Eleanor Palmer Trust

Eleanor Palmer Trust Home

Inspection report

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Date of inspection visit:
29 November 2016
13 December 2016

Date of publication:
06 February 2017

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?	**Inadequate**

Summary of findings

Overall summary

This was an unannounced inspection that took place on 29 November and 13 December 2016. Eleanor Palmer Trust Home, also known as 'Cantelowes House', is a care home that is registered to provide accommodation and personal care for up to 33 people and specialises in dementia care. The home is run by The Eleanor Palmer Trust, a voluntary organisation. There were 28 people using the service at the time of this inspection.

The inspection was prompted in part by four people raising recent concerns with us, and notifications of two incidents where people using the service fell, following which one person died and the other sustained a serious injury. These incidents may be subject to criminal investigations and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls. This inspection examined those risks.

At the last inspection on 23 February 2016, we asked the provider to take action to make improvements, to ensure staff received sufficiently regular supervision and appraisal, and training in a format that supported them to meet people's needs effectively. The provider subsequently wrote to us to say what they would do in relation to this breach of legal requirements.

There had been no registered manager in post since May 2016. 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. A new manager had been appointed shortly after our last inspection, whom we met during this inspection. They had not started the process of applying to be the registered manager.

Most people using the service provided good feedback about it. They felt the service was safe, that staff were caring, and that there was good food and drink. There were mixed views on whether there were enough staff.

However, we found some significant concerns about how the service was operated that particularly undermined people's ongoing safety and welfare.

We found that prescribed medicines were not safely managed. At both visits medicines had not been given to people without reasonable explanation. This included medicines left in the monitored dosage packaging, for which there was no improvement by the time of our second visit despite us informing the manager of our concerns at our first visit.

One person was having a phased change of anti-psychotic medicines following psychiatrist advice. At our first visit, we found that the phased approach had not occurred as planned, and that the new medicine had

run out the day beforehand with no plans to acquire more of the medicine. Despite the manager being informed of this, at our second visit, the medicine remained out of stock with no reasonable explanation, meaning the person had gone over two weeks without the prescribed medicine. Care and treatment was not provided to this person in a safe way.

Where people were experiencing falls, there were not often documented reviews of their falls risk assessments and adjustments to their care plans so as to minimise the risk of reoccurrence. One person had a fall during our first visit. At our second visit, we found there was no updated falls risk assessment in place for them since February 2016, despite this fall and another three months earlier that resulted in a check at a hospital due to a swollen eye.

The service did not have consistent systems for keeping people's individual risk assessments and care plans up-to-date. One person was assessed under their old care plan in February 2016 as being at risk of absconding. This was not transferred over to their new care plan. A recent incident of them being found outside the building had not resulted in a documented review of managing this risk and updating their care plan.

One person moved into the service a month before our first visit. A care plan was not started for them until twelve days later, and no risk assessments were in place for them at the time of our second visit except for an undated community falls referral form. This was despite them having two falls during their first week in the service, one of which resulted in paramedics being called due to them hitting their head. Their nutritional care plan also failed to document their diabetes, and we saw that they were not on the list kept in the kitchen of people with diabetes.

One person had a bruise near one eye at our second visit. Their care plan had not been reviewed to reflect this bruise, despite the bruise being a week old. Most care records since then did not document the bruise. The person also had no falls risk assessment on file, despite being found fallen a few months previously.

Community professionals provided mixed feedback about how well the service worked in co-operation with them. We found that records of healthcare professional input were not easily accessible and in some cases were not available. Additionally, we found cases where healthcare professional advice from a dietitian, an optician and a GP had not been acted on, which did not ensure the health, safety and welfare of the people the advice related to.

Whilst staff generally worked together to aim to meet people's needs and requests, there were occasions when we saw people with greater support needs being treated carelessly or without due respect. There were also occasions when people were not given appropriate choice around food and drink.

Records of the care provided to people, and of the management of the service, were not consistently up-to-date, complete and accessible. This undermined appropriate care practices and meant information could not always be easily accessed. For example, whilst there was feedback about recent staffing shortages from staff and people using the service, there was no accurate record of which staff worked when.

There was ongoing failure to effectively meet the needs of some people at high risk of malnutrition and dehydration. There were a number of gaps in the food and fluid charts of such people at our first visit. Prompt action was taken to improve on these matters by our second visit, at which time the manager had also produced a weight-monitoring chart for people using the service. This confirmed our findings from the first visit, that there had been significant gaps in monitoring the weight of some people at risk of malnutrition, although it was encouraging that oversight of that concern was now being established.

Most staff we spoke with during the inspection process reported poor morale. Comments included about the service being poorly run, of not being listened to, and of having no effective outlet by which to raise concerns. We found that the service was not appropriately supporting staff in their roles. Planned individual supervision meetings and staff meetings were infrequent, and records identified that a number of staff had not received recent training on certain key aspects of the work, including for safeguarding people from abuse, fire safety, dementia care, and nutrition.

We also found significant concerns with how well-led the service was. There were ineffective governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed. This included significant medicines safety concerns, despite an internal audit on the first day of our visiting that identified no concerns. Visits from representatives of the provider were also not identifying significant concerns such as people going into hospital following falls.

The provider had not kept us promptly notified when significant events occurred at the service, contrary to legislation. This prevented us from monitoring the service effectively.

There were overall eleven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

As a result of the concerns we identified, principally that the provider was not meeting the needs of people using the service who may therefore have been at risk of harm, we sent the provider a letter of intent on 16 December 2016 outlining our most serious concerns. The letter informed the provider of enforcement action we were considering, and requested an urgent action plan setting out how the provider intended to address these concerns. An action plan was promptly sent that planned to address the most serious concerns. We therefore reviewed our enforcement options, and served three enforcement Warning Notices on Eleanor Palmer Trust, to help ensure that prompt action is taken to address the most serious concerns we identified during this inspection.

