person would be able to understand and engage with being moved.

We found overall that staff were knowledgeable about the support needs and preferences of people, which helped to provide a personalised service. For example, they told us of different strategies to support people who confused day and night.

The management team told us they had identified that there was a high number of people that wanted to get up early. To respond to this, care staff hours had been changed and they started working at 07:00 to ensure that people could be supported and receive personal care when they were ready to get up. Care plans documented people's preferred waking and sleeping times.

The service provided people with a broad range of mental and physical stimulation. There was an activities programme seven days a week that was advertised and updated weekly. People generally fed back positively about the activities. Their comments included, "We have lots of activities and I enjoy it", "They're quite good, no complaints" and "They provide a lot of activities; it's a big place." A representative said, "The leisure activities are of high quality where family members are encouraged to join their relatives." Another told us of "excellent" activities, for example, "Music of their era, Scrabble, quizzes, arts, war documentaries; people really love it, and they remember lots."

Some care staff told us activity provision was a strength of the service. Their comments included, "Good activity programmes" and "The home puts on activities and social events which many residents enjoy." An activity co-ordinator told us people using the service had "opportunities to socialise with others of their own age and take part in activities. We have a lot of volunteers from the local schools, art and bridge clubs and once a week live music."

During the morning of our first visit an exercise activity took place in the main lounge that eight people and a few of their representatives attended. The various exercises and reasons for them were explained to everyone. People's different physical and communication needs and abilities were taken into account. During the afternoon a 1950s reminiscence activity took place that 12 people and a few visitors joined in with. People were stimulated by the activity, and we saw many positive interactions between people and

the presenter.

One person had chosen to be involved in helping facilitate activities within the home and was supported by the activities coordinator. The person ran a regular, well attended film club and we saw posters around the home advertising the next film night.

The service had a visit from a regular 'pet therapy' dog. An activities co-ordinator told us that many people really enjoyed this and the dog was very good with people. People that did not wish to take part had been identified and alternative activities were available for them.

The service supported people to follow their faith. One person told us, "Some people from Church of England come here on a Sunday." Another person said, "I am not religious, but I am sure they would arrange something (if I was)." People's faiths and support needs around this were identified in their care files. An activity co-ordinator told us of regular visits from representatives of some faiths.

The service supported the communication needs of people with a disability or sensory impairment. Care plans contained information around people's communication needs. This included if they needed equipment such as hearing aids or glasses. Where people were not able to effectively communicate verbally, care plans gave staff information on how the person was able to communicate. For example, for one person, their care plan stated the person has "difficulty communicating his needs. Staff to remind him to slow down and say a word at a time. When this is not possible, staff to encourage him to use gestures, pointing or using the first letter of a word to communicate." The person also had a file in their room with pictures that they would be able to point at, to help communicate their needs. The management team told us of listening to another person's relative for guidance on how to arrange items on a table for them so that the person could identify things easily despite their visual impairment.

Files showed that most people were living with dementia had regular assessments of their well-being and if they were expressing pain, to help pick up on what they were communicating and if further support was needed. One person's communication care plan guided staff well that they could muddle their words but that if asked would say what is wrong. Their dementia care plan guided staff to leave then return if refusing personal care.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death. A community professional told us of excellent palliative care being provided at the service. The management team told us staff were trained on end of life care within induction, via the clinical development nurse's visits to the service, and by their close working with the local palliative care team. The latter organisation would shortly be providing formal training.

People's end of life care wishes, where disclosed, were stated within their care plans. This included pain management, religious and cultural needs, whether advanced care planning arrangements needed to be observed, if resuscitation was to be attempted, and when family and friends were to be contacted. A copy of a hospice care plan was prominent in one person's file.

Requires Improvement

Is the service well-led?

Our findings

The service's registered manager had been in that role for over four years. Their registration indicated they had appropriate capability, qualifications and experience. The service was supported by a knowledgeable deputy manager.

