Miss J R Hira

Winterton House

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

The inspection took place on 4 November 2016 and was unannounced. At our previous inspection on 3 May 2016 the service was not meeting legal requirements relating to maintaining a clean and safe premises, staff training, appraisal and supervision, and quality assurance. During this inspection the service was still not meeting several legal requirements.

Winterton House provides care to nine people some of whom may be living with dementia. On the day of our visit, there were eight people using the service.

The service is not required to have a manager registered with the Care Quality Commission (CQC) as the service is provided by an individual who is the manager and registered person. 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.

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, 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 and there is still a rating of inadequate for any key question or their overall rating, 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.

We found shortfalls in the leadership of the service. There were ineffective systems in place to monitor the quality of care delivered. Records were not always accurate and were not always kept securely.

People told us they felt safe. However, we found that people were not always safeguarded from avoidable harm. Medicines were not always managed safely. In addition, infection control guidelines were not always followed leaving people at risk of acquiring infections.

The premises and equipment were not clean and properly maintained. There were several health and safety risks. Appropriate steps had not been taken to ensure identified risks were addressed and managed.

Staff had not received appropriate appraisal, supervision and training. This resulted in people receiving care that was not always evidence based or effective.

People were not always involved in planning their care and were not always offered choice. Food and activities provided did not always meet people's needs.

People were not always treated with dignity as their wishes were not always respected. The way in which care was delivered did not always ensure people's dignity was preserved.

Staff were aware of some of their responsibilities but demonstrated a lack of knowledge about the Mental Capacity Act (2005) and how it applied in practice.

You can see what action we told the provider to take at the back of the full version of the report in relation to the multiple breaches we found.

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 premises were not always clean and safe for use. Infection control principles were not adhered to. Medicines were not managed safely.

Steps to minimise identified hazards were not in place. Staff were not fully aware of the procedures in place to safeguard people from harm.

Is the service effective?

Inadequate

for staff. In addition, there were no recent supervisions or appraisals. Furthermore, none of the staff had continued professional development since they started to work at the service.

Staff were not aware of their roles and responsibilities in relation to the Mental Capacity Act 2005 and had not received any training.

People told us food was available but were not always included or informed of the menu choice available.

Is the service caring?

Requires Improvement

The service was not consistently caring. People told us that staff were kind to them. However, we found instances where people's dignity was not always maintained.

People were not always involved in planning their care. Their independence was not always facilitated.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plans were not always up to date. Activities were limited and not always suited to people living with dementia.

People were able to express their concerns. However one person felt their requests were not listened to.

Is the service well-led?

Inadequate

The service was not well-led. There were ineffective quality assurance mechanisms in place. The current systems in place had failed to recognise and act on inadequate infection control procedures, out of date staff training, and maintaining safe premises.

People and staff thought the registered provider was visible and approachable. However, some people felt the culture of the organisation was closed with the registered provider having the final say on care issues with minimum involvement of people using the service.

Winterton House

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 comprehensive unannounced inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 3 May 2016 inspection had been made. This was because the service was not meeting some legal requirements.

This inspection took place on 4 November 2016 and was unannounced. The inspection was completed by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we held about the service and the provider. This included details of statutory notifications, safeguarding concerns, previous inspection reports and the registration details of the service. We also contacted the local commissioners and the local Healthwatch in order to get their perspective of the quality of care provided. In addition we received information of concern from a whistle-blower relating to poor recruitment practices, out of date food and lack of staff training.

During the inspection, we observed how staff interacted with people. We spoke with eight people who used the service, two relatives, the registered provider, and four care staff. We looked at four people's care records, four staff files, five medicine administration records, a training matrix and policies. We observed care in the main lounge where six people were based for most of the day.

After the inspection we asked the registered provider to send us more information about records that had not been made available on the day of inspection. In addition a letter was sent to inform the registered provider of urgent action we were going to undertake.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Winterton House. One person said, "I feel safe here. It's quite good." Another person said, "I'm very happy here. I've got no problems." A third person said, "I like it here." A relative told us "We are happy enough with mum's care. We know she is safe."

We found that the service was not always safe. The environment had several hazards which could cause harm to people using the service. The toilet on the ground floor had broken hand rails making it unsafe for use. Throughout the inspection, six out of the eight people used this toilet. We asked the registered provider about this and they told us that it would be fixed.