The manager informed us on 22 December 2016 that the provider had made a decision to temporarily stop admissions into the service until care delivery concerns were addressed.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. We found that people were not always receiving their medicines as prescribed at both of our visits, despite us raising concerns about this at our first visit.

Where people experiencing falls, there were not often documented reviews of their falls risk assessments and adjustments to their care plans, so as to minimise the risk of reoccurrence. We found instances where further falls then occurred.

Overall, individual risk assessments were not kept consistently up-to-date, or put in place promptly for new people, so as to help keep them safe.

There were unsafe recruitment practices in place for staff recruited in 2016 as written references were not acquired from previous care employers.

Processes to prevent abuse of people were not consistently effective. The safeguarding policy was not robust, and a number of staff did not have up-to-date safeguarding training.

The service was kept clean and infection control procedures sufficiently protected people.

Is the service effective?

Inadequate

The service was not effective. We found cases where healthcare professional advice from a dietitian, an optician and a GP had not been acted on, which may have compromised the health and welfare of the involved people the advice related to.

There was ongoing failure to effectively meet the needs of some people at high risk of malnutrition and dehydration.

Records of healthcare professional input were not easily accessible and in some cases were not available.

Staff continued to be ineffectively supported for their roles. Planned individual supervision meetings were infrequent, and records identified that a number of staff had not received recent

training on certain key aspects of the work.

The service had not fully embedded the principles of the Mental Capacity Act 2005 into its practice.

Is the service caring?

Requires Improvement

The service was not consistently caring. Whilst staff generally worked together to aim to meet people needs and requests, there were occasions when we saw people with greater support needs being treated carelessly or without due respect.

However, people told us that staff were respectful to them, and most people spoke fondly of the staff.

People were enabled to retain their independence where possible. They were supported to have visitors and keep in contact with people important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. The service did not have consistent systems for keeping people's individual care plans up-to-date, so as to help ensure that their needs and preferences were addressed.

There were occasions when people were not given sufficient choice, particularly around food and drink.

There were improved activity provisions.

There was an adequate complaints system, but there was no system of overseeing concerns and complaints, by which to monitor trends and minimise the risk of reoccurrence.

Is the service well-led?

Inadequate

The service was not well-led. There had been no registered manager at the service since May 2016. The current manager had not started their application for registration at the time of the inspection despite working in that role for seven months.

There were ineffective governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed.

Records of the care provided to people, and of the management of the service, were not consistently up-to-date, complete and accessible. This undermined appropriate care practices and

meant information could not always be easily accessed.

Most staff we spoke with during the inspection process reported poor morale. We did not find a positive, open and inclusive culture at the service. Duty of Candour procedures were not being followed, and the rating from our previous inspection was not conspicuously displayed in the service.

The provider had not kept us promptly notified when significant events occurred at the service, contrary to legislation. This prevented us from monitoring the service effectively.

Eleanor Palmer Trust Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 November and 13 December 2016 and was unannounced. The inspection team comprised of two inspectors and an Expert by Experience which is a person who has personal experience of using or caring for someone who uses this type of care service. There were 28 people living at the service at the time of our visit.

Before the inspection, we checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider.

As part of the inspection process, we spoke with ten people using the service, one person's relative, four health and social care professionals, five care staff, three other staff members working in the service, the manager, and the CEO for the provider. In a few cases, the feedback was received by phone or email.

During our visits, we looked at selected areas of the premises including some people's rooms and we observed care delivery in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records of seven people using the service, a number of people's medicines records, and personnel files of five staff, along with various management records such as quality auditing records and staff rosters. The office manager sent us some further documents on request in-between and after the inspection visits.

Inadequate

Is the service safe?

Our findings

The inspection was prompted in part by notifications of two incidents where people using the service fell, following which one person died and the other sustained a serious injury. These incidents may be subject to criminal investigations and as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls. This inspection examined those risks. We found ineffective systems to assess, monitor and mitigate risk of falls, which undermined people's safety and welfare.

During our first visit, one person fell in the hallway. Paramedic support was provided to help the person get up. However, at our second visit, the related accident failed to record that the person vomited and that they received paramedic attention, and so was not a complete record of the incident. A staff member told us that the fall had been discussed but they were not aware of any changes to the care of the person as a result of the fall.

Records showed that the person had had two previous falls in the preceding six months, one of which resulted in hospital attendance for a swollen left eye. However, the person's latest falls risk assessment predated these three falls and was also incomplete. There was therefore nothing documented to show that the person's safety and welfare had been considered in light of the three falls.

The staff communication book had an entry shortly before our visits that the above person was outside the service after being let out by visitors in error. However, the person's care file had no information on this, such as an incident report or updated risk assessment or care plan. An older version of the care plan from February 2016 identified this risk and provided guidance for staff on how to minimise the risk. In contrast, the current care plan did not identify the risk. It included that the person had dementia but did not state what support staff were to provide in relation to that. This demonstrates a failure to assess and mitigate risks, and put in place a current care plan in relation to the risk of this person absconding, particularly in light of the recent incident.

Records showed that one person moved into the service a month before our inspection. There were three accident records relating to them falling, two within the first week, one of which the manager told us they were not aware of. The third fall, in-between our visits, resulted in the person having a broken hip diagnosed in hospital.

The person's care file contained no risk assessments except for an undated falls risk assessment tool used to refer the person for community healthcare support. The manager told us that was sent at some stage between the second and third fall. The person's care plan had an earliest date of 12 days after moving in, and so was not in place at the time of the first two falls. The plan noted that the person had a history of falls. The manager told us that the social worker needs assessment was used to plan care for the person before the care plan was set up; however, this assessment was not available for us to view when requested.

