Dr Shams Tabraiz & Mr Mahmood Hussain Raja Mr Manillal Rambojun

Dunedin Residential Home

Inspection report

10 Connaught Gardens East
Clacton On Sea
Essex
CO15 6HY

Tel: 01255476484
Website: www.dunedincarehome.co.uk

Date of inspection visit:
26 July 2017

Date of publication:
20 February 2018

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?	**Inadequate**

Summary of findings

Overall summary

Our previous inspections of Dunedin Residential Home found significant failures and risks for people living in the service. It was rated as Inadequate in October 2016 and placed into special measures. We also took action to restrict admissions and for the provider to submit to us, each month, a report on how the service was improving the areas of concern. We returned to the service in February 2017 to assess whether the service had improved. It continued to be Inadequate and remained in special measures.

At this inspection we found that whilst the manager had made some improvements to the service, they were not adequately supported by the provider. There was a lack of oversight, resources and infrastructure to ensure that the service provided consistent safe and good quality care. It therefore remains in special measures and the Care Quality Commission is taking further action. We will report on this once it is concluded.

Dunedin Residential Home is registered with the commission to provide care to up to 21 people over the age of 65, who may or may not be living with dementia. At the time of this inspection there were nine people living at the service.

The service is operated as a partnership, with three people registered as making up this partnership, within the report they will be referred to as the provider.

The manager had been in place for a number of months, they had yet to register with the commission at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility or meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were not always kept safe as there were insufficient staff deployed on shifts and whilst staff knew people well and were kind, they were not able to meet their care needs as they did not have sufficient time.

Risk assessments were in place and mitigations were reflective of people's needs, however staff were unable to ensure people were safe as they did not have the time to ensure risks were mitigated appropriately.

People told us that staff were kind and caring but they often had to wait for care to be delivered.

Staff had completed training required to enable them to meet people's needs and the manager was trying to implement a series of supervision and appraisals although these had not been effectively implemented. Recruitment processes were robust and staff had relevant checks in pace to ensure people were safe.

Care plans were reviewed monthly and were person centred and the documents were in place to support

people to remain as independent as possible. A lack of staff meant that these were not implemented effectively.

Whilst improvements had been made by the manager, there remained a lack of strong infrastructure to support them to ensure improvements were sustained, built on and fed into continued development plans for the service. Following the inspection the provider reported to us that they were unable to continue running the service due to a lack of staff and because the manager had resigned. They were unable to provide staff until people using the service had been supported to find alternative homes. Therefore the local authority provided staff and oversight to ensure this was done in a safe and planned way. No people currently live in the service.

.

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 safe

There were insufficient staff available to safely care for people and to ensure their needs were met.

Risk assessments were in place and reflected people's needs, however the lack of staff meant that risks were not well managed.

Staff were aware of safeguarding procedures and were able to describe what to do if they felt people were unsafe.

Medication was in general was administered safely although there were minor concerns identified which required addressing

Is the service effective?

Requires Improvement

The service was not effective.

The manager had started to implement supervision although this was early in the process.. However, annual appraisals had not been completed.

Mental capacity assessments in people's care plans demonstrated that the service had considered people's capacity and involved people and professionals in decision-making. However, not all staff had completed up to date MCA training.

Staff had not consistently responded appropriately to people's weight loss.

Is the service caring?

Requires Improvement

The service was not always caring

Care plans were in pace which were reflective of people's needs and preferences and staff respected their wishes

Staff did not have time to build or develop meaningful relationships with people. Whilst staff were kind they were not able to provide good care due to being rushed

End of life care plans were in place and reflected peoples care needs at the end of their lives

Is the service responsive?

Requires Improvement

The service was not responsive.

People did always have the opportunity to participate in activities that met their choices and preferences.

Care plans had been updated to reflect the current needs of people, however low staffing levels meant that it was not always possible for staff to put this into practice.

Systems were in place for the daily monitoring of pressure relieving equipment such as mattresses and cushions.

Is the service well-led?

Inadequate

the service was not well led

The provider did not have robust systems in place to monitor and develop the service. The quality monitoring systems were so weak that people were at risk of harm.

The provider was completely reliant on their manager to run the service yet did not provide the resources to enable them to do so.