We saw that the cupboard containing substances that were hazards to health was not locked. We also observed that the cupboard with the electric board was not locked. We found that the door leading to the unsecure basement was unlocked. This put people at risk of being exposed to avoidable harm if they accessed the unlocked areas.

We identified several fire hazards throughout the inspection. These included newspapers and boxes in the main lounge, boxes in two people's rooms with clutter and multiple piles of paperwork in the registered provider's office. Staff were unaware of the evacuation procedure and there were no evacuation plans for people using the service. Furthermore, none of the rooms had call bells to enable people to ask for assistance when required. This put them at risk of not receiving timely care when they needed it. On the day of inspection the registered provider confirmed that a call bell system had been purchased but could not provide us with an invoice or date of delivery. After the inspection they sent us the name of the company and contact details with evidence that this had been ordered.

We found two portable radiators within the service, which were a safety hazard to people using the service. There were no risk assessments or strategies in place to reduce risks in place for the use of these. We reviewed four care records and found these contained minimal guidance for staff on how to manage the risks associated with people's conditions. Some people's needs had changed but this was not reflected in the records we saw. A person's mobility had reduced, but their mobility risk assessment did not indicate that they were now very unsteady on their feet and at high risk of a fall. Another person had had a fall but there was no record of any observations or risk assessment after the fall to ensure the person was safe.

People were not always cared for in a clean and safe environment. The current cleaning arrangements were not effective and left people living in an unhygienic environment and at risk of developing dust related conditions such as allergies. Extractor fans in the kitchen and bathroom were covered in thick layers of dust. The cooker, fridge and utensil holder were dirty. The lampshade in one room was full of dust. Fixtures, fittings and window sills in people's bedrooms and communal areas were very dusty. Many areas of the accommodation were unclean and not maintained. The downstairs shower cubicle and the bath chair in the second shower cubicle were dirty. The flooring in both the upstairs and ground floor toilet was dirty as well as the small toilet on the ground floor. The tiles were visibly dirty in two bathrooms and chipped in places. We found that cleaning schedules had not been completed. The above practices put people at risk of cross

infection as appropriate guidance was not always followed.

Medicines were not always managed safely. On the day of our visit, staff had no recent medicine training. We were told this had been arranged for the 10 November 2016. There were no regular temperature checks in the room where medicines were stored. This did not ensure that medicines were kept at the appropriate temperature so that they did not lose their effectiveness. We found a box of topical cream in a person's room. When we highlighted this to the registered provider, she put the cream in her pocket and did not secure it in the locked medicine cabinet. One person's medicine had been changed to three times a day by the GP to reduce drowsiness but was still being administered two times a day as documented on the medicine record and confirmed by staff. This meant the person was not receiving their medicine as recommended and therefore remained drowsy during the day.

People were not protected from risks associated with their care because infection control practices were not followed. Although a hand wash sink was available staff did not wash their hands regularly after direct contact with people. We saw a staff member have direct contact with one person then move on to another without washing their hands. We also saw staff serving lunch without washing their hands. In addition the same staff member had a visibly dirty uniform which put people at risk of cross infection. We highlighted this to the registered provider who confirmed that none of the staff had up to date infection control training. Furthermore the infection control policy had last been updated in 2010. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always safeguarded from abuse or avoidable harm. One person told us they regularly asked to use the telephone to contact their relatives and that they were not allowed to use it by the registered provider. This was a restriction that had not been explained or documented as necessary. Staff had no recent safeguarding training and could not explain how they would report and record any allegations of abuse beyond reporting to the registered provider. The current safeguarding policy needed updating as it did not contain important signposting information. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought there were enough staff to support them. We were told and found that there were two staff on duty during the day and one at night. We saw that there was a recruitment system in place which included proof of identity checks and reference checks. However, disclosure and barring checks were not always refreshed in order to ensure staff remained suitable people to work within a health and social care environment.

Inadequate

Is the service effective?