The manager told us that the person had diet-controlled diabetes. However, the diet section of their care plan did not reference diabetes, and the person was not included in the list of people with diabetes on display in the kitchen.

At our second visit, one person had a bruise to their face around their right eye. The manager said that this was due to them falling asleep with their glasses on. However, the person's care file had no risk assessment relating to the bruise, nor an overall risk assessment, and their care plan had not been reviewed in respect of the bruise. The person's care records only referenced the bruise twice across the previous seven days. There was also a body chart recording the bruise from eight days beforehand, but no mention of it in the care delivery records.

There was an accident record for this person from August 2016 about being found on the floor with a bruise to their left arm. However, there was no falls risk assessment in place for them.

The person's care file also had records of them having broken skin on occasions from October 2016, plus reference to a pressure care concern in the same area of their body in June 2016. Despite there being some evidence of district nurse input, there was no care and treatment plan for the person for this health matter.

At our first visit, one person was entirely dependent on staff support, but stayed in their wheelchair throughout the visit except for intermittent toileting support. There was a care plan in place for them from October 2016 due to "pressure area breakdown" in three areas of their body. The plan required regular repositioning support, but there were no repositioning charts in place for them to help demonstrate the care plan was being followed. The plan was backed by a skin-care risk assessment that was last updated in mid-October 2016 despite evidence of increasing concerns since then.

At our second visit, an overall risk assessment was now in place for this person that included pressure care and advised "turn chart in place for nights" albeit this was not specified on the care plan. Only one such chart was found, for the previous day, with entries at 0300 and 0800 only despite two-hourly repositioning being specified.

We also found there to be no bed-rails risk assessments in respect of anyone using bed-rails. This put people at avoidable risk of a bed-rails related accident.

Overall, the service failed to comprehensively assess safety risks to these people, which was a failure to ensure that care and treatment was provided to people in a safe way.

People had mixed views on whether there were enough staff. Comments included, "At the moment they're down on staff", "No I don't think there is enough staff but it's getting better" and "Yes, there's enough, sometimes even seven for lunch." A relative's opinion was that "They're understaffed." Some staff told us of there being only three staff working on shifts during October 2016.

The manager told us there was always six care staff working in the morning, five in the afternoon, and three at night. This included a senior staff member during the day. There were additionally staff working in domestic, cooking, maintenance and administrative roles.

When we attempted to check past staffing levels, we found that records were not kept sufficiently accurately for audit purposes. Used staff rosters were not sufficiently clear on which staff worked. There were staff signing in/out records but these were not consistently used by all staff. The manager told us, after our visits, that this was an identified concern for which improved systems were being considered.

The above evidence demonstrates significant and wide-ranging failures to effectively operate systems to assess, monitor and mitigate risks relating to people's health, safety and welfare, which is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service's systems of medicines management were not safe. At our first visit, one person was having a phased switch between different anti-psychotic medicines for their dementia management under the guidance of a consultant psychiatrist. This included for one medicine to increase by 5mg a week until a maximum of 20mg was in place. However, records showed that this had stalled at 10mg for 25 days, including three days when nothing was recorded as administered. There was no stock of the medicine on the day of our first visit, having last been administered the previous day. We brought this non-administration to the attention of the manager, who told us that this might explain the person's screaming that day. The manager established that the instructions of the consultant psychiatrist were not being followed, and started making arrangements to rectify this.

At our second visit, two weeks later, we found that no new stock of medicine had been acquired since our first visit, and so the person had not received the prescribed medicine for 15 days. We noted records of two occasions in-between our visits of the person shouting. The manager could not explain how the ongoing medicines error had occurred for this person, but was able to confirm from the pharmacist that they had received a re-order request. Following our visits, the manager confirmed that the person had restarted taking the medicine following further guidance from the consultant psychiatrist. However, it had been necessary for us to intervene on two occasions to ensure the person received this medicine as prescribed.

At our first visit, we found a tablet for one person in the 28-day Monitored Dosage System (MDS) for the previous day. However, it was signed on the medicines administration chart (MAR) as given. We brought this to the attention of the manager.

At our second visit, the manager told us that she had been checking medicines daily and was not aware of any missed medicine administrations. However, we found medicines remaining in the lunchtime MDS on one day for three different people. These people had therefore not received those medicines as prescribed, despite what we brought to the attention of the manager at our first visit.

The MAR for one person stated for an inhaler to be administered twice a day; however, it was only being signed for once a day. This indicated a failure to manage the medicine for this person in a safe and proper way.

We found other aspects of unsafe and poor medicines practices at the service. We saw occasions when people were left with their medicines but were not observed to take them. There were a few occasions when people's medicines were not signed for despite being given. This included within the recent MAR for two people prescribed a once-weekly medicine. Variable dose medicines did not always specific the dose administered. Topic medicines were rarely signed as administered. Medicines coming into the service were not always recorded on the relevant person's MAR, making them difficult to accurately audit. Medicines prescribed on an as-needed basis did not have individualised guidance on when to offer or administer the medicine to the person.

The label on one person's liquid medicine was almost completely ripped off, with just half their forename evident. A sachet medicine of theirs was not in stock, albeit the MAR stated they always refused it. The medicines trolley contained the same sachet medicine for someone who had died earlier in the year.

There were regular temperature records for the secure medicines area, to help ensure safe and proper

storage. Records and remaining stock indicated that people received controlled drugs such as pain-relief patches as prescribed. However, the record of returning excess stock for one person's controlled drug did not account for two of the 85 tablets.

