Diomark Care Limited

Belmont Lodge Care Centre

Inspection report

392-396 Fencepiece Road
Chigwell
Essex IG7 5DY
Tel: 020 8500 5222
Website: www.foresthc.com

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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 27 August and 1 September 2015.

Belmont Lodge Care Centre provides accommodation for up to 46 older people who require personal care. People may also have needs associated with dementia. There were 38 people living at the service on the day of our inspection, including two people who were in hospital.

A registered manager was in post but was on leave at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were not available in sufficient numbers to meet people's needs safely and staff were rushed at times. Improvements were needed to staff deployment.

People's nutrition and hydration needs were not always properly assessed and met.

Summary of findings

Staff did not receive suitable training and support to enable them to meet people's needs effectively. Staff performance was not suitably monitored and appraised to ensure good practice was in place.

Records were not always available to guide staff on how to meet people's assessed care needs. People did not always receive the support required to meet their identified individual needs. People had varied levels of opportunity to participate in social activities and engage in positive interactions.

The provider's systems to check on the quality and safety of the service provided were not effective in identifying and acting on areas that required improvement. People did not always feel their views were listened to positively.

Medicines were not consistently stored, recorded and administered in line with current guidance to ensure people received their prescribed medicines safely. Risks to people's health and well-being were not always assessed or were not sufficiently detailed to ensure people's safety. People received varied support in the way their healthcare needs were met.

The provider had a clear complaints procedure in place. Improvements were needed to ensure everybody felt their concerns were listened to.

Appropriate assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

Staff had attended training on safeguarding people and were knowledgeable about identifying abuse and how to report it. Recruitment procedures were thorough.

People were supported by staff who knew them well. People's dignity and privacy was respected and staff were kind and caring. Visitors were welcomed and people were supported to maintain positive relationships with others.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

There were not always enough staff to meet people's needs safely and improvements were needed to staff deployment.

Risk management plans were not always detailed or in place to support people's safety. Medicines were not always safely managed.

Staff recruitment processes were thorough to check that staff were suitable people to work in the service.

Staff had a good understanding of safeguarding procedures to enable them to keep people safe.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were not provided with a level of training, supervision and appraisal that enabled them to meet people's needs well.

People's nutritional and hydration needs were not properly assessed and monitored to help them to maintain a healthy balanced diet.

Improvements were needed to ensure that people were supported to access appropriate services for all areas their on-going healthcare needs.

Guidance was being followed to ensure that restrictions on people's rights were consistently assessed.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach to people.

People's privacy, dignity and independence were respected, as was their right to make decisions and choices.

Visitors were welcomed and people were supported to maintain relationships.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care was not planned so that staff had guidance to follow to provide people with consistent person centred care. People did not always receive care in line with their assessed needs.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement.

Summary of findings

People were not always confident that their comments and complaints were positively received.

Is the service well-led?

Inadequate

The service was not well led.

The provider's systems to assess the quality of the service were not effective in identifying areas where improvement was required. Monitoring was not effective to ensure required actions were followed up promptly so as to make the necessary improvements to the service.

People did not always feel that their views were respected and used to improve the service people received.

Belmont Lodge Care Centre

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 27 August and 1 September 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience on 27 August 2015 and one inspector on 1 September 2015. An expert by experience is a person who had personal experience of caring for older people or people living with dementia.

Before the inspection we reviewed the information we held about the service including notifications received from the provider. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who used the service, five visitors, one healthcare professional, 11 members of staff, the deputy manager and the provider's representative.

We reviewed six people's care and six people's medicines records. We looked at records relating to three staff. We also looked at the provider's arrangements for supporting staff, managing complaints, safeguarding alerts and monitoring and assessing the quality of the services provided at the home.

Requires improvement

Is the service safe?

Our findings

Deployment of staff required improvement. Information prior to our inspection suggested that there were not always sufficient care staff on duty to meet people's needs and that records of staff on duty could not be relied upon as accurate.