Our findings

The service was not effective as there was no established system to ensure that staff received sufficient training, appraisal and supervision. Staff we spoke with had been working at the service for several years. One had previous experience in another service and told us they had received training a few years ago. All staff confirmed that there was no training provided within the service but said that "It is being arranged." Staff said that they would appreciate further training, such as in working with those with dementia. None of the staff had continued professional development since they started to work at the service. We found shortfalls in staff knowledge in relation to dementia care and aspects of diabetes care. This meant they were unable to respond effectively to people living with these conditions resulting in inconsistent care delivery.

People were supported by staff who did not have up to date training to enable them to deliver care safely. All four staff on duty said that they had not had any training in dementia, infection control, medicines management and moving and handling. There were no staff appraisals or supervision completed for all four staff on duty since 2015. Training records showed one staff member who regularly prepared food had last received food hygiene and infection control training in 2008. We saw a training matrix that confirmed that no training had taken place in 2015 or 2016. This left people at risk of having care delivered by staff who had not attended appropriate training and who did not have sufficient knowledge and skills.

This was a breach of Regulation 18 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 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 and found shortfalls. The registered provider could not explain what capacity meant and were not sure of how to lawfully deprive people of their liberty when necessary for their own safety. All four care workers we spoke with had not received training in the MCA and did not know what it was or if anyone was currently subject to a DoLS authorisation. We asked for evidence that DoLS were in place and were told that no formal authorisations had been applied for. We found that during the day people were not allowed to go outside without an escort and were deprived of their liberty without the relevant authorisations in place.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were given a balanced diet however the menus were not always available for people to see and

choose. Although there was a blackboard to write the menu of the day, this was not always completed. The lack of a visible menu and the lack of clarity of what was available did not seem to take into account the needs of people with dementia who would have benefited from seeing their choices or a picture of what was being offered them. One person asked staff what was available on the day and the staff member was unsure of the menu and responded, "Anything you like." Staff were aware of people on a diabetic menu and there were notices in the kitchen to remind staff.

People told us they enjoyed the meals with the exception of two people. One wanted culture specific food and another consistent quality. One person said, "I enjoy the food: it's good." Another person said, "The food here is good." A third person felt the quality was variable and said, "Sometimes the food quality is not so good but overall it's ok." A fourth person, whilst finding the food acceptable, told us, "There's no problem with the food-I eat what they cook-but they never cook Indian food and I would like that." We reviewed the hand written menu and found limited options. Furthermore staff and people said the menu was planned by the registered provider. This meant that people were not involved in planning their meals. We recommend best practice guidelines are sought in relation to meal planning.

The design and adaptation of the environment was not always helpful to people living at the service. Some people's rooms were identified with their photograph on the door, others had nothing, such as a name to personalise them. Bathrooms were identified with pictures and this was a good idea which could have been developed in a bolder, brighter way to enable people living with dementia easily identify different rooms. We recommend best practice guidelines are sought in relation to creating a dementia friendly environment.

We saw evidence that people were supported to access healthcare services when required. Three people told us that the registered provider arranged for them to see a doctor when necessary and that they had been visited by a doctor in the home. Another person told us they were supported to attend regular hospital visits. However, we found that sometimes there were delays in implementing the recommendations following medicine reviews. This meant that people did not always receive care in a timely manner.

Requires Improvement

Is the service caring?

Our findings

People told us they were cared for by staff who were kind to them. A relative said, "I don't care that the place is a mess: I'm concerned about the care and I think the care is good." A person said, "The ladies treat me nicely: they ask permission before doing anything in my room." Throughout the inspection we saw staff interact with people in a personalised and warm way. They addressed people by name and, particularly over lunch, there were warm exchanges which went beyond tasks such as conversation about Christmas and the weather. People were helped to and from the toilet with patience and care.

A relative told us, "They treat mum with dignity and respect." However, we observed during our inspection that this was not always the case. We observed a staff member enter a person's room without knocking. A relative mentioned that they had witnessed their family member asking to go to the toilet and being told by staff they could wait until after the meal because they were "padded up". Another person told us, "There are a couple of carers at night who shout and get impatient".
On two occasions during lunch, a staff member attempted to assist a person to eat from a standing position. On another occasion, the same staff member sat beside the person but they were also trying to help another person on their other side to eat at the same time. There was a lack of dignity in this arrangement which demonstrated a lack of training in maintaining dignity when supporting people to eat. Furthermore, one person was left with a protective bib on for almost 30 minutes after the meal had finished and plates had been cleared. The above instances showed that people were not always treated with dignity and respect.