The above evidence demonstrates significant and wide-ranging failure to properly and safely manage people's medicines, which is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment files of three staff members employed within the last two years. There to be no written references in place for the two staff members despite being employed to provide care for over two months. Whilst phone-reference records were in place, these were dated a few weeks after one staff member started work. This did not demonstrate that the provider had obtained satisfactory evidence of conduct in these staff members' previous care work.

Neither of these two staff members had proof of identification on file, to ensure the staff member was who they said they were.

We found that another staff member's proof of identification meant they had to have formal documents showing entitlement to work in the UK. However, this could not be provided to us on request.

We asked to see the provider's recruitment policy. We were sent a Disclosure and Barring Service (DBS) policy that only considered the acquisition of relevant criminal record checks for new employees. It did not cover other recruitment matters such as references, proof of identification, interviewing processes, and proof of entitlement to work.

The above information demonstrates unsafe recruitment practices, which is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with could give examples of abuse and what might indicate abuse was occurring. They knew who to report concerns to, including external professionals. However, the service's training matrix showed that only 12 of the 36 staff had had safeguarding training. Even amongst the 20 care and senior care staff, the matrix did not show safeguarding training for nine of them. Only one non-care staff member was listed as having had the training, despite all staff having the potential to receive information about or be accused of abuse.

The service had a safeguarding policy. Whilst it guided on actions to take in the event of an allegation of abuse so as to protect people, it did not provide clarity and examples on what could be seen as abuse. It did not clarify ongoing training expectations of staff, just that abuse would be covered in the induction of new staff. There were no induction records available for the two newest staff members, by which to confirm that this had occurred.

A community healthcare professional informed us of concerns with the time taken for the local authority to be informed of an allegation of abuse at the service. The provider's safeguarding policy stated that allegations of abuse were to be reported to the local authority's safeguarding team. However, another section of the policy stated for an internal investigation to be completed before the provider decided whether to alert that team, which was not in line with legislation.

The service did not have a safeguarding file in which all records pertinent to any safeguarding cases were confidentially stored. There was no oversight document by which to review any allegations of abuse, analyse

trends, and set actions to minimise the risk of reoccurrence to anyone using the service. The provider notified us of three allegations of abuse since our last inspection, however, we could not audit that appropriate actions were taken based on the records available.

The above evidence demonstrates a failure to effectively operate processes to prevent abuse of people, which is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives felt the service was safe. People's comments included, "They do stop arguments", "No-one has been aggressive towards me" and "The doors are locked and you have to sign in here." We were also told that the service was kept warm and comfortable.

The provider paid attention to environmental safety. Radiators had safety-covers. People's rooms had window-restrictors in place and wardrobes were securely fixed to walls. This all helped to prevent accidents. There were records of occasional checks that window restrictors were working correctly. Fire evacuation folders were readily available in case of emergency, and fire safety checks took place regularly. The first-aid box was well-stocked with in-date items. There were a number of service-wide risk assessments in support of maintaining safety.

External professionals undertook routine safety checks to help ensure equipment and the premises were safely maintained. Records showed that this included for hoists, passenger lifts, wheelchairs and fire equipment.

We saw people to be hoisted safely, and that two staff supported one person where two were assessed as needed.

People confirmed that their call-bells worked and that staff always came including at night. One person said, "My call bell is around my neck and I have one in my room. I made a mistake and rang my call bell and I had three staff arrive so quickly." Most call-bells we saw were accessible to people in their rooms. When we tested a few, staff attended quickly.

The service was clean and free of lingering odour during our visit. People confirmed this to be the case, with comments such as, "It's clean everywhere, they clean my room daily" and "It's very clean." We found cleaning staff to be working from early morning until early evening.

Inadequate

Is the service effective?

Our findings

At our previous inspection of 23 February 2016, we found that staff were not receiving sufficiently regular supervision and appraisal, and training in a format that supported them to meet people's needs effectively. The provider sent us an action plan to address these concerns, stating that they would all be addressed by 29 May 2016.

At this inspection, we found that there remained shortfalls with providing staff with appropriate support, supervision, appraisal and training as was necessary for their work. The majority of staff told us they did not feel supported to carry out their work effectively. Their comments included, "We're never praised, only criticised", "Staff feel they have been left to own devices" albeit trying to work as a team, and that staff do not feel able to challenge decisions about people's care.

Records showed that 18 staff received an annual appraisal meeting soon after our last inspection. However, there were 36 staff working in various duties at the service. Given that a few staff had not been working at the service long enough, there were still a number who were not recorded as having had a recent appraisal. This included four of the eight staff who regularly provided care at night.

Whilst there was evidence of supervision meetings now taking place for staff on an individual and planned basis so that they could discuss any concerns they had with carrying out their work effectively, these were not sufficiently frequent to provide staff with appropriate support. The provider's policies for supervision and safeguarding required staff to receive six planned individual supervision sessions a year. However, from April 2016, the supervision matrix the manager sent us after updating it did not show that this was occurring. Of the twelve day staff providing care on the matrix, three had had no planned individual supervision meetings, and four had only one. Of the six night staff on the matrix, three had had no such supervision meetings. Two other night staff were not listed on the matrix. Amongst the 13 staff working in non-care roles, only five planned individual supervisions were recorded as having occurring from April 2016.

Staff and the manager told us of recent beneficial training on falls management and training from the local authority's Quality in Care Homes team about early signs of the people's needs increasing. There had been training earlier in the year on health and safety and on moving and handling. Some staff mentioned that online training had reduced, which they felt was beneficial. This was therefore an improvement on the last inspection.

However, there remained training concerns. The manager told us staff followed a five-day induction and shadowing process. However, induction records by which to demonstrate what was covered by each staff member were not available on either day of our visit.