People provided positive feedback about the service's management. Comments included, "Staff have a meeting every day, the manager is very good" and "I like the attitude of all the management." People's representatives provided similar feedback. One said, "The manager is very supportive, always says if we want to chat, her door is open, plus we have phone numbers." Another told us, "Good infrastructure, evidence of clear and effective leadership," adding that the registered manager appeared to show "genuine concern" for everyone's welfare. Community professionals all fed back positively on the service's management.

However, we found there was a failure to notify CQC as required of injuries to two people using the service that resulted in changes to the structure of their bodies. The failure to submit notifications as required by law meant CQC did not have proper oversight of the service and could not fully monitor any risks associated with it. This undermined how well-led the service was.

The above evidence demonstrates a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider's governance framework was designed to ensure that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. The provider had a separate quality improvement team that audited the service every four months. Their most recent report showed diligence in ensuring the provider's procedures were being followed. The audits fed into an ongoing service improvement plan. We checked some of the actions marked as completed on this plan and found it was accurate. For example, more new staff had now fully completed induction training.

There were monthly senior manager reviews of quality and risk at the service. This included some oversight of the service improvement plan, seeking people's views of the service, and ongoing checks of key performance indicators such as accidents and complaints. There were also checks that specific audits such as for nutrition, housekeeping and documentation were up-to-date.

We were shown a report of a mock inspection the provider undertook at the service a few months before our visit. The senior regional director told us this confirmed many areas of good work, but resulted in some improvement actions. For example, the management team undertook daily informal walkabouts in the service, but these were now being formally documented and sent up the line management chain for improved oversight.

In summary, governance processes at this service were helping to identify and address risks to service quality. However, we identified breaches of regulations in this report. Auditing processes had not identified

and addressed the matters causing these breaches, which demonstrated weaknesses in the effective operation of governance processes at this service.

We also identified two recent instances where people's care plans and risk assessments had not been promptly reviewed and updated following hospital discharge. Whilst staff were aware of necessary changes to their care and treatment, plans to address risks to their safety and welfare in light of the hospital discharge advice had not been promptly recorded. This demonstrated failures to maintain accurate and complete records of decisions taken in respect of those people's care and treatment.

The above evidence is therefore a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear vision and strategy to deliver high-quality care and support. The provider's five core values were on display in the entrance hall, and were incorporated into staff training. The senior regional director told us the management team attended conferences at which the provider's vision and values were discussed, to help embed them at the service.

Each morning the management team held a 'stand up' meeting with all heads of department including, nurses, housekeeping and maintenance. The meeting during our first visit provided an overview of issues within the service and checked things like vacancies, hospital admissions, appointments for the day, any complaints, staff deployment and any maintenance matters. This allowed the management team to have a good daily overview of the service and any issues that required addressing immediately. One person told us, "Everyday between 10:00 and 11:00 I cannot speak to a nurse as they're in staff meetings." However, another person told us this had recently been improved on as nursing staff were now available during the meeting if needed.

Records showed staff meetings took place most weeks. These covered, for example, standards to improve on, recent audits and reports, imminent plans for anyone using the service, and staffing updates. A staff member also told us of weekly magazines that informed them of good practice or changes in the law such as for data protection.

Most staff told us they felt supported by managers and colleagues, and that the management team was approachable. Comments included, "Very helpful managers", "Very good team" and "The nurses are helpful if they've time or if you ask for help." There were occasional critical comments, or which the most measured was, "I feel like the management try to support me but they have limited resources."

We received some mixed views about staff retention. One person said, "I have made very good friends amongst the staff but they have left." Someone's representative told us, "Staff come and go, but nurses are consistent." A staff member said, "The staff turnover is very high," and cited a lack of support for their role as a reason. Some staff expressed frustration at having to train new staff "all the time." The senior regional director told us of many long-standing staff, which we also received some feedback about. They spoke of retention work such as through staff development so as to be more satisfied in their work. There had been no agency staff working at the service for over two years, and the provider's team of bank staff covered when needed. Those staff therefore understood the provider's policies and procedures. Our checks of recent staffing rosters indicated the same staff tended to work, which helped with meeting people's individual needs.

