Hooklands Limited

# Hooklands Care Home with Nursing

## Inspection report

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## Ratings

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| Overall rating for this service | Inadequate |

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| Is the service safe? | **Inadequate** |
| 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

This was an unannounced inspection which took place on 14 August 2017 and 17 August 2017. The registered manager was given notice of the second date as we needed to spend time with her to discuss aspects of the inspection and to gather further information.

Hooklands Care Home with Nursing provides accommodation for up to 27 older people who require nursing or personal care and who may be living with dementia. The home is located in Bracklesham Bay and the garden backs onto the sea. Communal areas include two lounges and a dining area. There is a lift to access bedrooms on the first and second floors. At the time of our inspection 19 people were living at the home. Of these, 16 people required nursing care and 10 people were living with dementia.

During our inspection the registered manager was present. 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.

We previously inspected the home in January 2017,which was the first inspection since the home was purchased and registered to be operated by a new provider. At the January 2017 inspection five breaches of regulations were identified. These related to safe care and treatment as risks to people's health and wellbeing were not being managed safely and staff were not being provided with sufficient training and support in order to provide safe and effective care. Also, recruitment practices were not robust as checks were not undertaken to ensure staff did not pose a risk to people. Mental capacity assessments had not been completed and applications had not been made to the authorising authority for people who were being deprived of their liberty. Quality monitoring systems were not in place and as a result shortfalls in service provision were not being identified and acted upon.

In response, the registered manager and provider sent us an action plan that detailed the steps that would be taken to achieve compliance. The home was rated 'Requires Improvement' in the Effective, Caring, Responsive and Well Led domains and 'Inadequate' in the safe domain. An overall rating of 'Requires Improvement' was awarded.

At this inspection we found that improvements had taken place with regards to recruitment practices and consent to care. However, insufficient action had been taken and a further deterioration had taken place in relation to safe care and treatment, staff training and support, and, good governance. Also, new concerns were identified in relation to the environment, safeguarding, staffing levels and statutory notifications and breaches of regulations were identified in these areas. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was no equipment such as sensory devices available in the home to alert staff if people fell and needed assistance. Referrals to external professionals had not been made when people fell to ensure action was taken to minimise the risk of further falls. Risk assessments and care plans were either not in place or incomplete for people who were at risk of choking. Skin and wound care management was not always robust. There was a lack of information about risks associated with choking and the provision of pureed meals meant that staff unfamiliar with the needs of people might give people meals that placed them at risk of harm. Medicine records were not complete and as a result could not be used to establish if people had received medicines as prescribed.

We identified multiple safeguarding concerns that placed the majority of people who lived at the home at risk of harm or poor care. As such, we shared the concerns that we identified during the inspection with West Sussex County Council Adult Services safeguarding team in order that they could consider these in line with their safeguarding procedures. As a result, representatives of the Council are reviewing everyone's needs and multiple safeguarding enquiries are currently taking place. Whilst the reviews are taking place the local authority are supporting the provider to make improvements to the care provided to people. Representatives of the local authority are visiting the home on a regular basis as part of this process. The local authority have suspended placing new people at the home and the provider has also agreed not to admit any privately funded people or new people from any other local authority.

The registered manager had not submitted safeguarding referrals' to the local authority or statutory notifications to CQC when concerns were identified that related to neglect of care or acts of omission. Staff had not received safeguarding training and did not report potential safeguarding concerns despite being able to explain their responsibilities to do this.

There had been a decline in staff morale due to a lack of formal support provided and the reliance of high numbers of agency staff to fill vacancies. Minimal training had been provided and this was not consistent and some staff had not been able to attend due to having to cover shifts at the home. Staff had not been provided with training in first aid, moving and handling and dementia care. People living with dementia did not receive a personalised service and nurses did not have sufficient knowledge to provide effective care and to meet people's individual nursing needs. Staffing levels were not sufficient to meet the needs of people who lived at the home. This resulted in people having to spend extended periods of time in their rooms in order to keep them safe.

Quality monitoring systems were still ineffective at identifying and driving improvements. Audits were minimal, had not been completed on a regular basis and had not identified the issues found at the inspection. The provider had not ensured sufficient oversight of the service provided to people and had not fulfilled his legal responsibilities to ensure compliance with the regulations. The provider had not recognised when quality and safety was compromised and as a result had not responded appropriately. He had not sought professional advice for areas outside of his expertise. He had not ensured systems and processes monitored and improved the quality and safety of service provided to people. The registered manager acknowledged that she was not fulfilling her responsibilities and had submitted her resignation.

Since our last inspection the flooring in the communal areas had been replaced and more homely lighting fitted in the home. Chairs were in the process of being replaced and new blinds were due to be fitted to lounge windows. However, we found that people had not been able to access or use the garden area during the summer and that there was no garden furniture or sun parasols that people could have used. There was very little in the way of visual stimulation for people living with dementia.

In the main, people expressed satisfaction with the meals provided. Despite this, we found that people who

required a specialised diet did not have the same range of choices as people who had a normal diet.

Despite the poor staff morale we saw that they were dedicated and tried to ensure people received a caring service. There was genuine warmth between people and the permanent staff and it was apparent that positive relationships had been formed. People told us that staff treated them with dignity and respect and that they were happy with the support they received with personal care. Relatives also confirmed that they were welcomed when visiting their family members.

There had been an improvement in the recruitment processes and practices at the home.

Since our last inspection advice had been sought from an external professional about The Mental Capacity Act (MCA) 2005 and training had been provided to staff. Where necessary, people now had MCA assessments completed and applications had been submitted to the relevant authority when people needed to have their liberty deprived for reasons of safety.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

## 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.

Risks associated with people's health and wellbeing were still not managed consistently or safely.

Medicines were not always managed safely.