The manager sent us an updated staff training matrix following our visits and told us of training being booked in January 2017 for safeguarding and malnutrition. We noted that five of the 36 staff were not listed on the matrix. Of the 21 care staff who had worked at the service for over three months, eleven had no fire safety training listed, ten had no food hygiene training or moving and handling listed, and eight had no

dementia training listed. No-one had training listed for malnutrition, end-of-life care, or equality and diversity. This was not supporting staff to enable them to carry out their care roles.

The above evidence demonstrates a failure to provide staff with appropriate support for them to carry out their duties, which is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were positive on the effectiveness of the service. Comments included, "It's like heaven here, I trust everyone" and "There's nothing wrong with this place." However, community professionals provided mixed feedback about how well the service worked in co-operation with them. Whilst one told of no concerns with care standards, another told us their recommendations had not been followed for some people they had provided specific guidance for.

We found that health professional guidance had not been followed for three different people, which may have compromised their safety and welfare. An optician's report from May 2016 for one person noted new glasses. If worn, it stated improved distance vision from fair to good, and near vision from poor to excellent. However, the care plan for this person did not refer to them wearing glasses, which matched what we saw of the person during our visit. A care staff member and the manager told us they were not aware of glasses for this person.

The care file of another person included a GP letter from August 2016 requesting that the service chart occurrences of a specific matter. However, there was no reference to this on the person's care plan for that period. There were charting records, but they frequently omitted entries across whole days and so were not effective. The care plan and the chart did not demonstrate that the GP's request was consistently followed.

Shortly after our second visit, a community professional emailed us to say that at their recent review for one person, their previous advice to the service as provided in a dietetic personal action plan had not been followed as the senior staff member they had liaised with was not aware of the plan. Additionally the person remained underweight and at high risk of malnutrition.

The above evidence demonstrates that timely care planning had not occurred where care and treatment responsibilities were shared with healthcare professionals, which is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not consistently accurate and complete to help ensure people's welfare. Body charts were in use to help show where people had marks and bruises on their skin. However, one person's file contained one body chart with numerous entries between May and November 2016. It was not therefore possible to monitor progress or deterioration of each concern over time. Other records showed that there were omissions from the chart in this period.

A review of this person's care plan mid-November stated that a district nurse had advised for further GP input. There was a record four days later of attempting to contact the GP but nothing further about this in their file to indicate the input had been obtained.

There was no consistency of recording health professional input within people's files or elsewhere, so it was not possible to oversee this input. Such records were sometimes added as updates to parts of people's care plan sections, or at the back of their file under a contemporaneous log of health care professional inputs. The manager also stated that these records may be missing from people's files and would instead be on the service's daily handover notes. For the person whose anti-psychotic medicines had not been acquired

between our first and second visits, there were no records in their file to identify or show actions taken to address the concern.

There was also inaccuracy of records between our visits. At our second visit there were monthly nutritional assessments of one person for September to November 2016. This was despite us having a copy of the assessment from our first visit with those dates blank. The September to November entries had therefore been filled in after our first visit, and so were not an accurate and contemporaneous record.

The above evidence demonstrates failures to maintain a complete, accurate and contemporaneous record of people's care and treatment, which undermines the effectiveness of systems to ensure compliance with the relevant regulations. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns, we saw staff trying to attend to people's health care needs. For example, people assessed as needing pressure-relieving equipment had it in place in the lounge. Someone was supported to have their legs raised as per GP advice.

Most people we spoke with were happy about the food and drink provided. Comments included, "It's very good food" and "The chef is very good. We have a drink and biscuits at 9pm and I never get hungry at night." A relative added, "The food is good, they have a three course meal." However, one person said, "The food is always the same", explaining it as lacking taste and seldom varying from the same format.

We found that the service did not consistently support people to eat and drink enough. Whilst there were regular trolley rounds of hot and cold drinks, there was insufficient oversight of people at higher risk of dehydration. At our first visit, one person's care plan stated for staff to make sure they drank enough each day, without clarification of how that was to be checked on. Their fluid charts were not consistently completed. This included no entries on four of the 17 days up to our first visit, and only one day in that period where there were records across the whole day. There was no record of reviewing the amount they drunk and so considering if it was enough.

Another person's fluid intake chart had no fluid intake entries for four of the 13 days leading up to our first visit. On five other days, they were recorded as having one drink. The manager confirmed they needed fluid intake monitoring, despite this not being recorded on their care plan. A third person's fluid intake was recorded on four of the previous seven days and in three of those cases, only recorded what they drank at breakfast.

We saw that one person was provided with meals at lunch but did not eat them and instead fell asleep. They were not offered other options. There was an accurate record for them that they did not eat at lunch, and it was passed onto the afternoon staff for monitoring.

We saw that there had been dietitian input for this person since August 2016. However, four subsequent monthly reviews incorrectly indicated that the care plan dated July 2016 had not been changed, and there was no record of reviewing the nutritional risk assessment. That assessment stated the person was at low nutritional risk in July 2016, contrary to the dietitian's findings of over 10% weight loss in two months on at their August 2016 visit.

Dietitian guidance included for weekly weight checks. However, whilst weight records were made four times in August, there were only two weight records for September and only one for October. The person had gained some of the lost weight by the time of the of their November 2016 dietitian review; however, the

dietitian recorded them as still at high risk of malnutrition and provided further guidance. Nonetheless, there remained no change to the service's nutritional risk assessment and plan for them 25 days after the dietitian's visit. Their food charts were not filled in on three of the four days prior to our first visit. As such, the service was not meeting this person's nutrition and hydration needs.

At our second visit, there were improved plans in place for individuals in respect of nutrition and hydration. However, the above person's plan still failed to mention dietitian advice of 4 November 2016, of adding skimmed milk powder to all milk. The manager and a kitchen assistant were unable to show us that skimmed milk powder was available for this person.

