Four Seasons 2000 Limited

Burgess Park

Inspection report

Burgess Park
Picton Street
Camberwell
London
SE5 7QH
Tel: 020 7703 2112
Website: www.fshc.co.uk

Date of inspection visit: 15 and 17 July 2015
Date of publication: 27/08/2015

Ratings

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

Overall summary

This inspection took place on 15 and 17 July 2015 and was unannounced. Burgess Park is a nursing home that provides accommodation and personal care for up to 60 people, some of whom are frail and live with dementia. People lived on the first and second floors of the service and the ground floor was closed for refurbishment. At the time of the inspection there were 32 people using the service.

At our previous inspection on 2 March 2015 the service had not met the regulations we inspected. We issued two warning notices, which relate to person-centred care and dignity and respect. We also found other breaches which relate to safe care and treatment, meeting nutritional and hydration needs, good governance and notification of incidents to the Care Quality Commission. We issued three requirement notices for these breaches. We asked the provider to send us a report about how they will improve the service to meet our regulations. The provider sent us the report as requested.

Summary of findings

At this inspection we followed up on the outstanding breaches of the regulations. We found that some action had been taken to address one previous breach relating to meeting nutritional and hydration needs. However, we found that the provider had not made sufficient improvements to address all the breaches. There were continued breaches in person-centred care, dignity and respect, safe care and treatment, good governance and notifications of incidents to the Care Quality Commission. We also found new breaches with regards to consent, premises and equipment, and staffing.

At this inspection we found eight breaches of regulations for person-centred care, dignity and respect, need for consent, safe care and treatment, premises and equipment, good governance, staffing and notifications of incidents to the Care Quality Commission.

There was no registered manager in post as 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. There was a peripatetic manager in post managing the service. They told us since our previous inspection on 2 March 2015, the registered manager had left the service and a new manager had been recruited. The newly appointed manager was not yet working at the service and therefore not present at the inspection.

Incidents and accidents which occurred at the service were not always recorded. The provider had not correctly assessed the level of staffing required to meet people's needs.

Medicines were not managed safely. People did not always receive their medicines in line with the prescriber's instructions. People were also at risk of infection because safe standards of cleanliness were not always maintained.

Whilst staff received regular training and supervision to support them in their caring role, they did not have regular appraisals. The manager was not aware of their responsibilities within the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People and their relatives were not always involved in discussions or in assessments about their mental capacity.

People's interests, social or cultural needs were not met by the activities provided. Staff were unaware of people's cultural needs and personal histories. The provider had not supported people to access local community groups or advocacy services which could provide help and support to them. People were not always provided with meals which met their needs because they were not offered any choice in their meals.

People or their relatives were not involved in making decisions regarding their care needs. People's assessments, daily observation charts and care plans were not regularly updated. The provider monitored the service and carried out quality audits; however these did not always identify areas of concern or make improvements, so that people received consistent quality of care.

People and their relatives told us they were treated with dignity and respect by staff. However, this did not reflect our observations during the inspection.

People and their relatives were asked for their opinions on the quality of the service and some of these were acted on. People were provided with information on how they could make a complaint and how the complaint would be managed.

Staff were aware of the signs of abuse and how to report an incident of abuse to their line manager or peripatetic manager of the service.

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

The service 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.

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?

Inadequate

The service was not safe. People were at risk of receiving unsafe care because assessments relating to the care for people were not always updated or accurate.

People did not receive their medicines safely.

Safe standards of cleanliness were not always maintained and this put people at risk of infection.

Is the service effective?

Inadequate

The service was not effective. Staff received regular training and supervision, however they did not have an up to date appraisal to support them in their caring role.

Staff were not aware of their roles and responsibilities within the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.

People's interests or cultural needs were not met by the activities provided.

Is the service caring?

Requires Improvement

The service was not always caring. People were not supported to make decisions regarding their care.

Staff were unaware of people's personal histories and things that mattered to them.

