Indigo Care Services Limited

Cambridge Park Care Home

Inspection report

Peterhouse Road
Grimsby
South Humberside
DN34 5UX

Tel: 01472276716
Website: www.orchardcarehomes.com

Date of inspection visit:
13 July 2017
18 July 2017
19 July 2017

Date of publication:
01 September 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cambridge Park Care Home is registered to provide residential and personal care for up to 60 older people who may be living with dementia. Accommodation is provided over two floors with both stairs and lift access to the first floor. Accommodation for people who may be living with dementia is located on the ground floor. There is an enclosed garden area, adequate parking and the service is close to local amenities. At the time of this inspection, 41 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found people were not always safeguarded from abuse and improper treatment. When safeguarding concerns were raised they were not investigated and responded to in a timely manner. Staff used unauthorised low level interventions to provide care to a small number of people without appropriate training to do so safely.

People did not always receive safe care and treatment. Appropriate actions were not taken to reduce the possibility of people suffering from avoidable harm. People's care plans failed to include relevant information and sufficient information to ensure staff could meet their needs safely and consistently.

Effective governance systems were not established and operated within the service. Shortfalls in care and support were not always highlighted through internal auditing and quality assurance systems failed to ensure required improvements occurred.

Staff, who had been recruited safely, were deployed in sufficient numbers to meet people's individual need. People received their medicines as prescribed. Staff who were responsible for administering medicines had completed relevant training and their competency assessed regularly.

Staff had completed a range of training, which enabled them to feel confident in the roles. Staff received one to one support and annual appraisals in line with the provider's policies. Staff understood how to gain consent from people but we found the principles of the Mental Capacity Act had not always been followed. People ate a varied and balanced diet and when concerns with their nutritional intake were identified appropriate action was taken. A range of healthcare professionals were involved in the on-going care and treatment of the people who used the service.

People received their care and support from an established team which, ensured continuity and consistency. People were not always treated in a dignified way and some aspects of their care showed they were not treated as individuals. Private and sensitive information was treated confidentially and managed accordingly.

People who used the service or their appointed representative were involved in the initial planning and on-going delivery of their care. We found that some people's care plans and risk assessments were not updated as their needs changed or after incidents had occurred. People's care plans did not always contain accurate and up to date guidance to enable staff to meet their needs consistently and effectively. People took part in a range of activities in groups or on a one to one basis. The provider's complaints policy was displayed at the within the service to ensure it was accessible to people. When complaints were received, appropriate action was taken as required.

The service had a registered manager who was aware of their responsibilities to report notifiable events to the Commission; despite this we found evidence that on a two separate occasions they had not reported specific incidents. People who used the service and their relatives were asked to provide regular feedback on the service and their opinions were used to improve the service when possible. During the inspection we received assurances from the provider's director of regional operations and the operations director that they were committed to improving the service. Following the inspection we received action plans stating how and when the required improvements would be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Some people were put at risk because staff who had not completed relevant training used low level physical interventions to deliver care.

Safeguarding concerns had not been responded to in a timely way and action had not always been taken to reduce the potential for avoidable harm to occur.

People received their medicines as prescribed.

Safe were recruited safely and deployed in appropriate numbers to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. Staff delivered care and support to a small number of people without the appropriate training to do so safely.

Appropriate consent had not always been obtained following the principles of the Mental Capacity Act as best interest decisions had been made unilaterally.

Staff received adequate amounts of one to one support or yearly appraisals.

People were supported to eat and drink sufficiently. Their dietary intake was monitored and action was taken when concerns were identified.

Is the service caring?

Requires Improvement

The service was not always caring. Staff's actions did not always demonstrate a caring approach and showed a lack of respect for the people who used the service.

People were not always treated in a dignified way.

People who used the service and relatives told us the staff were caring.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some people's care plans failed to provide appropriate guidance to enable staff to meet their needs and they were not updated following specific incidents.

The provider displayed their complaints policy at the entrance of the service. When complaints were received they were responded to appropriately and used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems and processes were not established or operated effectively to monitor and improve the quality of the service.

The service had a registered manager who understood but had not always fulfilled the obligations to report incidents to the Commission as required.

The registered provider was aware of and involved with the day to day management of the service.

Cambridge Park Care 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.

The inspection took place on the 13, 18 and 19 July 2017 and was unannounced. The inspection was completed by an adult social care inspector who was supported by a member of the local authority safeguarding team on the first day of the inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the provider. Notifications are when providers send us information about certain changes, events or incidents that occur. We spoke with the local authority commissioners and the local authority safeguarding team to gain their views about the service.

The provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, the deputy manager, director of regional operations, the operations director, a shift leader, two members of senior staff, five members of care staff, an activities co-ordinator and two members of domestic staff. We also spoke with four people who used the service, five relatives and a visiting healthcare professional.

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 six people's care plans along with the associated risk assessments and Medication Administration Records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their

best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included action plans, policies and procedures, business continuity plans, personal emergency evacuation plans, recruitment information for staff, staff training records as well as audits and quality monitoring information.

Requires Improvement

Is the service safe?

Our findings

Staff we spoke with were knowledgeable about the different types of abuse that may occur and the signs or symptoms that could indicate someone was suffering from abuse. One member of staff said, "I've done the safeguarding training, I know what to look out for and I wouldn't hesitate to report anything I saw." A second commented, "I have blown the whistle [report abuse or poor care] before and I would do it again. Our duty is to protect our residents." However, the staff failed to recognise that using low level physical interventions to provide personal care to people without appropriate authorisation or training could be seen as physical abuse and put people at risk.

Staff told us that a small number of people who were living with dementia would regularly refuse personal care and described the low level interventions used to deliver the support they required. A member of staff explained, "We do understand when people need help and when they don't. One man doesn't like us to shave him so on some days he doesn't have a shave but if people have been incontinent we need to make sure they are clean." Another member of staff said, "There are a couple of people that we have to hold hands with [to deliver personal care]. One person is aggressive so we need three of us to do their personal care, two hold their hands and just distract them by chatting about things they like and the third person gives the care."

The use of planned physical interventions must be agreed in a best interest forum so that it is only used when a marked threshold has passed and alternative strategies have been unsuccessful. It must only been carried out by trained staff who are following an appropriate care plan which ensures it is the least restrictive intervention required to meet the person's needs. When we checked the provider's training records we saw that none of the staff at Cambridge Park Care Home had completed appropriate training to enable them to carry out physical interventions safely. This meant people were being restrained to deliver personal care unlawfully.

Appropriate systems and process had not been established or operated to investigate, immediately, upon becoming aware of, any allegation of abuse. The registered manager had been contacted by the local authority commissioners regarding an allegation of abuse in relation to a person who used the service. The registered manager was asked on three separate occasions to complete an internal investigation and report back to the safeguarding team with their findings and actions. The investigation did not take place until the requirement to do so was highlighted to the head of regional operations during our inspection.

The above information demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. The action we have asked the registered provider to take can be found at the end of this report.

People did not always receive safe care and treatment and were not protected from avoidable harm. Accidents and incidents were recorded as required but they were not always reviewed in a timely way to ensure action was taken to reduce the possibility of their reoccurrence. We reviewed the accidents and incidents records for May and June 2017 and saw they had not been collated.

One person had fallen on seven occasions in May and another person had fallen on seven occasions in June. Appropriate action included contacting the falls team or ordering preventative equipment such as sensor mats [Sensor mats are connected to a call bell system and are triggered when they are stood on which, alerts staff that a person who is at risk of falls is walking and may need assistance.] did not occur until we highlighted the issue during the inspection.

Appropriate action was not always taken to prevent known risks impacting on people's health and welfare. We looked at the care records for one person and saw that a care plan had been created to minimise the possibility of pressures sores occurring. The person was categorised as being at high risk of developing pressures sores and their care plan stated two hourly repositioning was required. The repositioning charts we saw provided evidence that the two hourly repositioning had not been adhered to consistently in July 2017.

We saw that a person who used the service had been prescribed medicines on a PRN or 'as required' basis to reduce their levels of anxiety and agitation when they became distressed. The PRN protocol that had been produced to guide staff when the medicines should be administered lacked appropriate information to ensure they were administered consistently and appropriately.

The above information contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The action we have asked the registered provider to take can be found at the end of this report.

People who used the service were supported by suitable numbers of staff. The provider had recently delivered training to registered managers regarding the use of a dependency tool that was to be used across its services. This helped to ensure staffing levels remained appropriate as people's needs changed. The head of regional operations told us, "People's needs in nine keys areas including eating and drinking, personal care and washing and dressing are assessed each month. They are given a rating and those ratings are used to calculate the amount of support they need."

People who used the service and their relatives told us staffing levels were appropriate. Their comments included, "There is always someone around when I need them", "I think there is plenty of staff", "There are always staff around when I come, people don't have to wait for long when they want assistance", "We think the staffing levels are good, we come regularly and we see the care staff and the activities people", "The staff are busy but they respond to everyone's needs and are very attentive."

