Caring Homes Healthcare Group Limited

Southlands Place

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 9, 17 and 18 October 2017. The first two days were unannounced. Southlands Place is registered to provide nursing, care and accommodation to 71 people. There were 60 people living in the service when we visited. People cared for were mainly older people who were living with a range of care needs, including arthritis, diabetes and heart conditions. Some people were living with dementia, some of these people could show behaviours which may challenge others. The service also provided care for people who were at the end of their lives. Most people needed some support with their personal care, eating, drinking or mobility.

Accommodation was provided over three floors of a purpose-built building. There were multiple communal areas throughout the building, and accessible gardens. The service was situated in a quiet residential street in Bexhill-on-Sea.

There was no registered manager 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. A home manager had been appointed in July 2017. She had applied to be registered with us as manager for the service. The provider is Caring Homes Healthcare Group Limited, a national provider of care.

The last inspection of the service was on 17 and 20 March 2017. The service was rated as good, although come aspects of the well-led question required improvement. At that time there were 36 people living at the service and the upper floor had not yet been opened.

We performed this responsive comprehensive inspection because a wide range of issues had been raised with us, including from people's relatives, staff, external professionals and the local authority. Separate to this inspection, CQC are also reviewing a serious incident for a person, in accordance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there were a range of areas which needed action to ensure the safety and well-being of people. People's safety was not ensured in areas such as management of wounds, prevention of pressure damage, diabetes and infection risk. The service was also not consistently following national guidelines to reduce such risks. Staff had not received training in all relevant areas to meet all of the needs of people living in the service to ensure they knew how to reduce people's risk.

Procedures for safeguarding people were not always effective. This was because timely referrals had not been made to the Local Authority in accordance with policies to ensure risk of abuse was appropriately considered.

The service was not consistently following the requirements of the Mental Capacity Act (2005) by ensuring all

relevant people had an assessment of their mental capacity. There was a lack of documentation in relation to best interest decisions for some people and some Deprivation of Liberty Safeguards (DoLS) applications did not include all relevant matters.

People were not consistently involved in developing their own care plans. Some people were not always receiving the care they needed in relation to areas such end of life care, mobility and dementia care needs. Some people's care plans were not clear, to ensure all staff knew how to provide people with the care they needed. Some staff did not follow people's care plans when providing care.

The provider and home manager's systems for audit had not identified a range of areas, so had not taken necessary action to address issues before the inspection. This included areas such as confidentiality of people's records, some aspects of medicines management and certain aspects of management of people's urinary catheters. They had not identified that some records had not been made, others were not accurate or completed in a timely fashion.

As at the last inspection, several people raised issues in relation to staffing levels and responses to call bells. The service had not reviewed feedback from people since the last inspection to identify if there were issues where they needed to take action, such as by regular audit of response times to call bells.

Several people raised concerns about their care; many people felt this related to the different numbers of staff who cared for them. Some staff did not effectively support some people's privacy and dignity or ensure they could make choices about what they wanted to do. Some staff, particularly agency staff, did not always know relevant information about the people they were caring for. The home manager told us they were trying to recruit more permanent staff.

On the first day of the inspection we received mixed comments about the meals and also identified some issues where action needed to be taken. The home manager had taken action to address these issues by the second day of the inspection.

We received mixed comments about the service's response to complaints and concerns. Some matters may not have been documented. Where matters were documented, they showed the service followed their own policies.

The provider had established systems to ensure staff were trained and supported in their roles during induction, and for areas such as safely supporting people's mobility and fire safety. All of the staff we spoke with knew how to raise safeguarding alerts if they identified a person might be at risk of abuse. Some staff said they felt supported by management including by supervision and staff meetings.

People were supported by a wide range of activities to meet their individual needs. Activities staff were enthusiastic. They maintained clear records of the benefit to people of activities, so they could ensure people were supported in the way they wanted.

People commented on the caring nature of some staff, often identifying particular members of staff who they liked. Some staff, including some of the agency staff, showed an empathetic, kindly approach to people.

There were safe systems for the storage of medicines, with relevant records being maintained. There were records of maintenance, including safety of equipment and fire safety, these were updated when relevant. There were safe systems for the recruitment of staff.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

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

The 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.

People's safety was not always ensured. Where people may have been at risk of abuse, relevant referrals to the Local Authority were not always made.

People's safety from risk was not always ensured.

