Longwood Lodge Care Limited

Broom Lane Care Home

Inspection report

Broom Lane
Rotherham
South Yorkshire
S60 3NW

Tel: 01709541333

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03 December 2015

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced, and was carried out over two days; 2 and 3 December 2015. The provider registered this location earlier in the year and therefore the location had not been previously inspected.

Broom Lane Care Home is a 61 bed nursing home, providing care to older adults with a range of support and care needs. At the time of the inspection there were 50 people using the service.

Broom Lane Care Home is in Rotherham, South Yorkshire. It is in its own grounds in a quiet, residential area, but close to public transport links and the town centre. The home is a purpose –built building, and comprises two separate units, each with their own lounge and dining area.

At the time of the inspection, there was a registered manager in post. 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 and associated Regulations about how the service is run.

Arrangements at the home for monitoring the care provided, and ensuring it was of high quality, were inadequate. The registered manager did not undertake any formal auditing of care delivery, and, as result, care records and care delivery were inadequate. The company directors carried out a monthly formal audit, but this failed to identify shortfalls across the whole scope of service delivered.

The home was not operated safely. Staff practices in relation to moving and handling people were inadequate and put people at increased risk of harm. The arrangements in place to ensure medication was stored safely were not fit for purpose, and the home did not undertake all the legally required measures in relation to allegations of abuse.

Staff were observed to undertake care tasks without engaging with people, and at times used dehumanising language, or language which did not uphold people's privacy or dignity. Staff communication was not effective, which had a negative impact on people using the service.

There had been no formal assessments of whether staff were deployed in sufficient numbers to meet people's needs, and we observed incidents where people were asking for staff assistance but none was available. Staff described incidents where they could not meet people's needs due to low staffing numbers.

Staff and management had very limited knowledge of consent and the Deprivation of Liberty Safeguards. Care was delivered without people's consent being obtained, and where people did not have the mental capacity to give consent to their care, the provider had failed to follow the appropriate procedures as set out in law. Very few staff had received training in relation to this.

Staff did not receive a good standard of formal support. Team meetings and staff supervision did not take

place at the provider's planed frequency.

We identified seven breaches of regulation in this inspection. You can see what action we told the provider to take at the back of the full version of the report.'

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risk assessments were not always accurate or fit for purpose. Some people using the service were vulnerable to risks that the provider had not assessed. Moving and handling was not carried out safely.

Medicines were not safely stored, and the provider had failed to follow the legally required procedures when identifying incidents of suspected abuse.

Is the service effective?

Inadequate

The service was not effective. The vast majority of staff within the home had not received training in the Mental Capacity Act, and people's consent was not always obtained in relation to care.

There was no evidence of best interest arrangements being pursued where people lacked the capacity to consent, meaning that decisions were made for people without appropriate legal processes being followed.

Is the service caring?

Inadequate

The service was not caring. We found that staff practices did not uphold people's privacy or dignity. Staff did not consistently engage with people when carrying out care tasks.

There were minimal opportunities for people to be involved in their care planning or make decisions about how their care was delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care was not always tailored to people's changing needs.

There was a comprehensive plan of activities at the home, including a large amount of involvement in the local community.

Is the service well-led?

Inadequate

The service was not well led. The arrangements in place for

monitoring the quality of the service were not robust enough to identify or address shortfalls in service quality.

The registered manager did not provide leadership in terms of driving quality in the home, and formal support and guidance to staff did not take place at the provider's own required frequency.

Broom Lane Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out over two days; 2 and 3 December 2015. The inspection was carried out by two adult social care inspectors.

During the inspection we spoke with staff, the home's manager, and directors of the company. We spoke with five people who were using the service at the time of the inspection, as well as an external professional who was visiting the home during the inspection. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. Before the inspection, we asked the provider to complete a Provider Information Return (PIR) This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not return this form to us.

Inadequate

Is the service safe?

Our findings

We spoke with two people using the service about whether they felt the home was safe. They both said that they felt it was. One person said to us: "It's as safe as houses here, there's no problems at all."

During the two days of the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that at times people had to wait for assistance from staff, and there were lengthy episodes where people did not receive support when they required it. For example, we observed one person ask staff if they could go to the toilet, but the staff member told them that there weren't enough staff available and they would have to wait. We observed that the person had to wait 25 minutes before being helped to use the toilet. Another person, in a communal lounge area, appeared to be distressed and asked staff to help them. We observed them shouting "nurse, please talk to me" and crying, but there were no staff present in the lounge. One staff member entered the room after the person had been calling for help for ten minutes, and said to the distressed person "I know, I need a hoist" and then left. The person did not receiving any meaningful interaction from staff during the 30 minute period we were observing them.