The manager had recruited new staff however had not assessed people's dependency so their needs were not met.

Dunedin Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 26 July 2017 and was unannounced. It was undertaken by two Inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

Reports from the local authority and other health care professionals have been considered at this inspection. In addition the Commission required the provider to submit monthly reports to help demonstrate improvements and effective auditing. These have also helped to inform this inspection.

Whilst at the service we spoke with four people who lived at the service and two of their relatives, four members of staff, the deputy manager and manager as well as the cook. We observed staff providing care to people during the day and reviewed relevant documentation relating to care planning, risk assessments, quality monitoring, medication and recruitment.

Requires Improvement

Is the service safe?

Our findings

At the last two inspections serious concerns were identified which put people's safety at risk. Whilst the manager had worked to address these issues there were still shortfalls and some of the improvements we had been told about had not been sustained. Despite still falling well below the standards expected relatives and people using the service were positive about the changes that had been made.

There were nine people living at the service at this inspection and the staffing levels had been reduced from three to two care workers. However, we saw that a domestic member of staff had been off sick for the last six weeks and the activities co-ordinator had left. This meant that in addition to providing care the staff were expected to provide activities, clean and manage the laundry, which was not located in the main building. Consequently, the service was dirty and in places unhygienic with a risk of cross infection. There were regular periods during the day when there were no staff present in the lounge leaving people who had been assessed as a high risk of falls, unsupervised. A staff member told us, "We all try to pull together and yes things do work better when we have three staff on so we could do with another person."

During the course of our inspection one person was unsupervised and sustained an unwitnessed fall. They had to be escorted to hospital due to their injuries and an additional member of staff had to be called in to support the person to hospital as there were insufficient staff available to do this. We are looking into this incident to assess if the harm caused by this fall was avoidable.

People had mixed views in relation to the number of staff available to meet their needs. One person told us, "They tell me to ring the buzzer if I need any help. The other day I had a fall and I wasn't near the buzzer so I laid on the floor for 20 minutes before they came to see someone else and they heard me banging." However, another person told us, "Most of the staff are very reliable, it's nice we just ring and they come". From looking at the rotas and talking to staff and people living at the service it was clear that staff were able to manage during quiet times, however when it was busier or if someone needed support they were unable to meet people's needs in a timely way

During the inspection the manager reported our concerns to the provider who agreed to increase the care staffing levels back to three. There were no appropriate tools to use which were current for example, a dependency tool which would highlight staffing issues and demonstrate how staffing numbers were calculated to reflect the needs of people. A staff member we spoke with said, "It is difficult sometimes we could do with some more staff sometimes."
This meant the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 staffing.

The service had a process in place to ensure that staff were recruited safely. We reviewed five staff files and saw that the relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

All the staff we spoke with understood how to recognise signs of abuse and were confident in the action that they would take to raise any concerns both within the organisation and with external organisations.

Day to day risks to people had been assessed and care plans contained information for staff about how to minimise the risk of harm. However, the low staffing levels meant that we had concerns about staff's ability to effectively implement these plans. For example, during the day a majority of people sat in the communal lounge. but there were numerous times throughout the day when there were no staff present in the communal lounge because they were providing care to people in their rooms. This placed people at risk of harm. For example, during one 20 minute period when no staff were present in the lounge we observed a person repeatedly standing up from their chair. Their care plan identified them as being independently mobile but at a high risk of falling. A risk assessment had been completed to minimise this risk, which stated that staff should remain with the person at all times when they were mobilising. However, with only two staff on duty it was not possible for this to be put into practice.

Risks to individuals were assessed when they were admitted to the home and had been regularly reviewed. We found that people had detailed risk assessments in place to provide guidance and direction for staff about how to support people correctly and keep them as safe as possible. These included, risks that related to mobility and falls, weight, nutrition and the prevention of pressure areas. Where people had been identified as being at a high risk of falls, care plans detailed any incidents that occurred and had details of any mitigation of the risk. For example, One person we tracked had postural hypotension (quick drop in blood pressure causing light headedness) and was noted to regularly stand up quickly. Their care plan guided staff to remind the person to mobilise slowly and with supervision in order to mitigate the risk.