Systems and processes were not being operated effectively to prevent abuse and to ensure appropriate investigation by the relevant people.

Sufficient numbers of suitably qualified and competent staff were not always deployed to meet people's needs.

Safe recruitment processes were now followed.

### Is the service effective?

**Requires Improvement**

The service were not consistently effective.

Formal support and training was still not consistently provided to staff to ensure they were sufficiently skilled and experienced to care and support people to have a good quality of life.

People said that they were happy with the medical care and attention they received. However, people were not supported to access all external healthcare professionals as necessary.

Parts of the building and the environment were not well maintained or accessible.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and now followed the requirements of the Mental Capacity Act 2005.

Most people expressed satisfaction with the meals provided. People were supported to eat a choice of meals that promoted good health.

### Is the service caring?

**Requires Improvement**

Aspects of the service were not consistently caring.

People said that staff were caring. However, staff knowledge and their deployment affected the care that people received.

Systems for formally supporting people to express their views and to be involved in making decisions about their care and support were inconsistent.

People's privacy and dignity was promoted. Staff were able to explain how they promoted people's dignity and privacy.

Relatives were welcomed in the home.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People did not always receive a responsive service based on their individual needs. People's needs were not always accurately assessed or planned for.

A limited activity programme was in place, although people expressed satisfaction with the range of activities available. There was limited stimulation for people who lived with dementia.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns and their views and opinions were acted upon.

## Is the service well-led?

**Inadequate**

The service was not well led.

Systems were still not being used to identify and take action to reduce risks to people and to monitor the quality of service they received. The provider had not ensured sufficient oversight of the service.

Staff did not receive support and there had been a decline in staff morale.

Although the registered manager was open and honest she had not ensured a positive culture was embedded at the home.

# Hooklands Care Home with Nursing

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection which took place on 14 August 2017. We also returned on the 17 August 2017. The registered manager was given notice of this date as we needed to spend time with her to discuss aspects of the inspection and to gather further information.

The inspection team consisted of two inspectors, a specialist tissue viability nurse 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 checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the Provider Information Return (PIR) that the registered manager submitted. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the action plan that the registered manager sent us in response to the previous inspection. We received feedback from four external health and social care professionals on the service provided. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with six people who lived at the home and three visiting relatives. We also spoke with the registered manager, the registered provider, one registered nurse, four care staff and a kitchen assistant.

We observed care and support during the morning and afternoon. We also observed the nurse giving some people their medicines and the lunchtime experience of people.

We reviewed a range of records about people's care and how the home was managed. These included 11 people's care records. We also looked at five members of staffs training, support and employment records, audit reports, menus, policies and procedures and accident and incident reports.

Inadequate

# Is the service safe?

## Our findings

At our last inspection breaches of regulation 12 (Safe Care and Treatment) and regulation 19 (Recruitment) were identified and requirement actions made. There was a lack of effective risk management for people who were identified as being at risk of developing pressure areas. Incomplete wound care records were in place and tools for identifying and monitoring people who were at risk of malnutrition were not being used in full. Monitoring records were not completed in full and did not evidence people received support to turn to reduce pressure areas or fluids to maintain hydration. The registered manager sent us an action plan that informed us that risk management processes would be reviewed to ensure people received safe care. At this inspection we found steps had been taken and recruitment practices had improved. However, insufficient action had been taken to ensure safe care and treatment was provided to everyone who lived at the home.

Risks to people were still not managed consistently or safely. Risks had not always been reviewed or assessed correctly and the monitoring of people's health and condition was often ineffective. This meant staff may not have taken all reasonably practicable action to minimise the risks to people. This was the same as at our last inspection.

When incident and accidents occurred action was not always taken to minimise the chance of a re-occurrence. Staff told us of two people who were at risk of falls and who had recently fallen. Accident records for January to July 2017 confirmed that 14 people who lived at the home had fallen during this period of time. One person had fallen three times and three people had fallen twice. Staff had recorded that 15 of the falls were 'unwitnessed.' The registered manager and provider confirmed that there was no equipment in the home that could be used to alert staff when people fell, such as sensory devices. The registered manager also confirmed that advice had not been sought from relevant agencies or professionals such as the falls prevention team in order to minimise the risk of falls and to keep people safe.

Staff told us of another person who had recently moved into the home and the concerns they had to keep the person safe. They explained that the person was unsteady on their feet and that on occasions they had found the person attempting to climb over bedrails that were in place and to stand when in a wheelchair. A bedrail assessment was in place which stated that alternative equipment had been considered. However, the registered manager confirmed this was incorrect as no alternative equipment was available in the home. The person had a falls risk assessment that stated they were at medium risk of falls. There was no care plan for falls prevention and consequently there was no information to inform staff of the actions they should take in order to minimise the risk of falls. None of the people who had fallen had sustained a serious injury, however they were at risk of serious injury due to the lack of effective falls prevention strategies in place. This was compounded further by the deployment of staff that we have reported on below as they were not always available to assist people.

Permanent staff told us of five people who were provided with pureed meals in order to reduce the risk of them choking. None had risk assessments in place in relation to choking or the provision of pureed meals. People had nutritional care plans but these did not include information about the need to provide pureed meals. The registered manager was unable to confirm how it had been decided if people needed pureed

meals. Apart from one person, there was no evidence that advice had been sought from the Speech and Language Therapy (SALT) team to ensure people were supported safely to manage any risks associated with choking and the registered manager confirmed advice had not been sought. There were no recorded instances of people choking. However, agency staff were being used to cover shifts and the lack of information about risks associated with choking and the provision of pureed meals meant that staff unfamiliar with the needs of people might give people meals that placed them at risk of harm.