We asked the registered manager how staffing numbers had been assessed and whether any ongoing analysis took place to ensure that staff were deployed in suitable numbers, but they couldn't describe any processes which were used to do this. People using the service commented to us that there weren't enough staff. One said: "The staff are great but they have too much to do…they cannot do the impossible. There is a lot of waiting." We asked staff about staffing numbers and they gave us a mixed picture. Some said they felt they were deployed in sufficient numbers, but others commented that there was a lack of staffing. One told us that people couldn't get up when they wanted because staff were too busy to assist. They described that people who wanted to get up at 9:00am were left until 9:45am as staff were providing breakfasts to people who were already up. We looked at details of the most recent staff meeting and saw that staff had requested that staffing numbers were discussed, however, the minutes indicated that there was no discussion about this.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked whether staff had received training in moving and handling, to ensure whether they knew how to support people to mobilise safely. The provider's training matrix showed that all staff had received this training, and the registered manager told us it was undertaken annually. Staff we spoke with confirmed they had received training in moving and handling. However, when we carried out observations of care we saw that people were not always supported to mobilise safely. We observed two staff helping one person move from a chair to a wheelchair, by means of using a hoist. The wheelchair was placed further away from the chair than was needed. This resulted in the person being transported an unnecessary distance while suspended in the hoist. Transporting a person over a distance in a hoist increases the risk of injury through the hoist overturning or the person striking an object. Another person was supported by staff to transfer from a chair to a wheelchair, but the brakes had not been applied to the wheelchair, meaning it moved as

the person tried to sit in it, putting them at risk of injury.

We observed that each person who was transferred via hoist did so in the same size and type of sling. We asked the registered manager how staff knew which hoist name, sling type and loop colours were required for each person. She told us that this information was not recorded, meaning that it was not known which piece of equipment was most suitable for each person to ensure their safety.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that staff received annual training in the safeguarding of vulnerable adults. However, the staff we spoke with gave us a mixed picture of their knowledge of this area. We asked three staff about their responsibilities in relation to safeguarding and their knowledge of abuse. Two understood safeguarding procedures, but one could not describe the signs of abuse or what they would need to do if they suspected abuse. We looked at records of incidents of suspected abuse, and found that the provider had failed to follow the legally required procedures when addressing such incidents. We identified four incidents in the preceding year where suspected abuse of people using the service had occurred, however, none had been notified by the provider to CQC. We checked the provider's policy in relation to safeguarding and found that the policy did direct staff to notify CQC of any such incidents, but this had not been followed.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked nine people's care plans, to look at whether there were assessments in place in relation to any risks they may be vulnerable to, or any that they may present. The majority of care plans we checked contained risk assessments relevant to the person. However, they were not always fit for purpose, and some were absent. For example, one person's care plan indicated that they had bed rails on their bed when sleeping. Bed rails can present a risk of entrapment if not carefully managed. There was no risk assessment in place in relation to this. Another person had a care plan which described them as being at high risk of malnutrition, but there was no information about how staff should manage the risk of this. A third person had information in their records which was contradictory, with some information stating that they were unable to mobilise safely, and other information stating that they could mobilise with assistance. It was not clear, therefore, how the person should be supported safely This meant that the arrangements for identifying and managing risk were not adequate.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment procedures at the home had been designed to ensure that people were kept safe. Policy records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees. We checked a sample of five staff members' personnel files, and found that the provider's policies had been adhered to and all appropriate pre-employment checks had been undertaken.

We checked the arrangements in place for safely managing, handling, storing and administering medicines. Medicines were only handled by qualified nursing staff or senior care workers, and the majority of relevant staff had received training in this area within the last year. We asked one staff member to talk us through the procedure for ordering, recording, administering and returning medicines, and they were able to describe the process clearly. We checked medication administration records. Staff had signed in the majority of cases when they had administered medication to people, although there were a small number of omissions. Where people required medication on an "as required" basis, often referred to as PRM medication, there was no information in the records we checked about the signs and symptoms which would indicate they should receive this medication.