Is the service responsive?

Requires Improvement

The service was not responsive. People and their families were not asked

to contribute in the review of care records.

People were not supported to develop new relationships with their local community.

People were able to raise a complaint with the manager and were confident that their complaints would be managed appropriately and resolved.

Is the service well-led?

Requires Improvement

The service was not well-led.

The quality of care was monitored, but did not identify areas of concern we found.

There was no registered manager in post.

The manager had not notified the CQC of significant events at the service which they are required by legislation to inform us about.

Burgess Park

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 15 and 17 July 2015 and was unannounced. It was carried out by three inspectors, a nurse specialist professional advisor, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service and what we received from the local authority. We also reviewed the report the provider sent us following our last inspection. During our visit we spoke with ten people who use the service and 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 observed care and support provided in the communal areas of the home.

We spoke with one relative, two nurses, eight care staff, the activities co-ordinator, the regional manager, the peripatetic manager and deputy manager. We spoke with five external healthcare professionals and a social care professional during the inspection.

We reviewed people's records. We looked at 26 care records, 17 medicine administration records, accident and incident reports, nine staff records, staff rota and other records for the maintenance and management of the home.

Is the service safe?

Our findings

At our previous inspection on 2 March 2015 we found that risks to people's health care and well-being were not always assessed, identified and managed by staff effectively. We found that where people were identified as being at risk of weight loss, there were no plans in place to manage and monitor this. We issued warning notices. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people's medicines were not managed safely. We also found that the provider could not tell us how many staff was required to keep people safe These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had made some improvements. Assessment of people at risk of weight loss were completed, people had support from a dietician and a support plan in place to monitor this. However, we found that some people's assessments were not always updated or accurate, people's medicines were not managed safely and the standards of cleanliness were not always maintained. This was also the case at the last inspection. We found that the provider had not taken sufficient action to address all the issues we identified.

People told us that they felt safe living at the service. One person told us, "Yes, I am safe here; I'm not worried about my safety here." Another person told us, "Some of the staff are lovely. I have my buzzer next to me and they come quickly if I need them, at night too." However, our findings during the inspection did not support what people told us.

It is the policy of the service for staff to complete daily, hourly call bell checks to make sure the call bell was accessible to people, check whether there were faults with the bell, whether it was missing or whether people lacked capacity to use the bell. When we looked at the records for these checks they were not routinely completed. When we visited two people in their rooms we noted that they were unable to call for help and support because their call bell system was out of their reach and on the floor. We asked these people if they wanted us to bring the call bell closer and they agreed on each occasion. These people were unable to call staff for help without the call bell due to their frailty and mobility difficulties. The service did not ensure that there were methods in place to keep people safe in the event of an emergency. This increased people's risk of harm in the event of an emergency.

We met another person who was in bed, their call bell was on the floor and out of their reach. We retrieved the call bell and they pressed the call bell. No member of staff had come to assist the person in response, so we found a member of care staff and asked if they could assist the person. People were at risk of not receiving help in an emergency because they did not have access to staff when needed. The routine checks completed by staff had not identified that some people could not call for help in an emergency.

Some people lived in an environment which had an unpleasant odour of urine. We spoke with the nurse on duty about the odour in one person's room and were told that the cleaner was on duty and would clean the person's room that day. At the end of the inspection we went back to the person's room and found it still had not been cleaned.

We observed that staff did not wash their hands or use hand cleansing gel when providing care and support to people with eating, assisting with drinks or assisting people with their medicines. This increased the risk of cross infection for people.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not recorded safely. For example, we found date discrepancies in the controlled drug register (CDR) and the medicine administration records (MAR) for a person. We found that people did not have their medicines as prescribed. Staff had in discontinued the administration of two people's medicines before they were due to end, in error. This increased the risk of the deterioration in their health and well-being. Staff completed drugs audit daily in addition to monthly audits. However, these did not identify the areas of concerns with the management of medicines that we found.