Even when information was available to reduce risks to people this was not always followed. We observed a registered nurse give a person their medicines with a drink that was not thickened despite information at the front of the Medicine Administration Record (MAR) folder stating the person should be given their medicines with a drink that had been thickened. The person started to cough after being given the drink. No harm came to person as the nurse stayed with them and ensured they did not choke but there was the potential for this to occur as the nurse when asked, did not know about the guidance in place to reduce the risk of choking.

At the start of our inspection the registered manager informed us that two people had wounds that required nursing intervention. However, we were shown a file that identified six people with wounds. The file contained NICE Guidelines on Pressure Ulcers, the European Pressure Ulcer Advisory Panel Guidelines and guidance on management of skin tears from the NHS Sussex Community Nursing Service. The guidance included information on documentation for wound care management and treatment. We found that the guidance was not been followed for everyone with wounds.

Pressure relieving equipment such as mattresses and cushions to minimise the risk to people was in use. Mattresses were set correctly according to the person's weight and these people were being supported to change their position at regular intervals.

Medicines were still not managed safely. As a result of the concerns we identified at our previous inspection the provider informed us that all nurses would complete medicine training, their competency would be assessed and monthly audits would be completed. At this inspection, we found that nurses had been enrolled on training but had not yet completed this and their competency had not been assessed. One medicine audit had been completed by the pharmacy who supply medicines to the home. This identified a number of areas for improvement that had not been acted upon. No medicine audits had been completed by the provider or registered manager.

We saw that the disposal box for controlled drugs was not being used safely or in line with the manufacturer's instructions. The nurse on duty did not understand that liquid should have been in the box and that it should have only been filled three quarters full to ensure medicines were disposed of safely. We drew this to the registered manager's attention who instructed the nurse to address this immediately.

Medicines given on an 'as required' basis were not always managed in a safe and effective way. Protocols for 'as required' medicines were not always in place and those that were in place had not always been completed in full. One person was prescribed an 'as required' medicine for agitation. There was no protocol to guide staff about why and when the person should have this medicine, possible side effects, time between dosages and maximum amounts that could be given. Three other people had protocols in place for medicines but these had not been completed in full. Another person had a protocol in place for a medicine to assist with agitation but there was none of this in stock and the medicine was not referenced on the MARs. The nurse did not know if the person was still prescribed the medicine or if it had been discontinued and there were no records in place to confirm this.

One person's MAR chart included details of a medicine and instructed that they should have this once a day of an evening to assist with bowel movements. There were no entries on the MAR chart to confirm if the person had been given this and there was no record of the amount that was received at the home. Therefore, it could not be established if and when the person had received this medicine.

Another person was prescribed nutritional supplements. The form stated that the person should be given one per day. There were only two dates when staff had signed to confirm this had been given. The amount received by the home had not been recorded and therefore this information could not be used to check if the supplement had been given as prescribed.

Medicines were not managed properly or safely and the lack of action to effectively assess and mitigate risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicines management were safe. The nurse who gave people their medicines did not sign the MAR charts until they had witnessed people swallow their medicines. There were assessment tools available for staff to measure the level of pain people were experiencing to ensure the appropriate level of pain relief was given. The nurse who gave people their medicines was able to explain these and how people may show they were in pain. They said, "X (person) curls their body up and face scrunches so I give pain relief."

The registered manager had not ensured robust safeguarding procedures were always followed. Records confirmed that representatives of a person who lived at the home raised concerns about the care the person received. The concerns related to neglect of care and acts of omission as it was alleged that they were found dehydrated due to a lack of access to fluids and that they could not call for assistance as the call bell had been placed out of reach. Although the registered manager took action to address the concerns she did not raise a safeguarding alert with the local authority in line with her legal responsibilities. Another person had fallen from their bed in June 2017 and the accident record stated the reason for this as 'Bedrail not in the up position.' The record stated that the registered manager had spoken to staff about the importance of ensuring bedrails were used. When asked, she confirmed that she had not raised this with the local authority as a safeguarding concern. This demonstrated that the registered manager did not understand that acts of omission that resulted in harm or potential harm constitute abuse that should be reported to the local authority safeguarding team.

Although care staff that we spoke with were able to describe the different types of abuse and the procedures they should follow if they suspected someone was being harmed or were at risk of harm 13 of the 25 staff employed had not undertaken refresher safeguarding training in line with the provider's policy. During the inspection staff told us about concerns they had about people's wellbeing and safety. They told us that they had reported some concerns to the registered manager, others they had not. As staff had not reported concerns robust safeguarding procedures were not being followed to protect people from harm and abuse.

Systems and processes were not being operated effectively to prevent abuse and to ensure appropriate investigation by the relevant people. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection we shared our concerns about people's wellbeing and safety with the local authority safeguarding team. As a result, 11 separate safeguarding enquiries are taking place and everyone who lives at the home will have their care package reviewed to ensure they are in receipt of safe and appropriate care. The provider has been working with the local authority to address the concerns we identified during our

inspection to mitigate risks to people's safety and wellbeing. Referrals have been made to the falls prevention team and SALT for people identified as being at risk, sensor devices have been installed for two people to alert staff if they fall, nurses have been booked on medicine training and their competency will be assessed by 15 September and a review of care documentation is taking place.

People's views on staffing varied. One relative said, "My only complaint is the home's use of agency staff. There have been too many employed lately and this affects care." One person said, "Several carers are away at the moment." During the inspection we noted that when people used call bells to summon assistance these were answered quickly and one person confirmed this was the norm. However, we did note that one person wrote in a satisfaction survey in June 2017 that staff did not always respond promptly to call bells and that as a result they did not receive assistance to access the toilet when they needed it. The registered manager told us that she had not yet reviewed the contents of the satisfaction surveys and no action had been taken in response.