We observed that staff sometimes did not explain things clearly to people or respond appropriately to their requests. For example one person was asked if they wanted anything to drink. They requested water but were brought a hot drink instead. Information displayed within the service needed updating as some of the posters were out of date, some going as far back as 2012. There were many examples of out of date posters and this meant they were not likely to be read. Notices of particular relevance to people such as complaints procedures, menus and activities were not displayed in any kind of logical or accessible place. Neither were they in large or attractive type in order to make them easily readable by residents. Some of the notices read more like an instructions for people.

Care plans were not available in a format that people with communication difficulties could understand. Only one of the people we spoke with understood the idea of a care plan. They told us they had not seen their care plan or been involved in planning their care. The care plans we reviewed did not always indicate the degree to which people and their relatives had been involved. A relative said, "I think [my relative] has a care plan. I don't see it but I'm in often and the staff tell me exactly what she's been up to and what they've been doing."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's independence was not always facilitated. For example one person did not have mobility aids and instead were supported by one member of staff without assistance. The person told us that he was not able

to walk very well following an accident and he was not using a walking frame. He said there was very little room within the service premises for him to practise his walking and therefore had to rely on staff for assistance.

Requires Improvement

Is the service responsive?

Our findings

People told us they were cared for by regular staff. However, we found shortfalls in the way the service responded to people. People told us choice over bedtimes and rising times was variable and not always respected. Three out of six people felt that they were able to get up and go to bed whenever they liked: "I can get up and go to bed when I want," said one. "I do what I want when I want to do it," said another. A relative told us, "They don't force people to get up if they don't want to." However, one person told us, "We have to go to bed at 7.30 sometimes, depending on which worker is on shift. I don't think that's fair because I like to watch Coronation Street and Emmerdale but the carers have different ideas." Another person said, "The whole place goes to bed at the same time." A third person said, "We're not allowed to watch TV after 9.30pm." The above responses showed peoples preferences were not always respected.

Care plans were not always updated whenever people's needs, or preferences about their care, changed. Two out of the four care plans we reviewed had comprehensive details of people's history and likes and dislikes. The remainder had not been reviewed or updated to reflect people's current needs.

People were not involved in planning the activities and therefore did not always enjoy them or participate. Three out of eight people told us that they joined in and enjoyed the activities but others were not so happy about the things available to do. One person said, "I'm a bit bored. What can I do?" Another person said "I don't like the activities, I just watch the news. The singalongs drive me mad!" A third person said, "I used to like gardening but I can't bend down now." We noted that there was a large garden so there would be scope for some raised beds so that people could be supported to garden if they wished. A fourth person said, "I'd like to go out but I can't go without someone with me and there's no one to go with me." A fifth person said, "The manager won't let me go out because I might fall but I do go into the garden sometimes." A relative also said, "There doesn't seem much for [my family member] to do but it's difficult with her dementia." They also told us, "The garden hasn't been used much this year. They need more activities in the garden."

There was a programme of weekly activities on the wall in the dining room although not displayed in an easily accessible place. An additional blackboard had the morning's activity on it written by hand, which was not easily legible. It was not updated during the day of our visit. Morning activities always consisted of "Reading newspapers, exercises, singing and stretching" and afternoon activities appeared more varied, though not obviously suited to people living with varying degrees of dementia. However, there were not enough activities aimed at engaging with people living with dementia. The effect of having the lounge as an office or storage place for the registered provider made the room uninviting and it was rarely used during the day as a consequence. Instead people were cramped in the smaller dining areas where activities were going on with the TV and radio on at the same time making it difficult for people to focus. This was unfortunate in view of activities, as the fish tank in the room might well be engaging to those with more severe dementia.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they would speak to the registered provider if they felt they needed to complain about anything. One person said, "If something is wrong, I'd talk to the manager and she would put it right." Another person said "I would certainly take things to the manager if I had a complaint. I've had minor upsets but nothing important." However, one person told us "There is no TV in my room. The manager told me 'If you had one you would never switch it off'. If I go downstairs I am not always able to watch what I like as the other residents want different things." We asked for complaints but were told there had been no complaints in the last two years. We looked at the complaints log book and found no complaints. Staff told us they would refer complaints to the registered provider. We saw the complaints policy displayed at the main entrance of the service.