There was secure and appropriate storage for all medicines, although we observed one item of prescription medication insecurely stored in one person's bedroom. We checked the records of temperature checks for one of the home's two medication storage areas. There were no checks carried out of the storage room, and checks of the medication fridge temperature had not been undertaken for over a month. Prior to this, when they had been carried out, they had been recorded infrequently. Medicines which are stored at temperatures outside of the manufacturer's recommended parameters can spoil and become ineffective. As the provider was not checking the temperature that medicines were recorded at, it could not assure itself of the efficacy of medicines people were receiving.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

We asked two people using the service about the food available in the home. They were positive about their experience of the meals offered to them. One said it was well prepared, good food. Another said: "The food is very good, I'm happy with it." Staff told us that they thought the food was good, although one told us that some people had complained that the food could be bland, and that portions were very large. Staff we spoke with knew about people's dietary needs and preferences, and choices were offered at mealtimes which reflected these preferences or requirements. We noted that the home had achieved an accreditation from a national vegetarian organisation, and had been awarded five stars from environmental health.

We carried out an observation of a mealtime in the home. One person told us that they preferred to have their meal away from the dining room, and staff observed these wishes. Most people were given appropriate support to eat if they required it, and staff did this respectfully, although we noticed one person was struggling to eat their meal but there were no staff nearby to help. Some tables had condiments available, although condiments were not available on all tables. We observed that staff seemed to be rushing when serving people, which resulted in desserts being put in front of people when they were still eating their main courses.

We checked nine people's care records to look at information about their dietary needs and food preferences. Most files contained details of people's nutritional needs and preferences, including screening and monitoring records to prevent or manage the risk of poor diets or malnutrition, although one of the nine files we checked did not hold any information in relation to this.

The registered manager told us that only a small number of staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training, and described this programme as just beginning. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

We found that two appropriate DoLS applications had been made, however, the provider had failed to notify CQC of this, which is a legal requirement.

We also checked people's files in relation to decision making for people who are unable to give consent. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. People's care plans did not reflect appropriate decision making in accordance with the MCA. For example, two people's files contained information stating that they lacked capacity, however, there were no records of any assessments or best interest decision making in

relation to how their care was provided. One person's records indicated that a close relative had died but they had not been told as it was thought this would distress them. Again, there was no formal record of any best interest decision making in relation to depriving them of this knowledge. Another person's file indicated that they did have the capacity to consent to their care, but there was no evidence that they had given consent. There was a form in some people's files recording whether they had given overall consent to their care, but we did not identify one example of it being correctly completed.

The registered manager told us that plans were under way for everyone using the service to move to the same GP. We asked what best interests discussions and agreements had taken place in relation to this. The registered manager told us that no formal best interest planning had been undertaken.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed staff communication during the course of the two days, and saw that it was not always sufficiently effective to meet people's needs. For example, we noted some people being asked the same question several times by different staff, and staff not effectively communicating with each other in relation to how they were providing care. One staff member took one person in a wheelchair into the dining room ready for lunch, but then another staff member brought them back into the lounge a few minutes later. The two staff members had not communicated properly, which resulted in the person being moved around unnecessarily. We observed another person in a wheelchair moved from one side of the lounge to another by staff, and then another staff member move them back to the original spot some moments later. Again, we did not see any communication between the two staff about why they were doing this, or what benefit it was to the person concerned.

The registered manager told us that, with the exception of the Mental Capacity Act, staff had received all the training they needed. However, we observed practices that suggested staff training had not been effective. For example, most staff had received training in relation to moving and handling, but we observed incidents where staff did not follow good or safe practice when undertaking moving and handling. Similarly, the majority of staff had received training in dementia care but we observed that they did not provide verbal reassurance or engage appropriately with people when required.

CQC is considering the appropriate regulatory response to resolve the problems we found.

Inadequate

Is the service caring?

Our findings

We asked four people using the service about their experience of the care and support they received. Their responses were all positive. One person told us: "The staff are very kind." Another said: "They [the staff] are really lovely." One person we spoke with told us the home was "as I like it." During the inspection an external professional was visiting the home. They told us: "The staff here are great, they care, that's the difference." They said that they felt Broom Lane Care Home compared positively to other homes they visited.

We carried out observations of staff interactions with people using the service during the inspection. We observed that at times staff did not interact with people in a person-centred way, and did not routinely uphold people's privacy or dignity. We observed a number of times when staff carried out care tasks without speaking to the person to whom they were giving care.

