Diamond Care (UK) Limited

PineHeath

Inspection report

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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 inspection took place on 28 March 2017 and was unannounced. Our previous inspection carried out on 10 and 15 November 2016 identified eight breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found that limited improvements had been made and determined that the provider was still in breach of seven of the same regulations. Three of these regulations were in breach for the third consecutive time as a result of an inspection.

Pineheath is registered to provide accommodation and personal care for up to 44 people. At the time of this March 2017 inspection there were 28 people living at the service, some of whom were living with dementia.

A registered manager was in post. 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 found considerable maintenance issues that had not been addressed, including window and drainage problems. Safety concerns relating to unlagged hot pipes and unprotected heated towel rails that had been identified during our November 2016 inspection had not been addressed. We again found cleanliness and infection control issues that could put people at risk.

Plans to identify and mitigate risk to people in relation to their health were not clear. We had concerns about people not receiving prescriptions promptly which meant that they did not receive treatment for health conditions to help reduce their symptoms.

Despite training being received about the Mental Capacity Act 2008 there was minimal understanding and poor adherence to the requirements to ensure that people's rights were protected. There were substantial gaps in staff training so people could not be sure they were being supported in a safe and appropriate manner.

We again observed considerable poor practice that was not respectful to people and did not uphold their dignity.

People's care records were not clear, accurate or up to date. They did not provide staff with sufficient guidance about how people's needs should be met.

The provider remained minimally engaged in the day to day running of the home. Despite the significant improvements required they had failed to improve their oversight of the service or provide enough support in order that improvements could be made.

The overall rating for this service is 'Inadequate' and the service remains 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.

The service was poorly maintained. People were at risk because of risks from the premises and poor infection control.

Risk assessments were not always clear about how risks to people were to be mitigated.

Medicines were not always available for people when they needed them.

Is the service effective?

Inadequate

The service was not effective.

There remained little understanding and poor application of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Whilst staff training had improved, there were still large numbers of staff who had not received all their necessary training.

People had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst some staff were caring and respectful of people other staff did not always treat them with respect and promote their dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had care plans in place. However, these did not always provide guidance for staff which meant some people may not receive care in line with their needs.

People and their relatives were confident that the manager

would act upon any concerns they raised.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have sufficient governance and oversight of the service.

They had failed to take adequate corrective actions to improve the service since our previous inspection in November 2016.

PineHeath

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 inspection took place on 28 March 2017 and was unannounced. The inspection team consisted of one inspector, an inspection manager and an expert-by-experience.

During this inspection we spoke with three people living in the home, relatives of two people, three staff members and the registered manager. Prior to this inspection we liaised with the local authority and the Environmental Health team.

We made general observations of the care and support people received at the service. We looked at the medication records for six people and care records for seven people. We viewed records relating to staff training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection in November 2016 found that the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure that there were suitable arrangements in place to permanently supply the home with adequate supplies of hot water and heating and ensure the maintenance of the windows. This March 2017 inspection found that most of these concerns had been addressed, but we found other concerns that had not.

Our November 2016 inspection found that approximately 12 of the windows in people's bedrooms or communal areas were in need of urgent repair. These windows did not close properly and had allowed streams of cold air to enter the home. Work to repair these windows had been completed at the end of January 2017. Fittings to all windows to ensure that they held fast in the required open or closed position were replaced throughout the home in February 2017. However, we found a window in one person's room had a crack with a sharp edge, through two of the window panes. This presented a risk of injury and meant that the window pane might not be stable, particularly if the window was being opened or closed. The manager told us that this had been done when repairs had been made to the windows. This meant that this damage would have occurred at least one month ago. We also found one window in a corridor that did not shut properly and a high level bathroom window on the ground floor which did not have a window restrictor. The double glazing seal in a dining room window had blown so that the glass was now opaque and could not be seen through.

A communal toilet area on the ground floor smelled foul. We spoke with the manager about this. They told us that there was a problem with the drains in this area and sometimes the smell also permeated into a corridor that linked the main building to the activities room. We saw that dirty rags were being used to seal the drain in this corridor.

A water leak had been repaired in one of the shower rooms. However, there had been no subsequent maintenance done to redecorate the area. This was in a poor state of repair. Maintenance had not been carried out to ensure that hot water pipes were sufficiently cladded where necessary. This had been a recurring issue at the service for four years.