The management team told us that, due to the number of lounges and dining rooms, they could not allocate staff to monitor these throughout the day. They did expect that one particular lounge, used by people with behaviours associated with more acute levels of dementia, would be monitored. We spent time observing this lounge and noted a gap of 20 minutes without staff being in the room to support people. People were occasionally verbally rude and insulting to others during this time. While no attempts at physical contact were seen, people could have reacted negatively towards them. One person said, "You have seen nothing, it is very quiet here today. [Some people] do disturb us … when the shouting gets too bad I try to walk away." This presented a potential risk to their own and other people's safety as well as people's wellbeing.

People's views on the suitability of the staffing levels varied. Most people who were able to speak with us felt there were sufficient staff available. Four out of five staff told us there were not always enough staff available to meet people's needs, particularly in the morning and at lunchtime. The management team told us that they did not know how, or by whom, the current staffing levels had been decided. This meant that the provider could not be sure that staffing levels were suitable to meet people's changing needs.

The minimum safe care staff level advised as required by the deputy manager were not on duty on the first day of our inspection, however the rota was accurate. No clear explanation was provided for the reduced staffing level. The manager, the deputy manager and activity staff were not recorded on any rota to show what hours they actually worked in the service. On the second day of our inspection, which was announced, some changes had been made to the planned rota and there were seven care staff on duty to meet people's needs. We were not assured that the staffing levels would have been increased to this level had our inspection not taken place. The rota showed, for example, that one person who should have been on their rest day was working their sixth twelve hour shift.

The deputy manager told us that all staff, including management and ancillary staff who were suitably trained, helped out with people's care as needed. Ancillary staff provided support to the care staff at busy times. These staff knew the routines expected and it was clear that this was usual practice. One person said, "Everyone helps out including the kitchen staff, like a family, there is no us and them." Observations during the inspection showed that while there were enough staff to provide people with support, staff were rushed, such as when supporting people with transfers, which impacted on safety and care was sometimes task led.

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

The management of medicines required improvement in some areas. People's medicines were not always safely recorded, stored or handled. One person's medication administration record (MAR) was not completed to show that the person had received their evening medicines as prescribed on three occasions that week. The medicines were not available in the blister pack which would indicate the person had received them. With one person's controlled medicines, there was a discrepancy of one tablet between the tablets available and those recorded and signed for by two staff as remaining. This meant that the records relating to medicines could not be relied upon to ensure people received their medicines safely and as prescribed.

The temperature of the medicines fridge was recorded daily. The temperature was within recommended levels at the time of our inspection. However, there were five recent occasions where this had exceeded the recommended safe temperatures for medicines storage. Staff could not tell us of any actions taken in response to this to ensure the safe storage of medicines at all times. During a medication round a staff member was observed to directly handle people's medication to put it into their mouths. This meant that poor hygiene methods were being used and there was a potential risk of cross-infection. The member of staff confirmed they knew that this was not safe practice. Staff told us their competence to manage medicines safely was assessed although they could not tell us when this occurred. No records were made available to demonstrate these assessments.

People had varied experiences of feeling safe in the service. One person said, "On the whole I feel safe and secure."

Requires improvement

Is the service safe?

The management team were unable to show us that robust procedures were in place to identify and manage risks relating to the running of the service. This included the risk assessments for the environment, fire, legionella or potential emergencies in the service so that action could be taken to limit these. The management team advised that the manager may have these in place however, these could not be located at the time of our inspection. Updated information was provided to us after the inspection.

People's individual risks such as in relation to moving and handling people or nutrition were assessed and recorded in their care plans. However, these did not always include sufficient information on how to manage the risks or offer staff clear planned actions to limit their impact and keep people safe. Moving and handling assessments, for example, did not identify the procedure to be followed by staff for each transfer, how many staff were needed for each procedure and what equipment was to be used.

We had referred concerns we had received prior to this inspection to the local authority in line with safeguarding procedures. These related to unsafe moving and handling of people, insufficient staff to monitor people and keep them safe, people not receiving care that met their needs, lack of social stimulation and a culture where people felt that management did not respect people and listen to their concerns.