People's medicines were not handled appropriately. We found a hand written MAR chart for a person did not

Is the service safe?

contain all the information that appeared on the pharmacy label. This was in breach of the provider's Management of Medicines Policy and the Nursing and Midwifery Council (NMC) guidelines.

Staff had not followed professional guidance regarding the management and review of medicines. People who required covert administration of medicine were not routinely reviewed as required. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the person is unknowingly taking medication.

We found that a person had a mental capacity assessment (under the Mental Capacity Act 2005) and best interests' decisions were made relating to covert administration of medicines. However the person's GP had changed all medicines to liquid formulations and the person was not currently refusing medication and was being medicated in the normal manner so covert administration was no longer necessary. The provider had not identified that the initial decision regarding covert medicines should be reviewed due to the change in the person's needs. This was in breach of the provider's policy. People were at risk of continued poor management of medicines because these errors were not reported and staff were not provided with the opportunity to learn from the incidents.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was in a poor state of maintenance with peeling paint both externally and internally. People's rooms had areas were the paintwork was scuffed and required cleaning in places. A number of curtains were hanging at the ends, because of missing hooks. Some people lived in an environment which they were not encouraged to make their own by having their personal items around them.

These issues were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider assessed staffing levels in relation to the dependency levels of people living at the service. However, we found that on some occasions the level of staffing could not meet the needs of people. For example, when a member of staff had to leave the service to escort a person to the hospital this left reduced levels of staff at the service from four care workers to three carers, with no additional cover to support people.

We discussed the level of dependency with the nurse in charge who told us that there were 22 out of 32 people who required the assistance of two care workers to support them when they required assistance to move using a hoist. We asked staff how they supported people with reduced staff. One member of staff said, "We just manage", another told us, "There should be adequate cover to support our residents all the time." People were at risk of not receiving appropriate care because there were insufficient staff available to care for them.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a recruitment process which ensured staff were recruited safely. Staff records we reviewed held documents which were relevant to the application and interview process, including criminal records checks, with copies of references and qualifications. Staff records demonstrated that newly appointed staff had completed the service's application process. Nurses and carers undertook a period of induction before they were able to work independently. Staff received support from senior colleagues to help them develop skills in order to provide effective care for people.

We observed the general cleanliness of the home in the communal areas. We noted that the bathrooms and the toilet were clean as were the commodes people used.

Staff told us that they were aware of the signs of abuse. They described how they would raise an allegation of abuse first to their manager. One member of staff said, "it's about keeping them safe" another said, "it's about protecting people" and another told us, "We keep people safe by making sure that they don't come to harm." Staff told us that they had completed safeguarding adults training but all three members of staff we spoke with did not know what action to take if they suspected abuse if their line manager was unavailable. People were at risk because staff were unable to effectively protect them from the risk of abuse.

Is the service safe?

Staff we spoke with were aware of the whistle-blowing policy and procedures of the service. Staff told us that they would be confident to raise a concern with their line manager or whistle blow if necessary.

People had risk assessments in place and identified risks had management plans. For example, people who had been assessed as being at risk of weight loss had assessments, to determine the level of risk with action plan in place. Staff made a referral to a dietician for advice and support. We checked care records and the food plan records and this corresponded to what the dietician told us and the records we reviewed.

Is the service effective?

Our findings

At our previous inspection on 2 March 2015 we found people were not always provided with meals which met their cultural and health needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that people did not have access to healthcare when their needs changed. This issue was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people's medicines were not managed safely. This issue was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that the provider could not tell us how many staff were required to keep people safe. We issued requirement notices. This issue was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had made some improvements in meeting the nutritional and hydration needs and met the required standard. People had access to a balanced diet to meet their health care needs and to maintain their health. People told us, "The meals are much better now there is a permanent chef." Another said, "I get all the meals that I need, I can choose my meals now, where before I had very limited choices." There were knives and forks on the tables but no spoons, so people were unable to eat and drink independently. However, people were not supported to make choices at mealtimes. The menu was hand written on a blackboard for people, but it would have been difficult to read while sitting at the table. We observed one person who could not communicate in English was unable to understand what meal was on offer. The carer supporting that person did not show them the food to enable them to make a choice.