Food and fluid charts were now in place for people assessed as needing them. They were completed in full except on two days within the previous week. On only one day was a total daily fluid intake deduced for the person identified above as being at high risk of dehydration, by which to help monitor if their fluid intake was adequate. Therefore, there remained shortfalls at our second visit with consistently ensuring people's nutrition and hydration needs were met.

At our first visit, we identified inconsistent weight monitoring since March 2016 for most people using the service. The manager confirmed that she had had no oversight of this.

At our second visit, the manager provided a weight matrix based on available records. Whilst this showed better monitoring, it also confirmed a failure to monitor ten people's weights for a number of months. This included one person who had lost over 10% of their weight unplanned between consecutive weight entries of June and October 2016. The absence of monitoring people's weights did not ensure that their nutritional needs were met.

The evidence above demonstrates a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

One person said, "They don't force you." Another commented, "I can go everywhere in the home and garden." We did not see or hear of anyone being unhappy with any restrictions, such as not being able to leave the service unaccompanied, that they experienced in the service.

The manager told us that there were no capacity assessments in place for people where there was doubt that they could consent to care and treatment in the service. They said that about five people had bed-rails in place, to help protect them from falling from their beds. Records and feedback showed that one other person had their bedroom door locked daily once they were out of their room, to help prevent them from self-neglecting. Specific consent, or capacity assessments and if necessary, best interest processes, had not been gained for any of these decisions.

The manager told us there had been no DoLS applications since her arrival as no-one needed them apart from those who already had them in place. However, she confirmed there was no oversight records of people's DOLS status. One person's DoLS authorisation expired a few weeks before our visits with nothing on their file to indicate that a further application had been made.

Whilst staff fed-back appropriately about their responsibilities under the MCA, the training matrix showed that none of them had received training on the MCA. The blank induction checklist that we saw did not reference the MCA or check on applicable MCA knowledge for care provision except for a question on restraint.

The above evidence demonstrates failures to work in line with the provisions of the MCA, which is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Most people spoke fondly of the staff. Comments included, "They're never nasty", "Fantastic staff" and "We always have a laugh." One person told us of the service celebrating their birthday recently with a "lovely cake" that was a "nice surprise." A relative told us, "The staff are lovely."

People told us that staff were respectful to them. Comments included, "It's never rushed" and "They always knock" which we saw to occur. We saw staff speaking with seated people at eye-level, and attending to people who asked for help or who showed obvious distress. Staff generally interacted with people in a cheerful, friendly and age-appropriate manner. We heard requests such as "foot up please" and people being talked with whilst being supported.

However, there were occasions when people were not treated with care. One person was very dependent on staff support but did not receive appropriate care and attention despite a care plan stating that they liked it when staff interacted with them despite their dementia. One person had an apron on mid-morning for no reason. When everyone around them was offered a drink, they were not and staff did not interact with them until they belatedly received support to drink 15 minutes later. Whilst this staff member did well to ensure the person was not forgotten, they also accidently brushed the person's leg causing them to cry out quietly. The person also had the sun in their eyes at times. A staff member noticed this, but did nothing to alter things although they did try to reassure the person. As the person was in a wheelchair, they could have been easily supported to move out of the sun.

Whilst this occurred, we noticed that the television three people were facing was not audible over the volume of the television the other side of the room. None of these people showed signs of watching the television, and none of them had the remote-control for it. The registered manager later turned the volume up.

Whilst one person was being cared for in bed, we noticed they could not access their call-bell. The manager explained that they were physically not able to use it, but that a hand-bell was being considered. They also told us they preferred their door to be kept open, but it had not been during our visit which we saw to be the case. This was addressed at our request.

The above evidence demonstrates failures to treat people with dignity and respect, which is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the laundry system worked well. Comments included, "There's washing daily" and confirmation that they received their own clothes back. Most people were appropriately-dressed in well-fitting, clean clothes, and people had been supported, where needed, to be well-groomed. One person told us that bedding was changed weekly.

People were enabled to retain their independence where possible. One person had a key to their room which they locked when not in use. Most areas of the service had grab rails to help get around, and people's

frames and sticks were kept close by for when they needed then. There was some adapted cutlery available, to enable people to eat without support.

People told us that their visitors were welcomed at any time. One person told us their relative "can come up and go as and when she likes." We saw that there was a phone that people used just outside the lounge, and one person confirmed that a friend's phone call was passed onto them. Staff and a person using the service told us of weekly Holy Communions at the service, and a monthly Church of England service.

Requires Improvement

Is the service responsive?

Our findings

Most people told us that staff were responsive. Comments included, "They're very, very good and attentive", "Oh yes, they do help if asked" and "They listen to what you say." One person explained how staff supported them with their preferred routines, for example, providing a flask of tea every morning. They were also happy that a fire-safety door-closure device was being fitted to their door.

However, the service was not constantly responsive. The quality of choice that people received varied. Cold drinks were provided after breakfast, but when one person asked instead for coffee, it was agreed but they had to then wait until the warm drinks trolley 45 minutes later. People attending an activities session were all served tea without being asked, until one person stated that they did not drink tea. At lunch, unless there was a recognised dietary requirement, people were served the same meal with no choice being offered. Two people told us they were not asked what they wanted. One said, "The food is put there and if you don't like it you don't get anymore and we don't get a choice as you can see." Other people referenced little choice such as, "The food's alright but I don't get a good choice."

A few people told us that they could pre-book, by 1100, a different meal from the menu that was written in the corner of the dining area. However, this set-up did not support the needs of some people, for example, due to their dementia. We saw one person not eating at lunch, with no alternatives provided.