Consequently, the provider was still in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This March 2017 inspection determined that the emergency boiler installed on 11 November 2016 was still in use. This had proved reliable and was available for hire as long as it was required.

At our November 2016 inspection the service had been using three newly installed immersion heaters to heat the water, but these had not been able to supply enough hot water for the home. On 28 November 2016 the water supply had been connected to the emergency boiler. This had meant that from this date the home had received sufficient supplies of hot water.

Our previous inspection in November 2016 found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to do all that was necessary to assess and mitigate the risks in relation to people's care, the environment and the safe management of their medicines. This March 2017 inspection found some improvements. However, substantial concerns remained.

North Norfolk District Council's Environmental Health Team had issued an improvement notice in relation to water control risks on 22 November 2016. On 29 March 2017 they advised us that this notice was still in force. Much of the required work had been carried out, but some work was still remaining. Further water sampling was also required to determine whether the changes made to the home's water systems had fully eradicated the legionella bacteria and other associated risks.

Our November 2016 inspection found that the source of heating for the two shower rooms was heated shower rails. These were extremely hot to the touch and posed a risk of scalding. This March 2017 inspection found that this had not been rectified. In November 2016 we found that the corridor leading to the activities room had exposed hot water pipework which was extremely hot. This March 2017 inspection found that some attempts to repair the cladding in this area had been made, but large expanses of very hot water pipes remained uncladded. These issues put people at risk of burns or scalds.

We observed one person walking with a walking frame leaving a communal toilet. However, they were unable to get to the sink to wash their hands as the floor area in front of the sink was obstructed by a fallen plastic wet floor sign. This, along with cat food bowls, presented a trip hazard to people. Cat food pouches had been left on top of a hot radiator in the communal toilet area. These were giving off a strong odour.

We again found considerable issues relating to cleanliness and infection control in the home. Some communal toilets smelt unpleasant in addition to the one with drainage problems. The upstairs sluice room contained an overflowing bin and there were considerable lime scale deposits around the taps. We observed dirty roller blinds in one communal toilet area which also contained a dirty mop and bucket by the hand wash sink. Another dirty mop had been left in one shower room. Some toilet seat risers were stained and some carpets were heavily stained. One person's bedroom carpet smelled unpleasant and was soiled with faeces which had not been removed properly.

The dining room floor had debris on it from the breakfast meal when we arrived. This was added to during the lunchtime period and remained in place until the floor was then swept and mopped. However, this didn't take place until after the tea time meal.

Some rooms were undergoing refurbishment or were unused. These contained paint, power tools and furniture piled up in the middle of the rooms. The access to these rooms needed to be secured to reduce the risk of people going in to the rooms and coming to harm.

Risk assessments were in place. However, the associated actions to reduce these risks were not well documented in care plans. Plans had not always been appropriately updated and did not reflect people's current needs which placed them at risk, especially if a new or agency member of staff was relying on the accuracy of the information. One person's risk of developing a pressure area had last been reviewed two and a half years ago. The records for one person, who had experienced falls, did not show how or whether they were able to mobilise or what support they might require. Another person's care plan showed they were at risk of developing pressure areas, but did not state what action needed to be taken to reduce this risk.

Whilst some improvements had been made in relation to medicines recording, we again found concerns

with people's medicines. We found instances where the service had run out of stock of people's medicines. This included one person who required pain relief in liquid form as they were unable to take tablets. We found three recent occasions when people who had been prescribed antibiotics had waited between two and four days before these had been received. The service had failed to promptly take action when these medicines had not arrived. This meant that people had been put at risk of their health deteriorating when they should have been receiving treatment.

There was not always guidance in place or records kept for the administration of 'as required' medicines. These included medicines which helped people sleep or reduced their anxiety. Records for one person showed that they had been given these medicines on a frequent basis but there was no record of why they had been administered on each occasion. Their daily records did not indicate any concerns with sleeping or anxiety. Consequently, the provider could not be sure that this medicine was being given only when the person needed it.

We were unable to reconcile the stocks of some boxed medicines in the home with the records because stock levels were not always recorded properly. Some stocks of medicines were higher than we would have expected, whilst others were lower than we would have expected. However, it could not be determined whether these were recording errors or whether people had not been receiving their medicines as prescribed.

These concerns meant that the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection in November 2016 found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate action had not been taken when safeguarding incidents arose.