Staff had a clear understanding and knowledge of how to keep people safe from the risk of abuse. Staff had attended training in safeguarding people and knew how to report any suspected abuse. Staff confirmed they would do this without hesitation to protect the people they supported. The manager's records showed they had responded to concerns raised within the service and had acted to ensure people's safety. These did not included reference to the concerns identified by the people who contacted us.

People were protected by a robust staff recruitment process. Staff told us that references, criminal record and identification checks were completed before they were able to start working in the service and they had an interview to show their suitability for the role. This was confirmed in the staff records we reviewed. The helped to ensure people were being supported by staff who were suitable to do so.

Requires improvement

Is the service effective?

Our findings

Staff did not use the learning from their training effectively to support people safely. Staff confirmed they received induction and basic training, including moving and handling, before they started working in the service. Records provided by the deputy manager confirmed this. Staff induction included working alongside an experienced member of staff initially. We observed a new member of staff complete inappropriate moving and handling practice by lifting a person under their arm, instead of supporting their back as they stood up, as the experienced staff member did. The new staff member told us they had completed recently training in moving and handling and this was confirmed in the provider's records. The experienced staff member confirmed that they were aware of this unsafe practice, did not stop it or advise the new member of staff on safe practice. This meant that the induction did not support the staff member to develop the skills and competence to support people and meet their needs. In a separate situation, we observed two staff members move a person from a wheelchair to an armchair by lifting them under their arms and legs. The person was unable to tell us verbally their view on this experience. One of the staff members, whose main role in the service was not as part of the care staff team, told us they knew that this was not appropriate and only did it because staff were so rushed. Both incidents put both the people living in the service and the staff at risk of injury. The deputy manager confirmed that this was not in line with safe, competent and expected staff practice and confirmed they would take appropriate action in response to this.

Some staff did not demonstrate suitable skill in communication and supporting people living with dementia. They did not explain to people, for example, what food they were being served to help people to understand and make sense of the mealtime experience. While another staff member had had training, they administered medicines in an unsafe way by directly handling people's medicines.

Records provided by the management team showed that most staff had attended training on supporting people who become, at times, distressed and anxious with each other. In relation to this training and its use in supporting people in these events, one staff member said, "The training is good, and that certainly helps with there appears to be an impasse, we are taught to be calm at all times." However, while the service supported a large number of people living with dementia, the records also showed that 12 of 23 care staff, including a member of the management team, had not received training in dementia care. This included staff supporting people with social activities.

The poor practice and skills levels we observed showed that staff had not received suitable training, on-going observation and assessment of their practice to make sure they were competent for their role and that their competence was maintained.

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

Staff told us that they had regular formal supervision meetings. Records confirmed this and that supervision meetings and staff appraisals were planned for the remainder of the year.

People experienced differing levels of care in relation to their nutrition and hydration needs. People who were able to told us they were offered sufficient amounts of food and drink and that there was a choice. One person told us, "The food is good, I eat it all and there is plenty to drink." Another person said, "The food is very good." At breakfast we saw a good selection of foods and people also had a choice both at lunchtime and teatime. Where staff assisted people to eat, they did this in a positive way and at the person's own pace. This was not the case for people who received support whilst in their room. A visitor told us that they were concerned as their relative, who stayed in their room, did not always have access to drinks or enough staff interventions to encourage the person to drink sufficient amounts. The person had a medical condition that meant they were prone to infections and needed to drink sufficient amounts. The person was assessed as being at risk and records did not confirm that the person received suitable care and support for their assessed needs in relation to nutrition and hydration.

Specific written instructions were provided to staff by the manager that the person was to have all their fluids thickened in line with the dietician's instructions and those fluid intake levels were to be monitored daily. Staff gave us differing answers as to whether this action was being followed for the person. Senior staff could not show us that the thickening product was available and it was not recorded on the person's medication administration

Requires improvement

Is the service effective?

records as having been provided. The person's fluid intake records had been totalled only on the first two of 28 days. No record of any fluids being provided to the person was available for four days, on other days drinks were recorded as provided only between 9am and 5pm. This showed that, when guidance was available, staff did not follow it to ensure the person received consistent support that met their individual needs.