During the inspection we saw staff supporting and caring for people who required assistance to mobilise. One person at the service smoked. A risk assessment had been completed to manage this safely and included information such as where their cigarettes and lighter were stored. The person's representative had signed the assessment.

On the day of our inspection we saw that the lack of staff meant that a staff member had been forced to ask the cook to be the second signatory when a controlled drug was administered. This was due to there being no other member of staff available to sign for the medication. This member of staff was not trained to administer medication and should not have been designated to sign that the medication had been administered correctly. This meant that the administration of this medication was not done safely or in line with the provider's policy or best practice guidelines.

We found that other medication was usually administered safely. However, we identified that one person had a transdermal pain relief patch prescribed. It is advised that these patches should not be applied on the same site as the previous patch and site recording would minimise the risk of this occurring. The manager told us that this would be resolved and the rotation recording sheet was put in place before the end of the day. We observed that two people had incorrect readings documented on their blood sugar level monitoring charts. This was noted to be by the same staff member each time who had misinterpreted the form. This had not been identified as part of any medication audits or during supervision of the staff member concerned. The reading was recorded as higher than it was which meant that there was a risk of incorrect treatment for these people.

Staff were able to demonstrate a good knowledge about the medicines they were administering and were comfortable explaining to people taking the medicines, what it was and what it was for. Staff confirmed that they had completed their medication training and we saw the certificates confirming this training in staff files. A staff member told us that the, "Medication room is much better organised now. We had a lot of

medication we did not need before. Now things are much better."

Requires Improvement

Is the service effective?

Our findings

People living and the service and their relatives told us that overall their wishes and views were respected and they were confident in the staff's ability to care for them. However, we found that staff did not have up to date appraisals and not all staff had completed essential training in relation to the mental capacity act. We also had concerns in relation to staff's response people who had been identified as losing weight.

At the pervious inspection we found that the staff induction process for new staff was not robust. Records showed that improvements had been made regarding this. New staff had completed an induction programme which had been signed off by both the manager and the staff member once completed.

Records showed that a majority of staff had completed face to face training which provided them with the knowledge and skills to complete their roles. The manager used an electronic system to record the training that each staff member had attended and to monitor when they were due to attend revision sessions. We reviewed the training matrix and saw that all staff had completed up to date manual handling training and all but one staff member had completed safeguarding, infection control and fire training. This had been identified by the manager and addressed with the staff member during a supervision session. Other training sessions completed included dignity and respect, medication and record keeping. The deputy manager and manager were both diabetes champions and seven other staff members had also completed a 'Think Glucose Awareness' training day.

The manager had been in post for seven months and was in the process of completing appraisals for staff. However, not all of the staff had an up to date appraisal in place. Of the five staff files that we looked at only one included a completed appraisal and this was not dated. Despite this staff told us that they felt well supported by the manager and had regular supervision sessions. The manager had implemented a system for themselves and the deputy manager to support staff through formal supervision sessions. Records showed that supervision sessions and observations of practice had been completed and used to ascertain staff competencies. The manager had used supervision sessions to acknowledge staff strengths and to highlight how staff could improve their performance and to address concerns. For example, we saw that the manager had used supervision sessions with staff to highlighted gaps in staff training and concerns regarding poor time keeping and high levels of sick leave. However, the manager had not always responded appropriately to concerns raised during spot checks. For example, they explained to us that they had attempted to complete an unannounced night visit but had been unable to gain entry to the home because the front door had been bolted from the inside so they had terminated the visit. This is a safety concern because the front door was connected to the electronic fire door release system, by bolting the door it would not be possible for it to be released electronically in the event of a fire. There was no written record of the visit and the concerns around the door being bolted had not been raised with the night staff on duty.

Some people who lived in the service were not able to make important decisions about their care and how they lived their daily lives. 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 is called the Deprivation of Liberty Safeguards (DoLS).