We saw evidence to confirm staff were recruited safely. The staff files we saw included application forms, interview questions and scores, two references and a Disclosure and Barring Service [DBS] check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These checks help employers make safer recruiting decisions and help to minimise the risk of unsuitable people from working with people at risk. The director of operations informed us that DBS checks were carried out on a three yearly basis throughout staff's employment to ensure they remained suitable for their role.

We observed parts of two medication rounds and saw that people received their medicines as prescribed. We reviewed a number of people's Medication Administration Records [MARs] which, were completed accurately without omission. Only staff who had completed relevant training administered medicines and their competency was checked periodically.

Suitable arrangements were in place for the ordering, storage and administration of medicines. The service

had a temperature controlled medicines room which helped to ensure medicines were stored in line with the manufacturer's guidelines. Controlled drugs were held securely and a medicines fridge was available to store medicines at cooler temperatures as required.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us the staff who supported them were capable and carried out their roles effectively. One person said, "They [the staff] all seem to know what they are doing. If I need anything, I just ask and it's sorted for me straight away." Another person commented, "All the staff are very good, we are lucky in that respect." A relative we spoke with said, "I think they [the staff] know their jobs and do them well. I choose this home after visiting quite a few in the local area and one of the reasons I picked it was because of the staff."

Staff had completed training in a number of subjects including safeguarding vulnerable adults, health and safety, fire safety, infection control, diet and nutrition, first aid, dementia awareness, the Mental Capacity Act and Deprivation of Liberty Safeguards and understanding and managing challenging behaviour training.

We discussed the understanding and managing challenging behaviour training with the head of regional operations and reviewed its contents. The training did not cover the safe use of low level physical interventions which, staff confirmed they used to deliver care to a small number of people. This meant people were not always supported by suitably skilled and experienced staff.

Records showed that staff received one to one support during supervisions and annual appraisals in line with the provider's internal policies. Staff we spoke with told us they felt supported in their roles. Their comments included, "Lots of us have worked here for quite a while now; I've been here years. I think we get lots of support, we are a good team" and "We support each other, we have a manager, a deputy manager, unit manager and seniors so there is always someone to give advice and help us out."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection we saw evidence eight people had a DoLS in place and a 15 of applications were in the process of being considered by the authorising body.

People's capacity to consent to care and treatment was assessed and recorded in the care plans. We saw that best interest meetings were held when people lacked the capacity to make informed decisions themselves. Some meetings were attended by a range of healthcare professionals and people's relatives or advocates. However, we saw that some decisions had been made unilaterally within the service. We discussed this with the head of regional operations who provided assurance that the decisions would be

reviewed ensuring relevant people had an opportunity to influence the process.

People who used the service were offered a choice at each meal. We saw that people's dietary intake was monitored and healthy options were promoted. When concerns were identified appropriate action was taken and relevant professionals were contacted for their advice and guidance. Staff were aware of people's individual needs such as those who required a textured diet or high calorie diet and their preferences were catered for.

Records showed that people were supported by a range of healthcare professionals including GPs, physiotherapists, dieticians and speech and language therapists. A district nurse we spoke with said, "I come to the home regularly and have never had any problems, my advice is followed and if they [the staff] ever have any concerns they let me know straight away."

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that they were supported by caring staff. One person said, "The staff treat me very well. They are all very kind. I am respectful to them and they are respectful to me." Another person said, "I am happy here" and "The girls [care staff] are lovely."

Relatives we spoke with told us their family members were treated with kindness and compassion. One relative said, "I work in the industry so know how hard the carers work. I think they all work really hard and as a family we are happy with mums care." Another relative said, "I come to visit every day and there have been a couple of issues over the years but if I didn't think [name of the person who used the service] received good care I wouldn't let him stay here."

On the first day of our inspection we noted that a person, who was being supported back to their room by a member of staff, had their room number written on the back of their nightgown. Staff told us that a high number of people had their room number written in to their clothing to prevent them being lost or given to the wrong person. When we highlighted this practice to the head of regional operations they confirmed action would be taken immediately to ensure room numbers would be removed from clothing items and the practice would stop. Using people's room numbers to identify them or any of their belongings could be seen as institutional abuse.

We recommend that the provider follows through with its plans to remove room numbers from people clothes and seeks advice and guidance from a reputable source, regarding ensuring that people's dignity is respected and maintained.

Staff we spoke with told us they understood the importance of treating people with dignity and respect. They gave examples such as asking questions in private, discreetly offering care, covering people when delivering care and ensuring door were locked and curtains closed before supporting people to undress.