Since our last inspection the registered manager had introduced a dependency tool to decide safe staffing levels. We were shown a list of people who lived at the home dated 7 August 2017. This stated 17 of the 19 people were assessed as high dependency. This was due to a mixture of their moving and handling requirements, nursing needs and living with dementia. The registered manager told us that staffing levels consisted of a registered nurse at all times, supported by four care staff in the morning, three in the afternoon and two at night. The registered manager, also a registered nurse, was usually available during the week to offer additional support when needed. Nursing and care staff were assisted by domestic and kitchen staff which enabled them to focus on providing care to people. Despite, staffing being decided by the use of a dependency tool we found that sufficient numbers of suitably qualified and competent staff were not always deployed to meet people's needs. People's bedrooms were located on three floors. During the inspection we observed many occasions when there was not a staff presence on all floors despite people being cared for in their rooms. When spending time with people in their rooms we observed that people had emergency call bells close to hand in order that they could summon assistance if required. However, the registered manager and staff told us that some people were not able to use these due to living with dementia and the lack of staff presence meant that they could not summon assistance when needed.

At the start of our inspection the registered manager told us that only two people were cared for in bed. However, during our inspection we observed eight of the 19 people who lived at the home remained in bed all day. Although we observed that people who were in bed were using pressure relieving air mattresses they remained in the same position for eight hours. Even if a person has not been assessed as high risk, being in bed in the same position for long periods of time will make them more susceptible to pressure ulcers and the lack of movement would increase their risk of immobility.

As at our previous inspection there was a high reliance on agency staff to cover shifts. Staff duty rotas for 22 July 2017 to 17 August 2017 showed that either agency nurses or care staff or both had been used every day to cover shifts. On some shifts there had been more agency staff than permanent. This was affecting the moral of permanent staff and the quality of care that people received. One member of staff said, "Nine out of ten shifts there are agency on shift. Some afternoons we are short staffed as they couldn't get cover or too many staff booked leave in the same week. Some days there are only three care on shift and there have been times when there were only two. If you are helping one person who needs two staff that leaves no one to help the other residents." Another member of staff said, "Yesterday there were three agency staff on the afternoon. One had been here before but the others hadn't. You can't give the residents the care they want and need as the agency staff don't know them." The registered manager and records confirmed that staffing levels had not always been maintained as shifts had not always been covered due to a lack of availability of agency staff. In addition, staff had not received sufficient training or support and systems to ensure they

were competent were not in place.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to meet people's needs effectively and safely. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection the provider informed us that four new care staff had been recruited, two were due to commence employment in August and two in September. In addition, three staff were due to return to work. Two the week after our inspection and one in September. Other vacancies would be covered by the same agency staff for consistency. This gave us assurances that the need to rely on high numbers of agency staff would reduce.

Improvements had taken place with regards to recruitment processes and practice. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home.

At our previous inspection there was no staff member who had a lead role in infection control for the home and no audits of the policies and practices had been conducted. At this inspection the infection control policy stated that the registered manager was the infection control lead. Although there was a cleaning schedule in place that was signed by staff to show when tasks were completed we saw parts of the building and equipment that were not clean or maintained to an appropriate standard. The majority of people's bedroom carpets were badly stained and some wheelchairs were dirty.

Equipment was in place that was regularly checked to ensure it was safe to use. We observed that when bedrails were used protective covers were in place in order to reduce the risk of injury. Hoists had been serviced regularly and people had individual slings to assist with moving and handling. Small electrical items had been tested. There was a business continuity plan in place that would help minimise disruption to the service provided in the event of emergencies which included power failure. Fire plans and the home evacuation plans were posted on each level near the stairway.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection breaches of regulation were identified and requirement actions made in relation to regulation 11 (Consent to Care and the Mental Capacity Act (MCA) and regulation 18 (Staff Training and Supervision). Assessments had not been completed for people who lacked capacity to consent to aspects of their care, DoLS applications had not been submitted to the authorising authority and staff did not demonstrate understanding of the MCA. Staff had not received training in areas that included first aid, MCA and dementia care. Nurses had not received training in areas relevant to the needs of people. Staff had not received regular, formal supervision or appraisal. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. This included MCA assessments and DoLS applications being completed, training arranged and provided a programme of supervision for staff. At this inspection we found that steps had been taken in relation to MCA and that this breach was met. Insufficient action had been taken to meet the breach for staff support. Staff had not received training and support as per the action plan supplied to us.

There had been a decline in staff morale since our last inspection and the lack of formal support had contributed to this. Every member of staff that we spoke with said that they received very little formal support that enabled them to fulfil their roles and responsibilities. One member of staff said, "I have had no one to one at all." A second member of staff said the worst thing about working at the home was, "Support, we don't get any. Someone needs to do checks on things to see if things get done but no one does." A third member of staff said, "I've not had one supervision since working here." The supervision matrix detailed 25 staff employed. Of these, one member of staff had received two supervisions (one of which was an annual appraisal), three staff an annual appraisal and five staff one supervision. The remaining 16 staff had not received any formal supervision or appraisal in 2017. This was not in line with the provider's policy which stated that staff would be provided with formal supervision at least four times a year.

New staff who had commenced employment had not received a thorough induction in line with the Care Certificate. The Care Certificate covers 15 minimum standards that should be included as part of induction for new care workers. They had not had regular meetings to discuss their performance or to assess their competency. One member of staff told us, "On induction I went round the building, filled in a book about fire, did a bit of training. That's pretty much it really."

Staff had received training but as at our previous inspection this had not been consistently provided in all required areas. One member of staff said, "I have had some training but I've never had a test afterwards. You are just given a certificate. No one checks if you have learned anything." The registered manager confirmed that staff were not assessed to ensure training improved their knowledge and practice. A second member of staff said, "Last week was continence training but I couldn't do it as the floor needed covering." Since our last inspection the provider had purchased an online training package in order that staff could complete regular training. However, the registered manager confirmed this had not been implemented. The training matrix detailed 25 staff employed. Of these, 11 had not completed refresher moving and handling training, 13 had not completed annual safeguarding training or infection control training. Many people who resided at the home lived with dementia. Despite this only five of the 25 staff had received dementia training.