At the previous inspection we found that staff were not consistently working in line with the principles of the MCA. When we had spoken with staff they did not know whether a person was independent or not but had erred on the side of caution by saying they were always with them when they moved around. At the previous inspection we also observed the person was at times strongly encouraged to stay seated when they started to get up from their chair. During this inspection we found that staff understood their responsibilities under the MCA and around protecting people's rights and we saw no evidence of restrictive practices in place. We observed that people were encouraged to mobilise independently and care plans supported people to do this with the supervision of staff to mitigate the risk of falls. We found completed mental capacity assessments in people's care plans demonstrating that the service had considered people's capacity and involved people and professionals in decision-making. Where appropriate, best interest decision meetings had taken place with the support of advocates to support people and consent forms had been signed by the person and the advocate. For example, one person had bed rails in place, the person had fluctuating capacity levels and a best interest meeting had taken place to support this decision.

However, some people had been assessed as having a cognitive impairment which impacted upon their ability to make decisions for themselves, placing them at a high risk of falls. Whilst their care plans supported them to mobilise with the supervision of staff, due to the low number of staff on duty people were regularly left unattended during the day and therefore it was not always possible for staff to put care plans into practice. We also reviewed the training matrix for the service and found that not all staff had completed MCA training. The meant that we could not be guaranteed that staff always understood their responsibilities to ensure people were given choices about how they wished to live their lives.

We checked whether conditions on authorisations to deprive a person of their liberty were being met. We found that the manager understood when an application for DoLS should be made and we found the home to be meeting the legal requirements. The manager kept a log of DoLS applications, including the date the application was sent, when it was returned and the date it was due for renewal.

People told us that they enjoyed the food and were able to choose what they wanted to eat throughout the day. Comments included, "I've got no complaints about the food, no complaints at all really. We have our breakfast and a cup of tea at 10" and "The meals are amazing, the cheesecake was amazing." And "It's alright here, the foods good; I've chosen lamb casserole and cheesecake today. There have been times when I haven't been able to eat my lunch and they have said if you feel hungry later just buzz and we'll bring you something." During meal times we observed staff gently encouraging people to eat and providing appropriate assistance when needed. We heard one person informing staff that they were unable to chew the meat, the chef was informed and the person was offered an alternative.

People were able to choose where they ate their meals. Some chose to remain seated in lounge chairs with small tables placed in front of them but a majority of people were assisted to sit and eat at the dining room tables. We observed that the kitchen was clean and tidy and well-ordered and the chef had access to lists of anyone who required specialist diets and drinks. We observed that throughout the day people were given a choice of drinks and people could request a hot or cold drink at any time.

People's weight was monitored on a monthly basis. However, records showed that staff had not always responded appropriately to changes in people's weight. For example, one person's weight was recorded on

13/05/17 as 51.5kg and on the 28/06/17 it was recorded as 48.6kg. Records did not highlight this as a potential concern and staff had recorded the weight loss score for this period of time as 0, which indicated that there had been no weight change. Another person's weight was recorded as 66.4kg on 13/05/17 and 59.7kg on 28/06/17, their care plan contained an action plan for staff to monitor this and refer to the GP if their weight continued to decrease. However, on 30/06/17 staff had documented in their care plan 'continues to eat well no concerns to report.' This did not match the action plan formulated in response to the recorded weight loss, and therefore we could not be guaranteed that staff were effectively monitoring the person or putting the action plan into place.

Staff supported people to access healthcare professionals including the GP, District Nurse and optician. Records showed that people had regular intervention from chiropodists and where appropriate staff had referred people for specialist advice and support. For example, one person had been referred to the Parkinson's nurse and another person who had been coughing on food and fluid had been referred to the speech and language therapist. Records showed that staff kept relatives informed of any changes in people's condition. One relative told us, "One Saturday we were on our way to Southend and I got a call saying she had taken a turn for the worse. The end of life plan is to give them what they want, don't force them. We are so glad she is staying here, it's the best place".