During the inspection it was brought to the attention of the deputy manager that a member of staff had been witnessed acting inappropriately and heard making derogatory comments about a person who used the service after delivering care to them. Their comments and actions showed a lack of respect, were undignified and meant the person had not be supported in a caring way. The provider ensured action was taken without delay to prevent other people receiving similar treatment. The head of regional operations said, "It is clearly not something we condone. We will always do whatever is necessary to protect the people in our care."

Throughout the inspection we observed people being offered choices and staff respecting their wishes. It was clear people who used the service were involved in decisions about their care. When people lacked the ability to make informed choices advocates or appointed people were used to support any decisions. This helped to ensure people's known wishes and thoughts were respected.

People's independence was enabled by staff who understood their needs. It was clear staff knew people's

limitations but we observed staff encouraging them to do certain things themselves. During lunch we noted that people were provided with adapted cutlery, beakers and plate guards so they could enjoy their meal independently.

There were appropriate systems in place to control and store personal information. Paper records were held in locked offices and access to electronic records was restricted by personal log-on and password requirements. A member of staff told us, "We cover confidentiality on our induction. We all know what happens at work, stays at work.

The registered manager confirmed that no restrictions were placed on visiting times. They explained, "We don't tend to get visitors that late [in the evening] but people live busy lives so we don't want to stop them coming. One lady comes in a morning before she goes to work." They also said, "When people are on end of life care we encourage families to be here and if they want to stay we accommodate that." The visiting relatives we spoke with stated they were free to visit the service at any time. A relative told us, "I have never really thought about visiting times, we just come whenever we can, we don't call beforehand and we always receive a warm welcome."

Requires Improvement

Is the service responsive?

Our findings

People who used the service, their relatives or appointed representatives confirmed they were involved in the initial and on-going planning of their care. We saw evidence that initial assessments were completed before people were offered a place within the service. The assessment captured information regarding people's needs and levels of independence in areas including personal care and well-being, care needs, diet and weight, sight, hearing and communication and mobility. This information was then used to create a number of care plans.

The care plans we saw did not always accurately describe people's needs or provide appropriate guidance to enable staff to deliver safe care and treatment. We found evidence that people's care plans were not always reviewed and updated after accidents, incidents, falls and changes in their level of need. Known risks were not recorded appropriately or mitigated effectively.

A person who used the service displayed behaviours that challenged the service and others. Their care plan stated that staff should use distraction techniques to re-direct them when they became anxious or agitated but failed to provide any examples or stipulate what distraction techniques were known to be successful. A member of staff stated, "We do try and distract [name of the person who used the service] but most of the time that doesn't work so we end up just trying to move other residents away from them."

A second person, who had limited mobility and was cared for in bed, had a care plan that stated they required two members of staff to provide personal care. The care plan did not include an explanation as to why or what the second person was required to do. Staff told us that personal care was provided by two members of staff because low level physical interventions were required due to the person's agitation. A member of staff said, "We hold [name of the person who used the service] hands. They can be aggressive during personal care so one person holds their hands whilst the other makes sure they are clean." The registered manager told us, "I am very disappointed with some of the care plans. I would have thought there would be a lot more information in there."

We reviewed the incident records and saw two people had been involved in an incident which, led to one person sustaining an injury. There was no evidence to support that the incident had been reviewed when either persons care records were evaluated and no risk assessments were created to ensure staff were aware of the actions they should take to reduce the possibility of the incident re-occurring.

The above information contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The action we have asked the registered provider to take can be found at the end of this report.

Personal information about people's lives such as where they grew up, their hobbies, interests and family lives were recorded in their care plans. This helped to ensure staff knew the people they were supporting and could engage them in conversations about their personal interests. A member of staff we spoke with said, "We try and encourage everyone to take part in activities but people don't always want to so it's good

to know things about their lives. Sometimes just talking about where they grew up or what they did as a job is what they want to do."

During the inspection we saw an activities co-ordinator engaging a group of people in a reminiscence activity. The activities co-ordinator told us, "We try and do all sorts; we had the summer fair this weekend, it had to be inside because of the weather but everyone who came enjoyed it and we raised £220 for the resident's fund. We will use that to top up my monthly budget and get entertainers in or go out on trips." We saw photo collages of people enjoying differing activities and spoke with a person who had recently had a birthday celebration in the service and was visited by the Mayor of Grimsby.