Staff had completed training necessary for their role. The staff training records showed and the manager told us that staff had completed training in person centred care, infection control, medicine management. However, we observed that the training staff completed was not put into practice to meet the needs of people using the service. For example, although nurses had completed the medicine training by the dispensing pharmacy, we observed several medicine errors. Staff had completed person centred training, but this was not reflected in people's care records and people and their relatives were not involved in making important decisions regarding their health and care needs. The manager met with staff regularly, but that staff appraisals were not done according to the provider's policy. We found that no members of staff had received an annual appraisal in 2014 or 2015.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to have their needs and choices met by staff. For example, we saw that relatives of people who had a DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) instruction in place were not consulted if they lacked decision making capacity. We saw that where a relative had a legal responsibility to be informed of decisions relating to their health, they were not consulted in this decision. People's wishes and choices were not sought and relatives were not consulted where necessary in care decisions.

The provider did not have an understanding of their responsibilities of how to care for people within the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides protection for people who may not have the capacity or ability to make some decisions for themselves. The DoLS gives protection to people from unlawful restriction of their freedom without the authorisation to do so. At the time of the inspection there were six people who had applications under the DoLS authorised. However, staff identified that some people could benefit from an assessment within DoLS but an application was not competed for them. We found that staff were complying with the conditions of the authorisations. For example, we observed staff support a person in the appropriate use of bed rails and also in the management of another person's medicines.

Staff were unaware of the role of an independent mental health advocate (IMCA). An IMCA is an advocate for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. When the person had been assessed as lacking decision making capacity.

Is the service effective?

People had a mental capacity assessment in place. Some people who had a MCA completed were previously identified as able to make decisions independently. We found that the MCA's did not identify a specific decision to be made. For example, six MCAs we looked had identified the decision to be made was for complex health and financial decisions. Where people required further support in making decisions, this was not identified and appropriate support in place for them. People were at risk of not being supported to make decisions regarding their health and care because their needs were incorrectly assessed.

These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff practiced food hygiene practices before lunch was served. They wore new plastic aprons, washed their hands and completed food temperature checks to ensure that food was served at the correct temperature and was safe for people to eat.

Staff held a regular meeting with health and social care professionals to discuss people's individual needs. During these meetings a plan of action was agreed and actions implemented to meet outstanding needs. Referrals were made to the most appropriate health or social care professional to meet the person's needs.

Is the service caring?

Our findings

At our previous inspection on 2 March 2015, we found that people were not always treated with dignity and respect. We also found that people were not supported to be as independent as possible.

We issued a requirement notice as this was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that staff did not encourage people or their relative to be involved with the development of their care. People did not have the opportunity to make decisions in planning their own care. Staff completed assessments, care plans and risk assessments; however, people and their relatives were not always involved in this process. Assessments were focussed on tasks to be completed, such as weighing people, completing daily food charts, call bells and bed rail checks. These did not place the person in the centre of the assessment taking into account the person's, likes, dislikes, how they would like their care provided and what was important in their lives. During our discussions with people we identified that they had various interests and hobbies that they had before coming to live in the home. One person told us, "I don't do anything here, nothing happens that interests me."

However, people told us that staff were kind and caring. A person said, "The carers are so busy here caring for everyone." Another person said, "They are kind." The relatives we spoke with told us that staff were really helpful to their relative and they felt welcome when they arrived at the home.