One staff member said, "We need good care plans and risk assessments" We found that the service did not have consistent systems for keeping people's individual care plans up-to-date. There were detailed care plans in place up until March 2016, but plans were inconsistently reviewed and updated since then. The manager explained that new care planning systems were being introduced including through the training of senior staff at the service. This had occasionally resulted in care plans reflecting people's needs and preferences and guiding staff on their support needs. However, many people's care plans were incomplete and out of date. This undermined the service's ability to provide people with care that responded to their needs and preferences.

For example, one person's plan simply referred to them having dementia without explaining how this impacted on them or how staff were to support them. We saw this person wandering a lot during our visits, with little evidence of staff paying them attention. They did not have a plan in place for some other aspects of their care, including communication and activities. Another person's plan similarly only stated that they had Alzheimer's Disease within the section for how staff were to support them in terms of their medical history.

Another person's plans were not set up until almost four weeks after moving into the service, despite them having falls in the first week. Their nutritional plan did not reference their diabetes. The medical history section again only listed the medical conditions without stating how staff were to provide support in response to these matters.

We also noted that none of the care plans seen had evidence of involvement of the person using the service

or their appropriate relatives or representatives.

The above evidence demonstrates failures to provide appropriate and responsive care that meets people's needs and preferences, which is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said there was enough to do in the service. Their comments included, "As you can see we do painting and we have entertainers come in and they're very good; if they are not we'd soon tell them", "You can sing and play games, and the staff do take us out now and again" and "We do singing but not a lot, no exercises."

One staff member told us that activities had improved across the year, as there was some provision across the afternoons. The activities co-ordinator confirmed this. They told us of recent initiatives such as "sitting netball which I have just trained for" by a sports charity that had also provided "lots of equipment and the residents love it." They also spoke of "Silver Sunday," a painting competition for people using services which the local council provided them with an award for.

We saw nine people attend a well-organised morning art session in the service's designated activities room. At another time, we saw a staff member playing cards with three people, and we were told of people who stayed in their rooms being visited for activities. We saw that specific people had the day's newspaper of their choice delivered. However, we also saw some people sitting in the lounge with no stimulation apart from a television for which we saw no consultation on what to watch.

Most people told us of having had no need to complain. One person said they told the manager of any concerns. They had mixed views on how well matters were addressed. Records of recent meetings for people using the service and their representatives showed that people could raise concerns and be listened to.

The manager told us of one formal complaint at the service since her arrival, which had been responded to albeit the investigation was ongoing. The complainant had been sent acknowledgement and update letters.

The manager told us that some relatives had made "lots of complaints" about having to wait at the front door to be let in. This followed changes to entrance arrangements. These complaints were stored at the provider's head office, and were mentioned on the recent surveys of the view of people and their representatives.

There was one complaint, from someone using the service, in the complaint file. It recorded why staff were not able to respond as quickly as the person wanted, and included plans to minimise the risk of reoccurrence.

There were no systems of overseeing concerns and complaints, by which to monitor trends and minimise the risk of reoccurrence.

Inadequate

Is the service well-led?

Our findings

The service had not had a registered manager since May 2016 although the previous registered manager stopped working just before our last inspection. The new manager started working at the service in April 2016, but at the time of our second visit, there was no application for registration as manager. This delay did not assure us of the service being well-led.

People's comments about the manager included, "She's lovely" and "Very polite." A relative told us, "She's been very helpful. If we have a problem she will sort it out." We saw the manager interacting with people using the service and attending to people showing signs of distress.

However, staff provided mixed views on the culture of the service. Six of the eight staff we spoke with during the inspection process reported poor morale. Comments included about the service being poorly run, being "distraught that the service is going downhill," of not being listened to, that "we need an open working culture", and of having no effective outlet by which to raise concerns.

There were no notices or policies in the staff room about whistle-blowing. A staff member told us they did not know how to whistle-blow or they would have done so.

Despite discussing these staff concerns with the manager and a trust member during our visits, we received little in writing to demonstrate that staff views are being listened to and acted on, which fails to assure us of good governance. In particular, the action plan sent to us following the inspection visits about our urgent concerns had no specific response to our point about there being low morale amongst staff.

The manager told us there had been two team meetings since April 2016, although she was now aiming at monthly meetings. The frequency up to our inspection was not supportive of a positive culture at the service. We also noted that there had been no recent meetings for senior staff.

Team meeting minutes of May 2016 referred to staff surveys being distributed and returned. However, when we asked to see results or analysis of the surveys, none were provided, which we took to mean that no such results and action plan was available.

The above evidence demonstrates a failure to act on feedback from staff for the purposes of evaluating and improving services.

A report of the CEO's audit of the service from July 2016 referred to surveys for people and their representatives being received, for which the manager would be creating a report to present at the September board meeting. However, although there was analysis of the surveys which showed mainly positive feedback, the manager told us that there was no action plan to address any concerns raised. The manager told us that a complaint had been formally made about relatives not gaining access to the service easily following new front door arrangements. She said this was also mentioned in the surveys. This did not demonstrate action taking place, in general or in particular, in response to feedback from people and their

representatives for the purposes of evaluating and improving services.

There had been two such audits of the service in the previous six months, along with two trustee 'spot-check' reports across the previous nine months. However, the CEO told us that these visits were more for "feedback" not auditing. We saw that the reports were structured that way. They did audit some aspects of the service such as complaints and accidents. However, the September report stated that there had been no significant events. The audit did not therefore identify that three people were sent to hospital after falls, one of whom was diagnosed with a cracked rib. This undermined the effectiveness of the audit as risks to people's health, safety and welfare were not being assessed and monitored.

The provider's policy on quality auditing was not robust as it is only half a page long. It did not stipulate what the "Quality Assurance Audits" would consider and the frequency with which they will occur. The policy only sought the views of people using the service to influence how the service operated, without mentioning people's relatives and representatives, community professionals, or staff. The policy was not sufficiently robust so as to ensure effective governance of the service.