This March 2017 inspection found that improvements had been made. One referral had been made to the local authority in relation to a safeguarding incident. We spoke with the safeguarding practitioner from the local authority who had investigated the referral. They told us that the manager had taken appropriate action at the time of the incident and with their follow up actions.

Consequently, we were satisfied that the provider was no longer in breach of this regulation.

People we spoke with told us that they felt safe. However, one person told us that staff had taken their call bell away a few weeks ago because they felt that it was being overused. However, they told us that this issue had been resolved.

People felt that there was enough staff to meet their needs most of the time. However, one person told us, "Generally speaking, there is enough staff. However, I had to wait 45 minutes a few weeks ago." Staff held mixed views on whether there was enough staff. One told us that there was, whilst another felt that sometimes there were not. One told us that some of the staff on duty had gone to a training session on the morning of our inspection. This had left them short for some of the morning. No extra staff cover had been arranged for this.

There were 28 people living in the home at the time of this March 2017 inspection. The manager told us that six staff were on duty in the mornings, five in the afternoons and three overnight. We saw from staff rotas that the service was able to maintain these numbers throughout March 2017 on all but one occasion.

Whilst we found that there was enough staff on duty, better direction was needed to ensure that staff were deployed effectively and were carrying out their duties as necessary.

Inadequate

Is the service effective?

Our findings

Our November 2016 inspection found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to consent and the practical application of the Mental Capacity Act 2005.

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 authorisation 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.

Our November 2016 inspection found that training in the MCA and DoLS had only just commenced in the home and that no mental capacity assessments had been carried out. The manager and staff had limited understanding of the issues in relation to the provision of people's care.

This March 2017 inspection found that little progress had been made. Only about six care plans had been updated in relation to people's mental capacity. This meant that several people who were living with dementia still had not had their records reviewed in relation to their ability to make their own decisions. About half of the staff were yet to receive any training on mental capacity.

The mental capacity assessments we saw were not decision specific, were contradictory and poorly carried out. Some did not need to have been carried out at all. The section in relation to one person's ability to understand the issue discussed their forgetfulness, but said nothing about their understanding of the decision to be made. Where we would have expected to see an assessment, for example in relation to the use of bed rails for people living with dementia, there was none. Another person's records stated that they were happy to have bedrails fitted to their bed, whilst their records stated they had no capacity to make any decisions at all.

Some staff did not seek people's consent or accept answers they were given. We observed that some staff repeatedly asked people whether they wanted to join in activities despite people clearly answering that they did not. We saw one person being whisked off quickly in their wheelchair by a staff member without their consent being sought.

Applications had been made to the local authority to request authorisation to restrict some people's freedoms in order to keep them safe. However, these applications were of a general nature and were not clear about what restrictions were necessary or why.

Consequently, the provider was still in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our November 2016 inspection found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to staff training and support.

This March 2017 found insufficient progress had been made with staff training. The training matrix provided showed that between 15 and18 staff members still required safeguarding, mental capacity or fire safety training. One domestic staff member had still not received COSHH (Control Of Substances Hazardous to Health) training. Three night shifts had run in March 2017 without any staff member on duty having emergency first aid training. These concerns continued to put people at risk of receiving unsafe or inappropriate care.

Consequently, the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received quarterly supervisions and annual appraisals.

We looked at the arrangements in place to support people with their nutrition and hydration and sought people's views. One person told us, "I am not a foody and staff let me have things that are not on the menu if I want. However, I want a smaller portion. But they tell me to eat what I like and leave the rest." Staff had not recognised that larger potions could be off-putting for some people with smaller appetites. Another person told us, "The food is nice. But they want me to have Horlicks at night which I don't like as it's too sweet."

We saw that the food was hot, looked appetising and was presented nicely. People had chosen their preference the day before. If they then wanted something else on the day this was arranged. However, people were not given a choice of what vegetables or accompaniments came with the main meal.

We saw that people had cold drinks available to them in their rooms and in communal areas. Since our November 2016 inspection the main lounge had been re-organised so that there were enough tables for people to be able to put drinks on. However, the clear plastic glasses, although clean, had clouded with age and cold drinks did not look appetising.

A choice of hot drinks was available periodically throughout the day. However, the only snacks on offer at these times were biscuits. These may not have been suitable for some people with specific nutritional needs and there was no choice about the type of snack on offer.