People had documents called About Me which documented people's interests, likes and dislikes. We saw these had been completed by nurses with no reference to discussions with the person or their family. The information held on the About Me document reflected current care needs, and very little about the person's life history. People's life histories were not used to inform assessments and they were not encouraged to contribute to assessments regarding their care. People's care was focussed on tasks staff completed, and not what people wanted or how they wanted to be cared for.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found people were not treated with dignity and respect at all times. We spoke to staff about the care and support they provided to people. A member of staff told us, "It's about loving them." During our observations we heard staff speak with people in a way which did not promote respect or dignity. We heard staff call people 'darling' and 'sweetie' several times. We found that people were not protected people against the risk of a lack of dignity and respect.

We saw some examples of caring interactions and people and staff interacted and engaged each other in conversations. However, we observed staff did not understand people's cultural needs when providing care and support for them. We observed a person whose first language was not English who was unable to communicate with staff and staff were unable to communicate with them. There were no volunteers to communicate with or advocate for the person. A person who lived at the service told us, "No one can talk to them and they can't talk to us either, but they speak with their eyes." This increased the risk of social isolation and a risk that the person was unable to express their needs so staff could understand and meet those needs.

We checked the person's care records and found that an assessment of their capacity was completed and they were assessed as not having decision making capacity. There was no indication that the assessment was completed with the person in a language they understood. We asked the nurse in charge about this, and they told us there was no other assessment completed with this person. We discussed these issues with the peripatetic manager who had not identified this issue for the person or made links with a local community groups or interpreters to support this person. People were at risk of social isolation impacting on their well-being.

These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

Our findings

At our previous inspection on 2 March 2015 we found people and their family were not always involved in the development and review of care records. People were not supported to maintain relationships with people that mattered to them. Staff did not respond promptly to people's changing needs. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that people and their family were not involved in the review of care records. This was also the case at the last inspection. We also found people at risk of social isolation were not supported develop new relationships with their local community.

People's care and support needs were assessed before coming to live at the home. People told us that their assessment took place with the support from a relative who was invited to attend the assessment and added information where necessary. However, we found that some people's assessments updated since their admission to the home had some information missing. For example, in six of the care records we found that the assessed needs of people's were incomplete. People were at risk of receiving inappropriate care because their needs were not accurately assessed.

People and their relatives were not routinely invited to contribute to care plan reviews, during their admission to the service. This was identified in the minutes of the residents' meeting which stated that there was a plan for a new care planning system and would be encouraged to be part of the care planning process.

People did not have activities provided to them that met their interests. People interacted with staff in the lounge and dining room areas where people were sitting and relaxing. There was an activity board which detailed the activity for the day. We did not observe that the activity scheduled for the day took place or that another activity was offered to people. People's social needs were not met with activities that interested them.

We spoke with people about the activities which took place at the home. One person told us they did not like to join in with any activities and preferred to stay in their room. They added, "The staff pop in quite often to make sure I am ok and my daughter visits quite regularly." We asked if they were offered individual activities in their room they said, "They are all so busy and they look after me and feed me. What more can I ask for?"

People who could not join in the activities in the lounge, did not have support which met their interests or their needs. We looked at an activity record that stated that the person had one to one reading, two to three times per week. However, the record did not record what the person wanted read to them or for how long. When we spoke with the person about this activity they told us, "No, I read to myself." The identified plan of action for this person was not carried out and increased the risk of isolation.

People's preferences were not taken into account in providing activities. While in the lounge one person told us, "I would like to go out in the garden." When we asked the activity co-ordinator whether taking people outside as a part of an activity they said "I don't like to take them out when the weather's like this." It was a warm day with level access to the garden. There were two members of staff on duty in the room caring for and supporting 14 people, there were not enough staff to support a person who wanted to do a different activity. The person was unable to make a choice and have the choice supported by staff that cared for them.

The residents and relatives meeting on 10 June 2015 identified that life history work was planned to be included in developing "a more structured meaningful activity plan." The minutes stated there was a need for more activities in the home and "We are trying to develop this further." We identified through our discussions with people, staff and our observations that this action had not been completed.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives received a copy of the complaints policy. The service did not have any current complaints. People told us that they were able to make a complaint if needed and would be confident that staff would manage their complaint effectively.