The lack of supervision, training and checking staff competency increased the risk of inappropriate or ineffective care and support. Until staff have all received updated moving and handling training the provider was not mitigating the risks of potential falls. When talking to care staff we did note that their knowledge of managing incontinence was minimal despite people living at the home have needs in this area. At one point, they asked us for advice for one particular person as they said they were having difficulties managing the person's needs. None of the staff had received guidance on continence care.

There was evidence that the lack of support and training for nurses impacted on the care some people received. We observed a nurse give a person their medicines without a thickened drink which increased their risk of choking. Also, the nurse could not explain sufficiently good wound care management and did not understand about the safe disposal of medicines. The nurse had completed training in wound care but not in medicines, tissue viability or malnutrition. Competency had not been assessed in any area.

Staff had not always received appropriate training, supervision and appraisal to enable them to carry out their duties effectively. This put people at risk of receiving care from staff who had not been assessed as competent to carry out their roles. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did express satisfaction with the care and support they received. One person said, "I've been here for two years. I was very ill and they thought I was going to die. But the care in here is good, they sorted me out." A second person said of the staff, "I think they know what they are doing." People told us that staff arranged for them to see professionals such as the doctor and chiropodist as necessary and records confirmed this. One person said "The GP comes in on a Wednesday." An external professional wrote and informed us, 'Any concerns regarding resident's foot health are always noted by the manager before I leave and she has contacted me in the past if she has any concerns with new arrivals or problems between appointments. The home is a pleasant place to visit.' However, the registered manager confirmed that referrals had not been made when necessary to the falls prevention team and SALT.

At our previous inspection the provider had started to make improvements to the premises. New fencing had been fitted around the garden and window boxes fitted outside people's bedrooms. Also raised beds had been put in place to enable people to participate in planting. However at this inspection we found that the raised beds had not been tended to and people and staff confirmed people were not able to use the garden areas due to a lack of access and facilities. There was no garden furniture or sun parasols and as such people had not been able to spend time during the summer using the garden. Two people commented about improvements needed to the environment in satisfaction surveys that they completed in June 2017. One person wrote, 'Ramp required for dining room in order to access outside area. Garden area could be developed, would help everyone – independence, fresh air, good views.'

The majority of bedroom carpets were stained. The provider told us these were going to be replaced once all the communal areas had been attended to. There was little by way of adaptation to make the environment more suitable for people living with dementia. There was no signage to help people orientate themselves to and to easily locate their bedroom or communal spaces such as the dining room. Walls and doors had been repainted in neutral contrasting colours. However, there were still no photographs or objects of reference that could help people to identify their bedrooms. There was a contract in place to remove hazardous waste. However, we noted that clinical waste bins located at the front of the home adjacent to a public pathway were not secure.

Parts of the premises and equipment were not clean, properly maintained or suitable for people who resided at the home. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Since our last inspection the flooring in the communal areas had been replaced and more homely lighting fitted in the home. Chairs were in the process of being replaced and new blinds were due to be fitted to lounge windows.

People's views of the meals varied. One person who choose to have their lunch in their room said, "It was alright. They bring it up to me because they understand I quite like to sit here. I do go downstairs sometimes but prefer to eat alone." A second person said, "I'm a bit fussy with my food, I don't like it much. I especially don't like the meat here, unless it's in a pie. I like the puddings though, that's my sweet tooth!" A third person said the meals were, "Very nice."

As at our previous inspection meals were brought in from an external provider. There was a choice of two hot options at lunch and a lighter supper option. People were asked in the morning what they would like for lunch and in the afternoon about their supper preference. If people wanted something different, kitchen staff were available to make alternative dishes such as omelettes or sandwiches. Despite this, we found that people who required a specialised diet did not have the same range of choices as people who had a normal diet. Staff and records confirmed that of an evening people who had pureed meals were provided with soup and a pudding every evening and that although the flavour of the soup or the type of pudding varied other meal options were rare. After our inspection the provider informed us that pureed meal options had been reviewed and that choices were now provided. We did note that people's weight was checked and those we sampled confirmed that people either maintained a stable weight or had increased as a result of 'additional supplements'.

We observed the lunchtime experience for people in the main dining room. Everyone was offered a drink of water, juice or sherry. Two visitors ate lunch with their relatives and it was apparent that this was a normal routine and that people knew each other well. One of the visitors asked people if they would like some music put on and several people agreed. As soon as the singing commenced one person who lived with dementia joined in and knew most of the words to the songs. People who required pureed meals had these served and sufficient numbers of staff were available to support people to eat their meal safely. Staff chatted to people and a pleasant atmosphere was evident. Desserts were served as and when people were ready for them and not all together as people ate at different speeds.

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

Since our last inspection the registered manager had taken steps to manage restrictions on people's freedom. The registered manager had sought advice from an external health and social care professional who had provided guidance on assessments and who had provided training on MCA to staff. Where necessary she had submitted a DoLS application to the authorising authority for people who lacked capacity and were unable to leave the home freely. As part of this process a mental capacity assessment had been completed which considered what decisions the person had the capacity to make. There was also evidence of 'best interest decisions' having been made involving representatives of the person and other professionals involved in their care. We did identify that for one person who used bedrails and did not have

the capacity to agree to these assessments and DoLS applications had not been made. The registered manager agreed these would be completed as a matter of priority.