People who required assistance to eat received this. However, they were not always supported in an effective manner. One staff member was attempting to encourage one person who needed staff assistance to eat their meal. The staff member held the spoon against the person's mouth but did not invite them to open their mouth. The person ate very little. No alternative meal or finger foods were offered to the person to encourage them to eat.

We saw in people's care records that their health had been supported by a wide range of external health and social care professionals. This included GPs, community nurses, dieticians, speech and language therapists and physiotherapists. On the day of our inspection a visiting hearing aid clinic attended the home. One person's health had been deteriorating and we saw that appropriate actions had been taken to ensure that they received the necessary interventions from health professionals.

Requires Improvement

Is the service caring?

Our findings

Our November 2016 inspection found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to staff treating people with dignity and respect.

During this March 2017 inspection whilst we observed some good practice, we also observed some poor interactions with people.

We saw two staff members using hoisting equipment to help move one person. Apart from a comment by one staff member to say, "You're going up" there was no other interaction, explanation or re-assurance provided to the person. The two staff members were talking to each other or other people living in the home during the process.

We observed one person becoming distressed in the lounge. Two staff members were present. Neither acknowledged the person or took any action to help alleviate their distress.

Other than at mealtimes there were approximately 10 people in the main lounge during the day. During our November 2016 inspection there was no staff member in the area to help support people. During this March 2017 inspection we found that there was often a staff member in the room. However, they were sat watching the television and were not seeking to engage with people other than when needed to carry out a task.

We spoke with one person who was seated in a wheelchair outside the dining room. We asked if they were waiting to go in for lunch. They told us that they did not know. A staff member came from behind and, without any discussionwith the person, pushed their wheelchair into the dining room.

At lunchtime we saw one staff member sat between two people, each of whom required assistance to eat their meal. The staff member was alternating between the two people, giving them each a spoonful of food at a time. This arrangement was not respectful or dignified. One of the people repeatedly advised the staff member that they had put too much food on the spoon. However, minimal attempts were made by the staff member to reduce the amount of food offered to them at a time.

We also saw that aprons were put on some people without their agreement. One staff member was assisting one person to eat whilst they were standing up, so they towered over the person. Eventually they decided that they would sit down to assist them.

A staff member had placed a cup of tea for one person with a visual impairment out of their reach. This was pointed out to them by the manager, but the staff member did not respond.

Following lunch we observed a discussion taking place between staff in front of and about one person. One staff member said loudly, "I was going to toilet them and then take them to activities."

We observed staff repeatedly ask one person whether they wanted to join an activities session. The person consistently answered no. However, it was not until the person became annoyed that the staff member ceased asking them. We saw another staff member ask another person five times about whether they wished to join in the activities session about to start.

Consequently, the provider was still in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff interactions were more positive. One person told us, "Staff are very kind. The men at dinnertime brought my handbag back to me after getting some pliers and mending the handle." One staff member was observed supporting a person in their room in a kind and caring manner. We noticed that one staff member had seen that one person in the lounge needed to change their clothes and the person was assisted out of the room discretely.

We did see instances when approaching people staff smiled at them and their communication with people was warm and friendly, showing a caring attitude. One person asked if they could have a drink and a staff member said, "Of course, take a seat and I will get one for you" which they did.

The care records we reviewed did have some references to discussions held with people in relation to specific issues, but there was no routine obtaining the views of people or their relatives in relation to people's individual care. Some staff, including the manager, knew the people living in the home very well and were familiar with their likes and dislikes and how they liked their care to be provided. However, there was no mechanism within the care plans to share this knowledge with other staff.

Requires Improvement

Is the service responsive?

Our findings

Our November 2016 inspection found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the provision of person centred care.

During this March 2017 inspection a staff member told us that the door to the frequently used downstairs toilet area was usually left open so people living with dementia could recognise it as the entrance to the toilet. However, the light had been turned off at several points during the day of our inspection. We observed two people on different occasions right outside the room who told us that they were looking for the toilet but did not recognise the area because it was in darkness.

Some people living with advanced dementia walked around the home with little interaction with staff until they had a physical need which became apparent. Whilst there was some good activities provision in the home, not everyone was able to engage with this. Those that were unable to engage or find themselves something to do were left looking at the television or sleeping most of the day. During lunchtime we saw one person asleep with their head on the table.