An assessment of people's nutritional risk was recorded as completed by staff each month and a score arrived at. There was no indication as to what this score meant. The deputy manager could not find any explanation of what the score signified or implied for the individual person. Staff therefore did not have clear written guidance on each person's specific needs to enable them to respond to these effectively and consistently.

The menu was not displayed to support people living with dementia to be reminded of the meals available. We observed mealtimes on both days of the inspection. Staff supported people to go to the dining rooms and sit at the tables. The cook then served the main meal from a heated trolley, firstly in the larger dining room and then in the second dining room. Some people in the small dining room therefore waited longer than necessary for their meal and there were some instances where people became restless and distressed with each other. This did not make a positive mealtime experience.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found variations in the way people's healthcare needs were being met. People told us that their healthcare needs were responded to promptly and that staff helped to access the services that they needed. One person said, "Staff do keep a check on you and call the doctor if you need it." A health professional told us that staff called the health professional in an appropriate and timely way and followed their instructions in relation to people's healthcare. We found that this was not always the case for all people. People's care plans identified that they needed the attendance of a chiropodist to manage their foot care. We saw that some people had very long toe nails. This was confirmed by a visitor who was concerned regarding the condition of their relative's feet and nails. After discussions with a number of staff and checking records, the deputy manager confirmed that some people had not been treated by a chiropodist for some months. Staff told us that this was probably because people had refused to be assisted and became anxious and distressed. No other support or strategy was in place to meet these people's identified care needs. This meant the service did not provide the level of support identified as needed by the person.

Assessments of people's capacity had been completed in line with Mental Capacity Act 2005 (MCA) and where appropriate, best interest decisions had been made. The arrangements for the administration of covert medication, that is medication given in a disguised way, for example, had been assessed for individual people. Records showed that this had been agreed as in their best interests by appropriate people involved in their lives including the Pharmacist and GP. Applications had been made to the local authority in relation to the Deprivation of Liberty Safeguards (DoLS). Authorisations had been granted in some cases and some were coming up for renewal. Staff had received training and had a basic understanding of their role in relation to MCA and DoLS and how these should be applied.

Good

Is the service caring?

Our findings

People spoke very positively about the staff and their caring attitude. One person motioned to a carer and said, “Look at her kind, smiling face; could not be kinder. I like it here. The carers are very, very sweet." Another person said, "I am very content. The staff are patient and kind”.

Some people told us they were not sure whether they had been involved in their care plans. Other people confirmed that they and their relatives were involved in the assessment of their needs before they came to live in the service and also in planning their care. People told us that staff respected their right to make decisions, such as where to sit or whether to spend time in their own bedroom or in the communal rooms. One person said, “I prefer to stay in my room and that is not a problem.” Another person said, “They let me do what suits me. Staff stop and chat as they go past. I call out if I need help and they come in and help me.”

People also told us that staff respected their independence. One person said, “Staff are very nice, understanding people. I keep well away from the people who scream and shout. I do what I want and nobody interferes. This is a nice, clean, safe place with some lovely staff. I know my limitations and must accept my need for help.” Another person told us that they were able to assist with some of their medicines and felt well cared for. They said, “Staff are so good, they really look after the people and help them. They don’t have time to sit and talk to them as there are not enough staff for that, but they do care for them well though.”

People's dignity and privacy was respected. Staff showed respect for people and their personal space, advising us for example that one person did not like anyone to enter their bedroom without agreement. People who needed support with personal care were assisted discreetly and with dignity. We saw staff talk quietly to people and close doors when people were receiving care so as to respect their dignity and privacy. Staff were able to tell us what dignity meant during personal care such as keeping doors closed during care and explaining to people what they were going to do before starting to provide care. People’s personal information was treated with respect and securely stored to ensure it remained confidential.

People told us they had positive relationships with the staff and that they were caring and respectful. Staff addressed people by their preferred names and spoke with them in a way appropriate to the person’s stage of life. Catering, housekeeping and maintenance staff also knew the people living in the service and treated them with kindness and concern.