Staff we spoke with demonstrated understanding of consent to care and the MCA. For example, one member of staff said, "Some people have capacity and others haven't. If they can't make a decision we have to do what is in their best interest. That's why we are here for them. It's important to sit and talk to the person, try and encourage and help them understand. You can't tell them what to do. If they don't consent go away and come back later. You can't force them. Sometimes if a different person offers support they agree. It's about trying different things."

Requires Improvement

# Is the service caring?

## Our findings

The deployment of staff impacted on people's choices to spend time in communal areas of the home. Staff told us that they did not support people to use two of the three communal areas in the home as there were not enough staff available to have a presence in these rooms. One member of staff said, "We don't use the quiet lounges as there are not enough staff to keep an eye on people." We did observe some people using one of the communal areas on the second day of our inspection. However, this was only due to the hairdresser using this facility. When we gave feedback to the registered manager and the provider about our findings the registered manager confirmed that some people remained in their rooms due to the staffing situation and not from choice or need. Two people also commented about staffing and access to communal areas in satisfaction surveys that they completed in June 2017. One person wrote, 'I have never seen anybody in the two rooms overlooking the sea. Maybe it is not practicable or the residents all want to be on their own.' One member of staff said, "We have got no choice but to keep them in bed."

The lack of training for staff in positive dementia care affected their understanding of personalised and inclusive dementia care. Consequently, this did not promote a caring and personalised service. Although staff were kind and caring they did not have the skills and understanding to support people who lived with dementia. Staff cared for people but did not recognise that involving them in everyday tasks such as laying tables, dusting, folding clothes or pouring their own milk into drinks would help them feel valued as individuals. We noted that one person who lived with dementia sat for most of the day in a chair at a table in the dining room. Although staff placed a book in front of the person and spoke to them as they passed they did not engage further with the person. This was a missed opportunity; when we sat next to the person and explained who we were they immediately started to engage with us, discussed how we could obtain evidence for our inspection and shared their views on aspects of the service. As a result, when staff walked past the person proudly informed them how they were assisting with our inspection.

As at our previous inspection formal systems were not being routinely used to involve people in planning their care or making decisions about the home. No one we spoke with could recall having a care plan. There had been one residents' meeting in February 2017 where people's views were obtained in areas that included meals, the environment, staffing and activities. Regarding the residents meeting one person told us, "There is always a printed agenda. We haven't had a meeting for quite a while though." Although the majority of people did not express a view about the lack of involvement we did note that two people who completed satisfaction surveys in June 2017 raised this as an area for development.

Despite the poor staff morale we saw that they were dedicated and tried to ensure people received a caring service. There was genuine warmth between people and the permanent staff and it was apparent that positive relationships had been formed. Staff were seen and heard talking to people in a pleasant and respectful way. We saw people respond positively to the staff, smiling and laughing and joining in conversations. When visiting one person in their room we observed that staff had placed a soft toy in their arms and the person was seen cuddling this. It was apparent by the person's smile that they gained pleasure from this. One external professional wrote and informed us, 'The staff are always helpful and very friendly. They appear attentive to residents and efficient.'

When giving people their medicines we noted that the nurse did so with kindness and consideration for individuals. For example, when entering the room of one person they greeted them by name, asked if they were ready for their medicines and promptly wiped the person's mouth with a tissue when the person spilt some of a drink.

One member of staff told us how they promoted positive relationships with people. They explained, "It's important to talk to people when helping them. Chat about their families. Photographs are a good way to start a conversation. I talk about the view from their window, describe it if they can't see out. Talk about jobs they have previously had. Anything that helps trigger a conversation. Talk about what on TV."

People told us that staff treated them with dignity and respect. One person said, "They are very nice to me, I spill things but the room is kept very clean for me." A second person said, "When I'm having a bad time I can shut my door." A third person said, "They've put those knockers on our doors." Since our last inspection each person door had been fitted with a traditional door knocker that staff could use to seek permission to enter if a person door was closed. People and their representatives also confirmed their satisfaction in surveys that were completed in June 2017. Regarding privacy, one person wrote, 'I'm happy to have my door open so I can see people go by. If anyone wants to pop in that's lovely. But if I wanted privacy it would be respected.'

People said they were happy with the support they received with personal care. When complimenting a person about their hair they told us, "The hairdresser comes in and I have mine done, she's good." On the second day of inspection the hairdresser was at the home and a number of people were having their hair attended to. Another person told us how they liked to be as independent as possible with personal care but that they were unable to reach their feet. They said, "The carers wash my feet and lower legs, they then cream them, but I can wash the rest of myself. If I want help I only have to ask." A third person said, "The carers help me wash and once a week or so I have a bath. I like a lot of the girls here who see to us."

Relatives said that they were welcome to visit their family members. One relative said, "I think the care staff are brilliant, but they have a lot to do." A second relative said, "I have a good relationship with the care staff, they use my first name which I like." Relatives also confirmed that they were made welcome in the satisfaction surveys that were completed in June 2017. One person wrote, 'Very welcome, not made to feel in the way.' A second person wrote, 'Staff are always friendly, seem to know me and mum, always offer me a drink, tell me about mum.'

People's rooms were personalised and pleasant. Several people who were living with dementia had dementia friendly clocks and pictures in their rooms.

Requires Improvement

# Is the service responsive?

## Our findings

The care and service that people received was variable. Prior to our inspection we were informed about a person who had been admitted to hospital who had a urinary tract infection (UTI). This is subject to a safeguarding enquiry as health professionals involved in the persons treatment in hospital have stated the UTI was avoidable and concerns were raised regarding inappropriate catheter care. As a result of the safeguarding enquiry the registered manager and staff were given advice regarding the person's care requirements however the person was again admitted to hospital and treated for a second UTI. Discussions with external health and social care professionals and with the registered manager confirmed that robust and effective care had not been provided in full by the home despite advice and support from outside agencies. Consequently, the person had not received responsive care based on their individual needs.