The provider had a complaints policy in place and displayed their complaints information to ensure people could access it if required. The service had received a small number of complaints since our last inspection and we saw they had been investigated and responded to appropriately. The director operations told us, "All complaints are recorded so they can be viewed by the upper management and their progress can be monitored. I have implemented a new system so all complainants will be invited to meet with the manager and discuss their concerns on a personal level." The head of regional operations said, "We will make sure we complete a route cause analysis to determine what went wrong and why and use our findings to improve whenever we can."

People who used the service and their relatives told us they knew how to raise concerns. Their comments included, "I would speak to the manager if I had any problems, I would just tell them what I was unhappy with and I'm sure they would sort it out without any bother", "I have had some issues in the past, nothing major a couple of things have gone missing and one or two other little problems. I just speak to the staff about it or the manager and they do what they can" and "I know the manager, if I had any concerns I would tell [Name of the registered manager]."

Requires Improvement

Is the service well-led?

Our findings

When we asked staff if the service was well-led they provided mixed responses. Their comments included, "It is a good company to work for", "I think it is [well-led], we can speak to the manager if we need to, they are approachable and listen to us and what we have to say", "It is well-led but something's not right at the moment, we seem to be in a bit of a rut. I think morale is low" and "I think things are better now we are part of this new company, we saw more managers and they are more involved. I do think sometimes they [the management team] don't know what happens on the floor, what they think happens and what actually happens is two different things."

The provider had developed quality assurance and governance processes, however, we saw these were not used within the service. Audits had not always been completed of accidents and incidents which led to preventative actions not been taken in a timely way. Reviews of care records had not been effective in driving improvements and ensuring appropriate information and guidance was available to staff. There were no systems to ensure safeguarding requests and internal investigations were completed in a timely way or that people were protected from institutionalised practices.

The quality assurance systems being utilised had not highlighted, amongst other things, that staff were using low level interventions to deliver care to people; staff who had not been trained to do this safely and had no authorisation to do so under the Mental Capacity Act.

The deputy manager told us senior care staff were supposed to review people's re-positioning charts to ensure they were re-positioned at advised intervals. There was no evidence to show this task had been completed as required and records we saw showed people were not always re-positioned in line with professional advice.

The registered manager told us that senior care staff were responsible for developing and updating care plans. We saw that care plan reviews were completed on a monthly basis and that care plan audits were completed on a sample of care plans each month. The auditing process had identified that people's care plans did not always contain adequate information and guidance but had failed to drive required improvements. The head of regional operations stated, "We have identified issues with the care plans and have organised for workshops to take place so that we can be confident the staff have the rights skills and knowledge to produce detailed, person centred care plans."

The above information contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. The action we have asked the registered provider to take can be found at the end of this report.

The provider was involved with and took responsibility for aspects of the day to day management of the service. The head of regional operations explained, "If the manager uses the management tools created by the provider they can't go far wrong. I will ensure the manager implements them straight away and will personally complete audits myself so I know they are being used." Following the inspection the head of

operations has provided detailed actions plans to the Commission highlighting identified issues, objectives, actions taken and set timescales for completion.

People who used the service and their families were enabled to provide feedback regarding the service through questionnaires. Service user and relative meetings were held on a quarterly basis and meeting minutes showed topics including communication, activities and maintenance work were discussed. People's views and opinions were listened to and used to improve the service when possible.

People we spoke with told us the service was well led. One person said, "It's a lovely place to live, I couldn't think of anywhere better to be." Another person said, "I am happy here. I think it's a well-run ship and the crew are good enough." A relative told us, "Overall we are happy with everything. He [the person who used the service] calls the staff his girls and he is comfortable with them. If he is happy, I am happy."

Staff meetings were held regularly which, provided staff with the opportunity to discuss any concerns or raise issues. A member of staff told us, "The meetings are good we talk about what's happening in the units, what's working well, what isn't; that sort of thing."

A condition of the provider's registration is that the service is required to have a registered manager. The current registered manager has worked in the service for a number of years. They were aware of their responsibilities to report specific incidents to the Commission. During the inspection we reviewed the information we had received against the information held within the service. Although the Commission had routinely received notifications from the service we found two instances where the registered manager had failed to notify us of specific incidents. We discussed this with the registered manager who informed us that it was an oversight and provided assurance all notifiable incidents would be reported in the future.

The above information demonstrated a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the provider reminding them of their responsibility regarding notifications to CQC.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service did not always receive safe care and treatment because risks had not always assessed or mitigated. Care plans and risk assessments lacked adequate guidance to enable staff to meet people's needs.

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 People who used the service were not always safeguarded from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not established and operated to assess, monitor and improve the service as required.