Care staff told us there were handover meetings between shifts to ensure that all staff had up to date information in the event that people’s needs had changed. Staff spoke to people in a calm and reassuring way. Staff knew people’s needs and preferences. We saw, for example, that staff brought two mugs of coffee to a person and their visitor and addressed both by name. It was clear that this was the preference of the people involved. Visitors told they were able to visit freely without restriction. They also told us they were always made welcome.

Requires improvement

Is the service responsive?

Our findings

Whilst care was planned, people did not receive care that was responsive to their needs. Although no person at the service currently had a pressure ulcer, people at risk of developing pressure ulcers needed their pressure relieving mattress to be at a setting appropriate to their individual weight. These were recorded as checked routinely by maintenance staff as at the correct setting. However, there was no information in the care plan or the maintenance records as to what the correct setting should be and staff could not tell us what the setting should be for the individual. This increased people's risk of skin breakdown. We made the deputy manager aware of this and action had been taken to address it by the second day of our inspection. People at risk of malnutrition and dehydration had also not been assessed and supported in a responsive way.

We were concerned about how people were generally being supported in their day to day lives. The sound level of music, televisions, people's vocalisations and voice levels in the lounge areas and dining rooms at times made it hard to hear ordinary conversations. On one occasion, for example, one person's facial expressions indicated they were distressed and they had their fingers in their ears. Staff encouraged the person to move to a quieter area. We had received information that one person was taken to and left alone in their bedroom at times in response to the level of noise they made when they became distressed. The deputy manager confirmed this occurred so as to allow the person to become calm, to keep them safe from others and to relieve the effects on other people in the service. No assessment had been made in relation to any additional support strategies, such as staffing, interactions and monitoring that the person or other people required to respond to this need and ensure the person's emotional wellbeing was met so they did not become socially isolated.

People's experience of social interaction and opportunities varied. Some people we spoke with went out with their relatives or chose to stay in their rooms. One person said, "I do not go down for the activities, I am not a joiner." A visitor told us they worried that "[Relative] may slip through the cracks as they were so introverted and staff were pulled in so many other directions." One person said, "We do go in the courtyard sometimes but not in the garden anymore. There are few things on, I go out a lot and read, that suits me." Another person said, "It's bearable but the company is hard to take. It's the [other people] that make me depressed and angry." The person told us that reading was a favourite pastime of theirs but they found it hard to read because of the constant interruptions from noise made by other people.

We had received concerns that people did not have opportunities for suitable social activities. There was no clear plan of providing social interactions and activities that had relevance to individual people's past lives and interests and so sparked memories that mattered to them. The environment did not support opportunities for meaningful activities and engagement, particularly for people living with dementia. While memory boxes were in place by people's individual bedrooms, there were no objects of reference easily available around the service to capture people's interest. There were limited opportunities for people to be involved in everyday tasks, such as dusting or gardening to prompt engagement, so that people kept actively involved and busy to nurture a sense of well-being.

We saw some group quiz and puzzle games and additionally, on the second day of our inspection, a group art activity. Shortly after lunch we saw that many people were sat in the lounge with their eyes closed and heads on their chests, seemingly asleep. Staff told us that outside entertainers came in routinely to sing and dance and bring in animals for people to interact with. An outing to the seaside was planned for later in the month. The staff responsible for this aspect of people's care confirmed they had no training in dementia care or supporting appropriate social stimulation and support for people living with dementia.

People's social and healthcare needs had not been assessed and managed appropriately. People were not receiving care that met their needs and promoted their wellbeing. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a complaints procedure. One formal complaint was recorded. This had been investigated at a senior level and responded to in line with the provider's stated policy. People told us that they felt able to raise issues, however one person felt that the approach was not open and the response they received was defensive. Other people told us they had a positive response. One person

Requires improvement

Is the service responsive?

told us, for example, that their medication groupings had been changed without prior information and they had questioned this. They told us that staff responded to this in a positive way by explaining to them that it was due to the recent change of pharmacist supplier. Minor expressions of dissatisfaction were noted in a communal record book.