The manager told us that about six people's care plans had been revised. Whilst the revised care plans were tidier there was little improvement in the content. A significant pre-assessment was carried out to determine whether people's needs could be met before they moved in to the home. This was the first thing staff would see when looking for information about people's needs and it was often several years old and out of date as people's needs had changed. Subsequent information about people's needs were often in the form of a chart with ticks and scores. However, there was little meaningful narrative about how care was to be provided for people and their preferences in relation to this.

Some care plans did not detail how people's health needs were to be met. There was no care plan to advise on the support needed for one person with a visual impairment. Another person was living with a bowel condition. Professional advice had been sought, but the information provided had not been transferred to the relevant care plan. One person had recently been diagnosed as living with diabetes. The diabetes care plan did not provide any meaningful guidance for staff. There was nothing about the signs or symptoms of high or low blood glucose levels and what action staff should take to remedy this.

The care plans for one person whose health had changed rapidly in recent weeks had not been updated to reflect the care that they now received.

This failure to assess, plan for and provide person-centred care was a continued breach of Regulation 9 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2014.

People had confidence that the manager would be able to resolve any concerns. One person told us how the manager had resolved their complaint and explained what had happened and what would be done to prevent the same circumstance happening again. A relative told us, "I have no qualms about the care here. If

I did, I know that the manager would take of it."

Inadequate

Is the service well-led?

Our findings

Our November 2016 inspection found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the governance arrangements of the service.

The previous inspection had identified incorrect records, ineffective auditing arrangements and poor identification of risks to people from the environment and the way that the service was provided.

This March 2017 inspection found that minimal improvements had been made. The cracked window in one person's room had been known about, but no action had been taken to ensure that a repair had been booked or that the window was made safe in the meantime. Considerable hazards identified from our November 2016 inspection such as the heated towel rails and hot pipes had not been made safe.

Despite auditing arrangements in place we found considerable infection control issues again. There was still no assessment to determine overall themes and trends from falls and accident reports. There was no system in place to ensure that appropriate action was taken when prescriptions did not arrive from the pharmacy in good time.

The care plan audit did not consider the quality of the content of the records, only whether a specific document was present. We found considerable issues with care plans including inaccuracies, contradictions and missing information. The auditing systems in the home were ineffective.

The provider did not take suitable steps to determine the quality and safety of the service provided. When concerns were raised with them they did not take timely action to rectify issues of concern.

The manager had not addressed considerable poor staff practice in the provision of dignified and respectful care.

Consequently, the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the findings from our November 2016 inspection and interventions from visiting health and social care professionals and other government agencies about a wide range of issues the provider had not demonstrated tangible plans to make and sustain improvements.

No additional support had been provided to the home to support the manager. They were expected to make the necessary improvements as well as continue their day to day duties in managing the home. They told us that they now had more telephone contact with the provider than previously. The provider continued to visit the home on a fortnightly basis but did not carry out any formal auditing or monitoring themselves.

The provider felt that the management of the home was the day to day responsibility of the manager and had little acceptance of their own responsibility in this despite being a registered person.

Due to the level of our concerns about the service on 22 November 2016 we issued a notice of decision which prevented the service in admitting or re-admitting people to the home without written permission from us. However, this March 2017 inspection found that this had been disregarded on two occasions. Consequently, we have concerns about the integrity of the management of the service.

Staff told us that the manager was supportive and worked hard. Meetings were held with staff and people living in the home and their families. The manager had been open about the difficulties the home was facing and clearly wanted things to improve. However, they did not have enough practical support to bring about the changes required.

Our November 2016 inspection found that the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because we had not been notified of incidents that the provider was under a statutory obligation to tell us about which included safeguarding incidents.

We were satisfied that improvement had been made in this area and that the provider was no longer in breach of this regulation.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided met people's needs or reflected their preferences. Regulation 9 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity and respect Regulation 10 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to assess and mitigate the

	risks in relation to people's care and the safe management of their medicines. Regulation 12 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises were properly maintained. Regulation 15 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were in place to demonstrate effective governance of the service. Regulation 17 (1)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff were supported with appropriate training. Regulation 18 (2)

The enforcement action we took:

We commenced enforcement action to cancel the provider's registration. Whilst this was ongoing the provider took the decision to close the home on 31 May 2017. We completed our enforcement action and cancelled the provider's registration.