The provider engaged with and involved stakeholders in the development of the service. One person told us, "we get survey from time to time." The management team explained that an independent company carried

out annual quality surveys for the provider. The last one, held in the autumn of 2017, analysed responses from 40 people using the service and 17 of their representatives. It showed improved satisfaction compared with the 2016 results, and a much higher satisfaction from people using the service than the national averages from the provider's other services. There continued to be a satisfaction rate of 100% for 'overall happy living here' and 'satisfied with standards' from people using the service at that time. An action plan had been set up as a result of the weakest areas of the survey, including for timely responses to call bells and ensuring everyone was involved planning their care.

There were occasional meetings for people using the service and their representatives by which to gain their views and keep them informed on service matters. One person told us they occurred twice a year, and were "mainly to tell us about refurbishment and ask people about food." Another person said, "If we say something, sometimes they listen, sometimes they don't." A third person told us few people came to the meetings despite them being advertised. Someone's representative spoke of being sent invites to these meetings, and that there was a note in their family member's room about it.

Minutes of the last residents' meeting in July 2018 showed ten people including representatives attended. The registered manager told us the meetings were advertised to people and their representatives in advance, including through letters, the weekly activity timetable, and by reminding people on the day. Whilst there were clear action points arising which showed people were listened to, for example, in relation to meals, changes of staff and the decor, there was nothing documented about reviewing the action points of the previous meetings. The registered manager agreed to ensure updates were publicised.

We noted the registered manager's copy of the latest residents' minutes showed she was considering each point and taking action accordingly, for example, on the various suggestions for the meals. We also saw that monthly senior manager visit reports of visits to the service included checks that actions from the last residents' meetings were being implemented. The most recent case included much focus on feedback about the menus, but covered all action points.

The service generally worked in partnership with other agencies to support care provision and development. The management team told us of working with the local authority's CHAT team who helped reduce hospital admissions through gaining the support of relevant community professionals. Last year they had taken part in a local university's dementia study project which enabled staff to have specific training on people's dementia care needs. The service was also involved in the new capital nurse programme, which involved supporting the development of student nurses.

The management team told us the local authority had completed a recent monitoring visit with nothing of significant concern being fed back to them. We contacted the local authority who confirmed this was accurate, but that a draft report was with the service for them to send an action plan on minor improvement areas.

However, whilst the management team was welcoming of our inspection visits, requested records were not always made available to us promptly, and occasionally not at all. This included that on our first day of visiting, the management team told us the registered manager's audits of call bells were locked away and could not be accessed as the registered manager was on leave. Some requested records including information about any whistleblowing cases had not been forwarded to us after our inspection visits, a timespan of 19 days at the time of drafting this report; others were made available somewhat later than the requested two working days.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Where services were being provided in, or as a consequence of, the carrying on of the regulated activity, the registered persons failed to notify the Commission without delay of injuries that result in changes to the structure of service users' bodies Regulation 18(1)(2)(a)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered persons failed to ensure that all service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered persons failed to ensure that care was only provided with the consent of the relevant person. This included acting in accordance with the Mental Capacity Act 2005 where the service user was unable to give such consent because they lacked capacity to do so. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Receiving and acting on complaints The registered persons failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate and complete record in respect of each service user; Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure persons employed for the purposes of carrying on the regulated activity were of good character, and failed to ensure the following were available before employing anyone to provide care: • A criminal record certificate • Satisfactory evidence of conduct in previous care-related employment • A full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(1)(a)(3)(a) S3 parts 3, 4, 7.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The registered persons failed to ensure sufficient numbers of suitable staff were deployed to meet service users' needs at all times.
Regulation 18(1)