The lack of action to effectively assess and mitigate risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection care records were not always accurate, daily records were brief and task focused and did not give a picture of how the person spent their time or of the extent of the care provided. The registered manager and provider were aware that records needed to be improved and informed us that an electronic care records system was going to be installed during February 2017. At this inspection we found that although some steps had been taken, the new system was not being operated and people's care records were still incomplete.

The contents of people's assessments and care plans varied in accuracy and detail. Some people had all the required documentation to inform staff and to ensure they received consistent quality care whilst others did not. For one person there was evidence of a dressing change in July 2017 but no wound assessment or further recordings about treatment of a wound. For a second person with a wound there was no assessment or care plan or documentation regarding treatment other than a photograph of the wound. For a third person it was documented that they had skin tears but again there were no assessments, care plans or documented treatment. The nurse on duty did not demonstrate sufficient knowledge and understanding of wound care management and prevention. They were able to explain about the use of pressure relieving equipment such as mattresses and changing position regularly but could not offer any further information. They confirmed that they had attended a study day on wound care and pressure ulcers but were unable to explain about types of skin at risk, exercises (passive and active) and risk assessments and care plans. We could not establish if people's wounds were deteriorating. However, there was a potential that this could occur due to the lack of robust wound management plans and the high use of agency staff at the home.

As the home was having to use high numbers of agency staff to cover vacant shifts the lack of accurate and complete records in respect of each person put people at risk of receiving in appropriate or inconsistent care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Permanent care staff knew people well. They were able to explain to us the individual needs of people

without referring to records. For example, a member of staff told us about a person who lived with dementia. They told us how this affected their memory, how at times the person became frustrated and of the actions they took to reassure the person. They were able to explain objects that were important to the person, clothing and food preferences.

People spoke positively about the activities that they could participate in. One person said, "I like to play cards. On Mondays we have Bingo, I like to help the others to tick their numbers off, it's a scream!" and "On Wednesdays we have film club, one of the carers was coming in but she's hurt her back." A second person said, "They do baking here sometimes. We have singers come in. One is X and I'm her sound engineer, I like to help her set up the speakers and the other singer is X. There's also a local man who comes in and plays his guitar." A third person, "I join in with any singing and I like the bingo."

We found that people were able to engage in limited activities. Activity staff worked in the home for one and a half days each week, and during the afternoons on alternate weekends. However, when the activity staff were on leave their shifts had not always been covered and this had reduced the opportunities for people to participate in events. An activity planner for the month was displayed in the home that detailed a monthly outing, a communion service and a visiting entertainer and weekly bingo. Chiropody, hairdressing and nail care were also advertised as activities. We questioned this with the registered manager who agreed personal care was not an activity but a basic care provision that everyone was entitled to.

On the first day of our inspection three people were taken out for the afternoon by staff at the home. The relative of another person took their family member out into the back garden in their wheelchair so that they could look at the sea. One person who was living with dementia was seen sitting in the dining room all day. Staff and visitors chatted to the person but nobody gave her anything to do or look at. There were some books in the dining room. We found a picture book and showed it to the person who appeared to enjoy looking at it. However, there were no tactile items for people to hold or access freely that would have offered stimulation for people living with dementia. There was a large fish tank in the dining room but most people were seated away from this. One person had a memory box in their room that contained objects that could be used to stimulate conversation however; we did not see this in use. The registered manager confirmed that advice from a dementia specialist organisation regarding stimulation had not been obtained that could have been used to influence the quality of service that people received.

It is recommended that the provider researches and implements regular opportunities for stimulation for people who live with dementia.

Information of what to do in the event of needing to make a complaint was displayed in the home so that people could raise concerns if they wished. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. This information was also included in the home brochure which people were given a copy of when first moving to the home. The PIR informed us that no compliments or complaints had been received since our last inspection. However, an incident record stated that a representative of a person who lived at the home had raised concerns with the registered manager. There was evidence the registered manager had responded to the concerns which demonstrated that she listened and attempted to resolve issues. One person said if they had concerns, "I'd have no trouble in telling the first person who came in here."

Five people and their representatives completed satisfaction surveys in June 2017. They all confirmed that they would approach the registered manager if they had concerns. Additional comments included, 'Happy that any concerns would be dealt with appropriately' and 'If I was unhappy about any of mums care I would go to X (registered manager).'

Inadequate

# Is the service well-led?

## Our findings

The home was not always well led and people did not always receive a good quality service. At our previous inspection five breaches of regulation were identified. Requirement actions were set and the registered manager and the provider submitted an action plan to us that detailed the steps that would be taken to achieve compliance. This stated that the breaches of regulations 17 (good governance), 18 (staff support and training) and 19 (recruitment) would be met by April 2017 and the breaches of regulations 11(consent to care) and 12 (safe care and treatment) would be met by June 2017. At this inspection we found that three of the requirement actions remained unmet. These related to safe care and treatment, staff support and quality assurance systems. New breaches were also noted, none of which had been identified by the registered manager or the provider within the quality monitoring systems. These related to safeguarding, staffing levels, statutory notifications and the environment.

At this inspection we found there were ineffective systems in place to assess, monitor and improve the service. The provider had not ensured sufficient action was taken to address the breaches of regulation identified at the previous inspection and they had not prevented new breaches of regulation from occurring.

The registered provider had not ensured sufficient oversight of the service provided to people. The action plan submitted by the registered manager and the provider in response to the previous breaches of regulation was detailed and informative and stated that a range of audits would be conducted and actions taken to make the required improvements. However, at this inspection we found that the contents of the action plan had not been followed in full and this had not been monitored by the provider. The registered manager confirmed that all aspects of the action plan that was submitted to CQC had not been acted upon. Actions that had not been completed included medicine competency assessments, monthly medicine audits, establishment and following a planned programme of quality assurance audits and regular supervision. In addition, an electronic care planning system had not been implemented and the garden had not been improved as per the action plan. She said that this was due to other aspects of the service taking priority such as ensuring staff vacancies and shifts were covered.