Is the service well-led?

Our findings

At our inspection on the 2 March 2015, we found that the service was not well-led. People and their relatives were encouraged to feedback on the service; however, people's responses were not always acted on. The quality of care was not monitored, reviewed or improved by the registered manager. The registered manager had not sent appropriate notifications relating to DoLS approval and notifications of death to the Care Quality Commission (CQC). We issued requirement notices These issues were in breach of regulation 18 (CQC Registration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, people continued not receive a service that was always well-led. There was not a registered manager in post. The peripatetic manager told us that the provider had recruited and employed a manager to take on the role of the registered manager at the service. The provider failed to ensure that the Care Quality Commission were kept informed of incidents which occurred at the service. The peripatetic manager had not sent appropriate notifications relating to people who used the service. Where people had a DoLS approval agreed and in place and when a person died we were not informed of these. This was also the case at the last inspection.

The peripatetic manager undertook internal audits on the quality of care and support. These had not identified the concerns that we found in each of those areas. For example, there were daily, weekly and monthly medicine audits which did not identify the areas of risk of the management of people's medicines which we found. When medicine errors occurred these were not routinely recorded or reported and therefore no learning was achieved from these incidents. There was a risk that people received care which was not monitored and action not taken to make improvements promptly.

People and their relatives were encouraged to feedback to staff and the manager regarding the quality of care for people. The registered manager analysed the responses people and their relatives made. The analysis showed that the majority of people were satisfied with the quality of care, cleanliness, meals, and environment. However, we found that there were seven out of 32 people or their relative that completed the survey from April to July 2015. People and their relatives did not comment or provide feedback regarding their experiences of the quality of care.

We found a number of gaps and missing information in people's care records and monitoring charts. For example, five care plans we looked at were not completed in order to fully assess people's needs. People were at risk of receiving an unsafe service because action had not been taken to improve the quality of care records which had been identified by the provider in February 2015.

These issues were a breach of regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

Staff were supported to be accountable for their caring roles. Staff we spoke with told us they were in charge on some days, this meant that they had to make sure colleagues filled in charts properly and reported sickness to management so alternative staffing could be sought.

Staff told us their manager listened to their views. Staff had regular team meetings where they discussed issues relating to the service and their caring. Team meetings were held on a regular basis with all members of staff of the service. Staff were encouraged to participate in team meeting and offered their opinions and suggested changes to improve the quality of the service. We saw that the suggestions made were acted on. For example, staff were involved in the development of the menu and were involved in making suggestions to revise the mealtimes.

Staff we spoke with told us they liked working at the home and felt they could get support from the nurse in charge and manager. However, they were unsettled by the changes in the management of the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use services were not treated with dignity and respect by staff that cared for them.** **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 15 HSCA (RA) Regulations 2014 Premises and equipment **People who use services were not protected from the risk of living in a service which was not properly maintained or clean.** **Regulation 15 (1)(a)(e)(2).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People were at risk of unsafe care because the provider did not have enough staff which could meet people's needs.** **Regulation 18(1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The provider failed to tell us about notifiable of incidents. Regulation 18.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected against risks associated with care that did not meet their needs, preferences or choices.** Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)(e)

The enforcement action we took:
We are considering the action we take and will publish an updated inspection report in the future.

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 **People who use services were not supported to provide consent to care and treatment.** Regulation 11(1)(2)(3)

The enforcement action we took:
We are considering the action we will take and we will publish an updated inspection report in the future.

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 **People who use services were not protected against the risks associated with unsafe care and treatment.** Regulation 12 (1)(2)(a)(b)(c)(d)(f)(g)(h)

The enforcement action we took:
We are considering the action we take and will publish an updated inspection report in the future.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

People who use services were not protected against the risks of receiving care that was not assessed, monitored or improved in quality.

Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

The enforcement action we took:

We are considering the action we take and will publish an updated inspection report in the future."