We identified medicines management concerns at our first visit despite a senior staff member undertaking a medicines audit that day which failed to identify any concerns. The manager was informed of all these medicines concerns. At our second visit, we found an ineffective response to addressing the medicines concerns. This included further instances of medicines remaining in Monitored Dosage Systems which had therefore been given to people as prescribed. There also continued to be no stock of a new anti-psychotic medicine for one person. Whilst the manager told us of daily checks of medicines, she had no records of this available. Effective mitigation of the identified risks to people's health, safety and welfare in relation to their prescribed medicines had not occurred.

All the breaches identified in this report indicate ineffective governance of the service. Many of the concerns we identified related to the health, safety and welfare of people using the service. The service was demonstrably worse than at our inspection of February 2016 in terms of outcomes for people using it and staff morale.

The above evidence demonstrates significant and wide-ranging failures to effectively operate systems to assess, monitor and mitigate risks relating to people's health, safety and welfare, which is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were internal health and safety audits occurring regularly. These checked on the safety of matters such as window restrictors, slings used to hoist people, first aid boxes and infection control. This helped to ensure risk management and improved service quality.

Action was being taken in response to the recent death and serious injury to two people after falling in the service. Along with ongoing investigations, the manager and the CEO told us that all staff had received further training on falls prevention and management. Records showed that this included night staff. There was greater emphasis on not moving people if they could not move themselves, and of acquiring urgent paramedic support, which recent accident records confirmed as occurring. Staff confirmed they had received the training and were clear on expectations. Further training from the local authority was being provided at the time of the inspection.

The service had an appropriate Duty of Candour policy in place, by which to define and guide on obligations to act in an open and transparent way in relation to people's care and treatment. In reference to three incidents since April 2016 where people had been seriously injured in the service resulting in bone fractures

and hospital treatment, we asked to see any Duty of Candour letters sent to the person involved or where applicable their relevant representative. These letters are required to summarise the results of the provider's enquiry into the incident. The manager told us that there were no such letters. This was contrary to legislative requirements.

The evidence above demonstrates a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that, since June 2016, three notifications of people's deaths, one serious injury and two allegations of abuse had had not been sent to us promptly. Whilst the manager provided evidence of attempts to send some of these notifications promptly, there was also evidence that relevant emails had been returned undelivered which had not then been acted on without delay. These failures to promptly notify us of significant occurrences prevented us from monitoring the service effectively.

The above evidence demonstrates breaches of regulations regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

We noted at our first visit that the service's previous inspection rating was not conspicuously display in the service entrance or elsewhere. The manager quickly found the copy of the last report which she said was ordinarily available to people in the entrance seating area and which had the rating on the front. A copy was arranged for permanent display. However, at our second visit, the inspection rating was again not on display conspicuously. Since April 2015, it has been a legal requirement to conspicuously display our rating in a place accessible to people using the service.

The above evidence demonstrates a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered persons failed to notify the Commission without delay of the death of service users. Regulation 16(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons failed to notify the Commission without delay of an injury to a service user that resulted in changes to the structure of the service user's bodies, and of allegations of abuse in relation to service users. Regulation 18(1)(2)(a)(ii)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons failed to ensure that the care of service users was appropriate, met their needs, and reflected their preferences. This included through failing to involve service users or their appropriate representatives in decisions relating to their care, and failing to design care with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9(1)(a)(b)(c)(3)(b)(f)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered persons failed to ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons failed to ensure that consent to care and treatment was only provided with the consent of the relevant person. This includes acting in accordance with the Mental Capacity Act 2005 where the service user is unable to give such consent because they lack capacity to do so. Regulation 11(1)(3)

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 The registered persons failed to ensure the effective operation of systems and processes to prevent abuse of service users. Regulation 13(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure that the following were available before employing anyone to provide care: •□Proof of identity including a recent photograph •□Satisfactory evidence of conduct in previous care employment •□Evidence of entitlement to work in the UK Regulation 19(3)(a)(b) S3 parts 1, 4.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered persons failed to act in an open and transparent way with relevant persons in relation to the care of service users who were involved in notifiable safety incidents. This included failure to provide a written notification to the relevant person and keep a copy of all such correspondence. Regulation 20(1)(4)(5)(6)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered persons failed to conspicuously display, in a place which is accessible to service users, the rating of the most recent CQC inspection. Regulation 20A(3)(7)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons failed to ensure that staff received appropriate support, training, supervision and appraisal as was necessary to enable them to carry out their employment duties, Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that care and treatment is provided in a safe way to service users, including through the proper and safe management of medicines, and by ensuring that timely care planning takes place to ensure service users' health, safety and welfare where responsibility for their care and treatment is shared with community professionals. Regulation 12(1)(2)(g)(i)

The enforcement action we took:

We served a Warning Notice on the Registered Provider to become compliant with the regulation by 19 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered persons failed to ensure that nutritional and hydration needs of service users are met, including ensuring the receipt by service users of suitable and nutritious food and hydration which is adequate to sustain life and good health. Regulation 14(1)(4)(a)

The enforcement action we took:

We served a Warning Notice on the Registered Provider to become compliant with the regulation by 19 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to establish and operate effectively systems to ensure compliance with the Fundamental Standards. This included through failure to

- assess, monitor and improve the quality and safety of the services provided,
- assess, monitor and mitigate the risks relating to the health, safety and welfare of service users,
- maintain an accurate and complete record in respect of each service user, and
- act on feedback from service users, their representatives and staff, for the purposes of continually evaluating and improving your service. 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

We served a Warning Notice on the Registered Provider to become compliant with the regulation by 23 February 2017.