The environment had recently been updated and decorated. The manager told us that people had been involved in choosing the colour palettes for their rooms and we saw that people's bedrooms had been painted a variety of different colours. However, despite some improvements to the décor the environment was not dementia friendly. There was poor signage throughout the home, with no visual signage to help identify toilet doors. Whilst toilets had been painted, some of the bathrooms had writing above the taps to indicate hot and cold but some of the letters had peeled off and not everyone would have been able to read this. The updates to the environment had not included the use of coloured toilet seats or coloured crockery. Contrasting colours are recommended to help people with a cognitive or visual impairment define objects more clearly. For example, using coloured rubber mats and/or crockery that contrast with tablecloths helps to define the edge of plates and dishes and might be helpful for some people and toilet seats in colours that contrast with the toilet and with other nearby surfaces can help make them more visible and identifiable.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2017, we found that the environmental concerns found meant that people lived in a dirty home which did not respect their dignity. We also found that staff did not always treat people with respect. At this inspection people told us that they felt well cared for and that there had been improvements over the recent months. For example, one person told us, "They have changed all the staff and it's much better." A visiting relative told us, "Nothing is too much trouble, it's a lovely atmosphere now, before you could cut the atmosphere with a knife. They are dedicated now, on Sunday one of the staff was crying and saying she wished there was more she could do more for (relative)".

Care plans included one page profiles which highlighted to staff people's likes and dislikes, preferences as to how they wished their care to be provided and any key areas of risk. For example, one person's mobility section highlighted that they were able to mobilise independently but that in the morning they were often unsteady on their feet. When we spoke with staff they clearly knew people well and how they wished to be cared for. However, given that there were low staffing levels, staff were not able to ensure that they spent quality time with people building relationships and supporting people to live their lives well.

Since the previous inspection care plans had been updated with new paperwork and we saw that care plans reflected people's choices well. Care plans detailed peoples preferred nighttime routine and we saw that staff tried to ensure these were respected. For example, we saw that one person preferred to go to bed early and specific times were mentioned. They had always gone to bed early and this was specified in their care plan. When we spoke to staff about this persons nighttime routine they were able to tell us what they preferred. We asked the person their views and what they told us matched what was in their plan of care. Another person's care plan detailed in their nighttime care routine stated. "May wish to go to bed early or stay up a little later." We also found that this preference was being adhered to.

The home's deputy manager was identified as the dignity champion. People told us that staff respected their privacy. One person said, "Most knock on the door, they should always give a little knock shouldn't they. The men definitely do." Staff told us they did not rush people and encouraged people to complete activities at their own pace dictated by the person receiving it. Throughout the inspection we saw staff knocking on the doors to people's rooms and communal bathrooms and waiting for permission from people before they entered. We did observe a toilet on the ground floor which had a door which would not shut due to re painting. This meant that people could not use this toilet in privacy and there was no sign to indicate it should not be used.

The service worked with the community matron to support people receiving end of life care. All of the care plans reviewed had end of life plans contained within them which reflected people's end of life care wishes and detailed how they wished to spend their final days and who to contact.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were able to choose how they spent their time. One person told us, "I go to bed early as I like the peace and watching the telly. I read a lot. There is a local group that does a sing song." Another person told us, "I come out here, I watch telly, I play bingo and won some sweets." A relative had written to the service thanking them for the care provided to their loved one. The letter read, "In the last few months I have seen a great improvement in my [relative]. [They are] a lot more happy in [themselves]."

At the previous inspection in February 2017 we had concerns that care plans were basic and lacked detail and information for staff about how conditions affected people. During this inspection we found that this had been addressed and care plans contained information for staff outlining people's specific needs. For example, one person had a diagnosis of Parkinson's Disease (PD), their care plan contained detailed information about the symptoms of the disease and the medicines that they were taking and what their medicine was for. The person often displayed symptoms of lethargy and depression which are common side effects associated with PD. Their care plan contained clear guidelines for staff about how to support them with these symptoms.

Care plans were reviewed monthly and supported people to remain as independent as possible. For example, one person's care plan contained detailed information for staff about how they wished to be supported with washing and dressing including, 'encourage [person] to use the flannel to wash [their] face and hands and maintain some independence.' Due to cognitive impairment another person was unable to use their call bell at night; they were able to get out of bed independently. Their care plan contained instructions for staff to leave their bathroom light on at night to minimise the risk of them falling at night. However, whilst care plans had been updated to reflect the current needs of people, low staffing levels meant that it was not always possible for staff to Follow the guidance recorded in people's care plans and be responsive to their needs..

A system was in place for the daily monitoring of pressure relieving equipment such as mattresses and cushions. We reviewed the recorded settings for the equipment and found that they were all maintained at the correct setting. We also reviewed the turning chart for a person who was identified as having poor skin integrity and who required the assistance of two staff for manual handling. The chart was completed and showed that staff had assisted them to change their position at regular intervals throughout the day. Bathing and shower charts showed that people were receiving a bath or shower in line with their wishes in their care plans.