The registered manager had completed checks of accidents and incidents. She had collated information about these and recorded on one form the total events and a monthly average. She had not analysed the information that she had collated in order to identify potential trends and as a result had not completed any subsequent actions. As a result, quality monitoring processes had not identified the lack of equipment to help alert staff if people fell, the lack of risk assessments for the management of falls and the lack of referrals to external professionals such as the falls prevention team.

The registered manager had completed a wound audit on 7 July 2017. This identified that six people had wounds on 17 July 2017. The audit stated that 100% of people had risk management documentation in place that included wound care charts and assessments. The audit was ineffective as it had not identified that three people with wounds had no assessment or care plans and other incomplete wound care documentation as reported on in the Safe domain of this report.

Quality monitoring processes had failed to identify the lack of risk assessments for people at risk of choking, the lack of risk assessments for management of choking, the lack of referrals to external professionals such as SALT and the lack of choice of evening meals for people who required pureed meals.

A medicines audit was completed by the pharmacy that supplied medicines to the home on 3 August 2017. This identified a number of areas that required action that included the need to ensure accurate records of medicines entering the home and when they are given. The registered manager confirmed an action plan had not been completed to address the audit findings and our evidence demonstrates aspects of medicines management was not safe. This had not been identified within the quality monitoring processes at the home.

Although, the registered manager completed dependency assessments for people who lived at the home she had not identified or taken action to ensure staffing levels did not impact on the time people could access communal areas of the home.

Records were not always accurate and up to date. These included five people who were at risk of choking who did not have risk assessments in place for this, three people with incomplete medicine records, three people with wounds who did not have assessments or care plans and one person who was nearing the end of their life who had no care plan in place regarding the care they needed at this time.

The provider visited the service on a regular basis and spoke to the registered manager and people who lived at the home. However, formal audits of the service were not conducted during these visits. The provider told us that they did not have a health or social care background. At our previous inspection we found that the provider had commissioned an audit of the service by an external agency in November 2016. Since then they had not sought further assistance to ensure robust oversight of the service. They had not sought professional or expert advice to help ensure systems and processes improved the quality of service people received.

The lack of a system to assess, monitor and improve the quality and safety of the service and to monitor and mitigate risks to people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always reported significant events significant events in line with her legal responsibilities. She had not always submitted statutory notifications when alleged incidents of abuse occurred. She had not submitted a notification for staffing impacting on the service that people received. This meant that we could not monitor that appropriate action was taken to protect people from harm. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

After the inspection, the registered manager submitted the above notifications retrospectively.

On other occasions notifications were submitted to the Commission in a timely and transparent way. For example, when deaths occurred.

Staff did not feel the home was well led. One member of staff said, "We need a manager who can put everything in place. X (registered manager) has tried but admits the jobs not for her." A second member of staff said, "To me the whole year has just gone down, down, down because of bad management. Checks have not taken place. Things have been raised at staff meetings. Despite that I love it here. There are lovely staff and atmosphere." As previously mentioned in the Effective domain staff had not received sufficient support to fulfil their roles and responsibilities and this had affected morale. There had also been a lack of

staff meetings. Since our last inspection there had been one staff meeting in May 2017 and one registered nurse meeting in June 2017 where subjects were discussed that included cleanliness, documentation and training.

We spoke with the registered manager and the provider about the decline in the service and the staff morale. They were aware that the morale of staff was poor and said that the staff vacancies had contributed to this. They had been trying to recruit staff and had recently recruited permanent nurses but had not been able to recruit to the care vacancies. The registered manager said, "I know I've not been achieving. That's why I've resigned. Someone good coming in will be good for the staff."

The registered manager completed her registration with the Commission on 25 April 2017. She was appointed as manager at the home in October 2016. The registered manager demonstrated an open and honest demeanour. When we brought to her attention concerns that we identified during our inspection she immediately acknowledged these. She said, "I never wanted the job but they needed a manager."

People did speak spoke positively about the registered manager and the provider. One person said of the registered manager, "It's X, she's lovely." One relative said, "He (the provider) comes in most Wednesdays." A second relative said, "Having seen other places I think this place is very good. The new owner has made lots of improvements, he listens to you, your inputs good he says to me."

People were asked for their views of the home and the service provided via annual satisfaction surveys. Five people completed a survey in June 2017. The surveys asked people if they felt safe and happy at the home, if visitors are made welcome, if they could talk to someone if they were treated badly, if their views are welcomed on areas for improvement, if they are involved in making decisions about the care, views on privacy and respect, communication, staffing, activities, management, meals and their bedrooms. People were asked to score 'one' to 'four' with 'one' equating to poor and 'four' excellent. Everyone rated all aspects of the service either 'three' or 'four' apart from staffing and management which two people rated as 'two'. The registered manager said she would be analysing and responding to the survey at the end of August as this was the cut-off date for surveys to be returned.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not managed properly or safely and the lack of action to effectively assess and mitigate risks to people was a continued breach. 12(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes were not being operated effectively to prevent abuse and to ensure appropriate investigation by the relevant people. 13(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Parts of the premises and equipment were not clean, properly maintained or suitable for people who resided at the home. 15(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The lack of a system to assess, monitor and improve the quality and safety of the service and to monitor and mitigate risks to people was a continued breach. 17(1)(2) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to meet people's needs effectively and safely. Staff had not always received appropriate training, supervision and appraisal to enable them to carry out their duties effectively. This is a continued breach. 18(1)(2) |