Improvements were needed in the way the service gained people's views of the service. There was no detail as to what, if any, actions had been taken to capture people's views and use these as a learning tool in response to people's day to day experience of the service. The service could not be assured that they were responding and acting on people's comments and views and systems were not in place to allow people to do this routinely.

Inadequate

Is the service well-led?

Our findings

The service was not well organised. The registered manager was on leave at the time of our inspection. Senior staff and the provider's representative could not demonstrate that the service was managed to ensure the safety of the people living and working there. They confirmed they were unable to provide us with some information we requested over the two days. This was because they did not know whether the information existed or where it might be kept. Examples included risk assessments relating to the environment, fire or legionella, an emergency business continuity plan and some information on the provider's quality monitoring systems. A business contingency plan was sent to us one week after the start of our inspection when it was first requested.

Systems in place to monitor the quality and safety of the service were not effective. Although the manager had completed some audits these had identified but not resolved issues in, for example, medicines management and care planning. We saw that a medication audit for June 2015 and July 2015 had recorded failings in poor ordering and stock control of medicines and new medicines not obtained in a timely manner. There was no detail as to what the issues actually were and whether people's medicines had been always available to them or not. No action plan was provided in relation to either of these audits. The provider's representative confirmed the lack of clarity of the audit. They advised that some issues could be identified as still outstanding such as no current pharmaceutical reference book explaining about individual medicines and their uses and side effects. A care plan audit identified areas of care plans that were not in place or not updated. These were not evidenced as followed up to check that actions had been completed. This meant that there were no proper systems to monitor progress against action plans to improve the quality and safety of the service.

The provider's representative advised that they validated the manager's audits in the reports of their regular visits to the service. Their report of 22 May 2015 identified that some people complained of being bored, there were significant periods observed when there were no staff in lounges and people who were at risk were left unattended. We identified similar concerns at this inspection that were having a detrimental effect on people's care and well-being. The system had identified but not resolved issues and so was not effective in ensuring continuous improvements.

The provider's quality monitoring systems were not comprehensive to include all aspects of the service. No audits were in place, for example, in relation to control of infection in the service. There was no method in place to assess people's dependency needs and no system to calculate and review the number of staff required to meet people's changing needs. The provider's representative told us however that this had recently been recognised by the provider who was working on improving this. Systems to review staff training and competence to ensure that staff were adequately skilled to keep people safe and to meet their needs were not demonstrated as successful. Areas of concern were not identified, or where concerns were identified, action was not being taken to address the concerns and make the necessary improvements to the service.

The culture in the service was not consistently open and inclusive to all. Staff understood the management structure and knew how and with whom to raise concerns should they need to do so. In general staff told us that the manager was approachable and supportive, however during our inspection, one person told us that concerns they raised were not openly received and positively responded to. We had received information of concern about the service from more than one person who told us that the manager did not listen. This indicated that people did not feel able to raise concerns within the service or were not confident their views would be listened to and acted upon.

Meetings for staff had taken place for staff. A meeting for relatives took place in May 2015 which was attended by a health professional. Minutes of the meeting were not available. The provider's representatives told us they believed a survey had recently taken place of managers and staff. No outcome or action plan in response to this was yet available. Surveys to ascertain people's satisfaction with the service and their representatives views had not been undertaken.

The systems in place to assess, monitor and improve the quality and safety of the service for people and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk were not operated

Inadequate

Is the service well-led?

effectively. Records were not always accurate and well maintained. The manager did not always seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered provider had not ensured that people's care was planned for so that staff had information to guide them on how each person's needs and preferences were to be met and ensured that the care provided was person centred and met the person's identified needs. This was in breach of Regulation 9(1) and (3) (a), (b) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: The registered provider had not protected people against the risks of receiving inadequate nutrition and hydration. This was in breach of Regulation 14(1), 14(2)(b) and 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The registered provider had not ensured that their established systems and processes were operated effectively and evaluated to assess and monitor the quality and safety of the service provided and to ensure continuous improvements.

This was in breach of Regulation 17 (1) &(2) (a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not ensured that staff had received suitable training, on-going supervision and appraisal to make sure they were competent for their role and that their competence was maintained. This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.