At the previous inspection we found a breach of regulation 9 of the Health and Social Care Act 2008. This was because staff were required to fulfil multiple roles which meant that it was not possible for staff to engage people in meaningful activities. During this inspection we found that there had been little improvement in relation to this. At the time of the inspection, and for several weeks prior to it, staff had been required to fulfil multiple roles within the service. The limitation that this placed upon their time meant that it was not possible to engage people in meaningful activities of their choice.

There was no activities co-ordinator not present on the day of the inspection and the expectation was that care staff would support people to participate in activities. We observed that whilst there were aspects of the day when care staff engaged people in group activities there were large parts of the day when this was not possible because the staff were busy providing care to people. On the day of the inspection there were only two care staff on duty, this meant that it was not possible for activities to be person centred and meaningful to individual people or to support them to access the community if they chose to. Consequently, people spent much of their time just sitting in the lounge with the television or music on without meaningful engagement. In addition to this people who remained in their own rooms were placed at risk of social isolation because it was not possible for staff to spend time with them.

This was a continued breach in regulation 9, of the Health and Social Care Act, 2008; 2014, person centred care.

There was a complaints matrix in place, however since the manager had come into post no complaints had been received. We observed at the front entrance of the service there was an easy read complaints process available which clearly explained to people to raise a concern or complaint.

Inadequate

Is the service well-led?

Our findings

Whilst improvements had been made by the manager, there remained a lack of a strong infrastructure to support them to ensure improvements were sustained, built on and fed into continued development plans for the service. The provider's arrangements for supporting effective governance were not robust and were solely reliant on the manager. They could not demonstrate that systems were in place to operate the service in a consistently safe way which mitigated potential risks and protected people as far as possible from harm. Without these systems in place people using the service remained vulnerable.

We saw the manager had made some improvements through the recruitment of new staff and systems to monitor the quality of the service. However, further resources were needed to ensure that staff deployment, skills and numbers were appropriate so standards were maintained consistently and people were safe. This included enough staff to provide care and ensure the service was kept clean. The feedback from people living at the service, relatives and staff was all very positive about the changes made. However, this was all reliant on the current manager's approach and leadership. The provider was not supporting this progress for example, they had reduced staffing numbers against the manager's advice. This had a direct impact on the manager's ability to ensure that the service was being run in the right way.

Because of this lack of support/resource there continued to be systemic failures. A consultant had some input at the service however, this has not continued. It was not clear from our inspection why this had stopped, whether or not any replacement for this support was needed and how it affected the overall action plan for the service. Discussions with one of the providers showed that they felt that they had delegated responsibility to the manager and relied on them to tell them what needed doing. However, the manager was clear that they did escalate concerns via email and telephone but were not confident the provider understood why the improvements were needed and the level of input they would require to improve.

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

The provider had been required to submit monthly reports to the Commission but had failed to do so. This was an opportunity to demonstrate how the service was progressing and what changes were being made to improve and develop. Failing to do this is a breach of their conditions of registration. This demonstrated a lack of understanding and/or disregard of the importance of the regulations and their responsibilities to ensure the quality of care.

This is a breach of Section 33 of Social Care Act 2008 (Regulated Activities) Regulations 2014 Failure to comply with conditions

Following the inspection the provider reported to us that they were unable to continue running the service due to a lack of staff and because the manager had resigned. They were unable to provide staff until people using the service had been supported to find alternative homes. Therefore the local authority provided staff and oversight to ensure this was done in a safe and planned way. No people currently live in the service. The

Commission is taking further action under its enforcement policy. We will report on it once it is concluded.

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	Section 33 HSCA Failure to comply with a condition The provider had been required to submit monthly reports to the Commission but had failed to do so. This was an opportunity to demonstrate how the service was progressing and what changes were being made to improve and develop. Failing to do this is a breach of their conditions of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were required to fulfil multiple roles which meant that it was not possible for staff to engage people in meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure resources were in place to ensure that staff deployment, skills and numbers were appropriate so standards were maintained consistently and people were safe