Inadequate

Is the service well-led?

Our findings

We found significant shortfalls in the way the service was led. Management and staff did not understand the principles of good quality assurance. As a result, infection control procedures were not always followed and cleaning was not thorough. The premises were not clean or well maintained. In addition feedback had not been sought from staff or people who use the service for the past three years. Policies had not been updated to ensure staff were kept up to date with practice. The current systems in place had failed to identify and address shortfalls in staff training, supervision and appraisals. This resulted in people receiving care that was not always appropriate by staff who did not have enough knowledge on issues such as moving and handling, capacity and consent, dementia, dignity and infection control.

Records relating to the management of the service were not always secure or organised in such a way as to be available when we asked for them. We asked for certificates to prove emergency lighting had been tested and serviced and for servicing the hoist. The registered provider was unable to find these during our inspection, however found them later. In addition not all incidents and accidents were recorded in the incident and accident book. Health and safety checks of the environment were incomplete. Hazards within the environment were not always identified leaving people at risk of avoidable harm.

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People were not always involved in the way the service was run. There were no regular meetings for people and their relatives. A relative told us there were no organised meetings for relatives although they did bump into each other informally and got to know each other because of the home's small size. One person said, "Sometimes we have meetings about things that might be happening. We're all friendly." The other people we spoke with were not aware of any regular meetings or discussions about life in the home. One person when asked if they felt involved replied, "The staff don't listen to me." Staff confirmed that there had been no recent meetings for people and their relatives.

People knew who the registered provider was and said they were very visible and involved in daily care. Four out of six people and staff said that they felt the registered provider was very approachable. One said, "They are the boss. They respect me and I respect them." Another said, "It's like a home here." However, we noted that some people said they were "not allowed" by the registered provider to do various thinks like go out, watch what they wished on TV or go to bed late. This indicated a very closed culture with people not allowed to voice their opinions or preferences. Notices throughout the service also confirmed this with some reading, "Friends welcome, relatives by appointment" and "Visitors do not play with the games." In addition we had not received any notifications of important events as required by law.

Staff to an extent understood part of their role. They talked warmly about the people they supported, and clearly recognised that they had varied backgrounds and that Winterton House was "their home". However, they were not always deployed effectively. For example, during lunch there were long periods when there were no staff in the dining room, up to 10 minutes at one time and some people began to fall asleep. When the staff re-entered they gently encouraged those who had lost interest to eat.

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

2014

There was no sign displayed on the premises to show the most recent rating by the Care Quality Commission that relates to the service provider's performance. We asked the registered provider about this and they were not aware that they needed to display this.

This was 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 9 HSCA RA Regulations 2014 Person-centred care Care did not always meet need or reflect people's preferences. Care or treatment was not always designed with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9 : 1 (b) (c) 3 (b)

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 Safeguarding service users from abuse and improper treatment People were not always protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. People were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (1) (2) (5)

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 There must be displayed at each premises from which the service provider provides a regulated

activities at least one sign showing the most recent rating by the Commission that relates to the service providers performance at those premises.

Regulation(offence) 20 A 3

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 Care was not always provided in a safe way. The registered person did not ensure risks to the health and safety of service users were assessed. They did not do all that was reasonably practicable to mitigate any such risks. The premises used by the service provider were not always safe to use for their intended purpose. The equipment used by the service provider for providing care or treatment to service users was not always safe for such use as it was dirty and in need of repair Medicines were not managed safely. The risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated was not always assessed. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

We issued urgent conditions and restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively. Systems or processes did not enable the registered person to assess, monitor and improve the quality and safety of the services

	provided in the carrying on of the regulated activity. The risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity were not always assessed, monitored and mitigated. Records were not always maintained securely or an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Other records as are necessary to be kept in relation to the management of the regulated activity were not always securely maintained. The registered manger did not always seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e)

The enforcement action we took:

We issued urgent conditions and restricted admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have sufficient skills and knowledge to enable them to support people living with dementia. Persons employed by the service provider in the provision of a regulated activity did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. They were not always enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (2) (a) (b)

The enforcement action we took:

We issued a warning notice.