One person was taken from the lounge in a wheelchair without the staff member speaking to them. Another staff member then shouted them back saying that they wanted to remove the person's nail varnish. The person was brought back and their nail varnish removed without the person being spoken to. Another person, again using a wheelchair, was moved by staff around various points of the lounge without staff speaking to them or telling them why they were moving them, or enquiring as to their preferences. We observed staff remove one person's hat without speaking to them or asking if they wanted to remove their hat. The person put it back on afterwards, suggesting that they had not wanted staff to remove it.

We observed incidents where staff carried out conversations with each other when carrying out care tasks, and did not involve the person or refer to the person. We saw this occur commonly when people were being transferred by means of a hoist. A hoist is a piece of equipment in which the person is lifted in a suspended sling, and its use can cause anxiety. Good practice when using a hoist involves speaking with the person being hoisted to alleviate any anxiety and give reassurances.

When we were observing care, we noted that at times staff used dehumanising language, talking about people they were providing care to in terms of tasks. We observed two staff discussing who was going to move someone to another room. One staff said: "I'll do her" to which the other replied: "No, she's alright there, I'll do her later." We heard staff in communal areas loudly name which people they had "changed" indicating that the people named had required continence care. This failed to uphold the named people's privacy in relation to such a sensitive and personal matter.

One person was overheard to ask for something, to which a staff member replied: "We've got 30 residents here, We can't give you one to one care. We're doing our best. What do you want?" When the person then described what they wanted, the staff member went to fetch it. It had not been necessary for the staff member to use such challenging language when asked to provide assistance.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked nine people's care plans, and asked staff what involvement people had in planning their care. Staff described that they spoke with families to get their views about care, and they said that they knew people's preferences well. Care plans were predominantly in electronic format. We asked a senior staff member how people using the service accessed the electronic care plan to check what was recorded about them or have input into their care plans. They told us that this didn't happen.

Requires Improvement

Is the service responsive?

Our findings

There were a large number of activities available for people to take part in, both inside and outside the home. The home had good links with local schools and places of worship, and trips out were planned regularly. During the inspection a singer came to the home to entertain people, and one of the people using the service told us that the local school was coming to sing carols soon. People told us they enjoyed the activities available to them. The home employed a dedicated activities co-ordinator, who was observed to be enthusiastic and engaging with people

We checked care records belonging to nine people who were using the service at the time of the inspection. We found that care plans did not always have sufficient detail or set out how staff should support each person so that their individual needs were met. For example, one person had a care plan in relation to personal hygiene. It stated that they required assistance from two staff, but it did not set out how the support should be provided or what staff needed to do to meet the person's needs. Another person's care plan had information about how they should be supported to mobilise around the home, but the file held contradictory information so it was not clear which information was accurate.

One person's care plan showed that they moved around the home using a wheelchair to lean on, however, staff notes showed that the wheelchair had been broken and the person had been advised to use a frame instead. Their risk assessments and care plans had not been updated to reflect this. We spoke to this person, and they told us that they were anxious without their wheelchair, and had concerns that their mobility and freedom was restricted without it.

Each care plan contained daily notes where staff recorded the care provided to people, however, it was often limited and did not allow for an overview of any developments or issues with people. For example, one person's daily notes recorded that they were "aggressive" with no other information. Other notes recorded "all personal care delivered" with no information about what this consisted of or how the person had responded to it.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at records to show whether the provider had met people's personal preferences, however we found incidents where this hadn't happened. One incident was recorded as a person being unhappy because they didn't receive their meal when they wanted it, which they were told was due to short staffing. Another incident was recorded as a person being upset as they had been temporarily moved from one unit to another. We asked a senior staff member about this. They told us that it was a short term arrangement, but that the person concerned had slept in the communal area overnight due to their unhappiness.

There was information about how to make complaints available in the communal area of the home, and people we spoke with told us they would feel confident in making a complaint should they feel the need to. However, we noted that the provider's complaints procedures did not direct complainants to the correct

route of external remedy. We checked records of complaints and found that each one was responded to within an appropriate timescale.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager and a deputy manager. Additionally, the registered person or other directors visited the home on a monthly basis and carried out a documented audit.. Staff told us that they found the management team within the home to be approachable. Staff we spoke with were confident in their knowledge about how to raise concerns or give feedback to managers. There was a whistleblowing policy in place to support staff who had any concerns, and this was available to all staff in the home.

The registered manager told us that the directors' monthly visit to the home was the predominant method of monitoring the quality of service provided to people. She said that she also carried out a visual audit every day but that this wasn't documented. Additionally, an audit of medication was undertaken by night staff. The registered manager told us their audits of care records were not documented, and were the responsibility of nursing staff.

We carried out a check of care records, and found that they contained errors and omissions which had not been identified by means of any audit. For example, one person's file contained a care plan for mobilisation, which stated they were nursed in bed constantly, and were unable to transfer from the bed unaided. There was no information in the records about how assistance to transfer should be carried out, or what type of equipment should be used. Their records also contained a care plan for diet which stated that they were "able to sit in the dining room." This contradicted the information in their mobilisation plan, and it was unclear how they should be safely cared for. This contradiction and lack of information had not been identified via any form of quality auditing. Another person's records showed that they had bed rails on their bed. Bed rails are a form of restraint and can cause injury. As such, their use should be carefully monitored. There was no risk assessment relating to the use of bed rails. This lack of appropriate assessment had not been identified via any form of quality auditing.

A third person's records showed that they had been admitted to the home approximately six months earlier. We found that there were no care plans in their electronic records, and a very limited paper care plan in their paper file. The daily notes, where staff recorded the care given, showed that they had been provided with personal care, continence assistance and nightly checks. None of the details in their files set out how staff should provide this care, so there was no evidence that staff were acting in accordance with the person's assessed needs. This had not been identified via any auditing of their records.

We checked the systems in place for auditing medication. There were records showing that checks were carried out every night by the night staff. However, the audits had failed to identify errors in relation to medicines management. For example, one person's medication records showed that they were prescribed a specific medicine to take on an "as required" basis. The audit of their records described that this had not been checked as they were not prescribed any "as required" medication. A second person's records showed that they had also been prescribed a medicine to take on an "as required" basis, but again, the completed audit of their medication stated that a check of "as required" medicines was "not applicable." One person's medication chart had missing signatures, where staff had failed to sign to show that they had administered

the medication. However, the audit of their records recorded that all medicines had been signed for. This showed that the audit was not effective as it did not accurately reflect the standard of medicines management in the home, or identify where improvements or rectifications should be made.

We carried out a check of incidents and accidents at the home. The home's records indicated that four safeguarding incidents had occurred in the preceding 12 months. None of the four incidents of suspected abuse had been notified to the Commission. As such notifications are a requirement of law, this showed that the systems in place to ensure that the location complies with legal requirements was ineffective.

We looked at how health and safety at the home was monitored. The registered manager told us that this was done as part of the directors' monthly visit to the home. However, the last two records of these visits stated that health and safetly at the home was "up to date." There was no evidence of any form of check or assessment to ensure the home was operating safely.

The directors' monthly checks also audited staff supervisions. For both of the most recent checks, supervision was recorded as "up to date." None of the staff files we checked contained evidence that supervision had been carried out at the frequency set out in the provider's own policy. Staff we spoke with also stated that they had not received supervision since commencing their roles. The audits of staff supervision had failed to identify or address this lack of staff support.

Throughout the course of the inspection, we observed incidents where staff had failed to uphold service users' dignity and privacy. We asked the registered manager what had been done at the home to ensure staff understood the importance of protecting service users' dignity. They stated that this had been discussed at the last team meeting. We checked the minutes of this team meeting, but they did not reflect this issue was discussed. The registered manager could not provide any further evidence of activity undertaken to address this aspect of service quality.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

CQC is considering the appropriate regulatory response to resolve the problems we found.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was failing to ensure that people using the service were treated with dignity and respect, and their privacy was not always upheld. Regulation 10(1)((2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements in place to ensure that people received care in a safe way. The arrangements in place for managing medicines were not adequate to ensure they were managed safely. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to act appropriately where incidents of abuse or suspected abuse were identified. Regulation 13(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that suitable numbers of staff were deployed to meet people's needs. staff did not receive

Treatment of disease, disorder or injury	appropriate support to enable them to carry out their duties effectively. Regulation 18(1)(2)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place to act in accordance with people's consent, and did not act in accordance with the law where people lacked the capacity to consent to their care and treatment. Regulation 11(1)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's arrangements for assessing and monitoring the quality of the service provided were inadequate. Regulation 17(1)(2)(a)

The enforcement action we took:

Warning Notice