People raised issues about staffing levels, this was not audited by the provider to identify if there were matters where action was needed.

Some areas relating to management of medicines had not been identified. Other areas for medicines were safe.

There were safe systems for recruitment of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) were not always being followed.

Staff were not trained in all relevant areas, particularly in relation to supporting people with their healthcare needs. There were training and supervision systems for other areas of care provision.

Improvements were made during the inspection in relation to supporting people with their meals. People received the support they needed to eat and drink, in a pleasant environment.

Is the service caring?

Requires Improvement

The service was not always caring.

People who were at the end of their lives were not consistently supported in the way they needed.

Some staff did not ensure people's privacy and dignity or

respond to them as individuals. Other staff showed a caring, empathetic approach to people.

Action was taken by management after the first day of the inspection to ensure confidentiality for people's records.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people were not involved in developing their own care plans.

Some people's care plans did not clearly set out how they needed to be cared for. Some staff did not follow people's care plans.

People felt some concerns and complaints had not been responded to. Where they were documented, people were responded to appropriately.

People were supported by a wide range of recreational activities.

Is the service well-led?

Inadequate

The service was not well-led.

Whilst monitoring systems were in place, they were not embedded and had not detected shortfalls identified during our inspection.

A range of records had not been made, were unclear or inaccurate.

The service did not have a registered manager in post. A manager had been appointed and was applying to register with us.

The home manager and some staff described how they were keen to develop the service to ensure it was centred on people's diverse needs.

Southlands Place

Detailed findings

Background to this inspection

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

This responsive comprehensive inspection took place on 9, 17 and 18 October 2017. The first two days of the inspection were unannounced. The inspection was undertaken by two inspectors for all three of the days and a third inspector supported them on 17 October 2017.

Before our inspection we reviewed the information we held about the home, including the previous inspection report. Because this was a responsive inspection, we did not request a provider information return (PIR) before this inspection. The provider had sent us a PIR before the previous inspection. We had been contacted by a range of persons before this inspection including staff, people's relatives and the Local Authority. As part of the inspection, we reviewed this information as well other information about the service. We looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. After the inspection, the home manager, people's relatives, staff and the Local Authority gave us further information and we considered this as part of the inspection.

We met with 16 people who lived at the home and observed their care and treatment, including lunchtime and support with medicines. We spoke with six people's relatives and six external professionals, both before, during and after the inspection. We inspected the home, including the laundry, bathrooms and some people's bedrooms. We spoke with 13 of the care workers, including five agency care workers, six registered nurses, two activities workers, a receptionist, three domestic workers, the chef, the deputy manager and the home manager. We also met with an area manager for the provider on 9 October 2017.

We 'pathway tracked' 11 of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included six staff recruitment records, the service's training and supervision records, medicines records, risk assessments, accident and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

Before this inspection, several people raised concerns with us about the safety of people in the home. One person's relative told us they did not think their relative was safe and another told us that some of their relative's falls had not been reported to the local authority in accordance with safeguarding procedures. An external professional also raised concerns with us about the safety of people at the service who were at risk of falling. One member of staff told us they did not feel all people were safe at the service. Separate to this inspection, CQC are also reviewing a serious incident for a person in accordance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Local Authority (East Sussex) safeguarding policy sets out how people who receive care are to be protected and kept free from abuse or neglect. A key area relates to services making timely reports about incidents such as falls, pressure wounds and medicines errors. The service was not ensuring they were consistently following this policy to safeguard vulnerable people. On 9 October 2017, we observed a person who had bruising down one side of their face, some bruising was still evident on 18 October 2017. The person told us, and staff confirmed, they had recently experienced a fall. On 9 October 2017 we discussed with the home manager that this matter needed to be reported to the Local Authority in accordance with their safeguarding procedures. We also met with a person who had developed two pressure wounds, which staff confirmed and their records showed, had developed in the service. An external healthcare professional told us these wounds were in a serious condition. The home manager told us a safeguarding referral was not needed because the person was already known to the safeguarding team. A third person's records showed evidence of a medicines error. The home manager told us the error related to their previous care provider, not this service. We advised the home manager that in such cases safeguarding alerts still needed to be raised to ensure people cared for by the previous provider were also protected. On 23 October 2017, the Local Authority confirmed they did not have an alert about any of these persons. We therefore raised three safeguarding alerts to ensure people were safeguarded, following the inspection.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 because the service was not following current policies and procedures to ensure vulnerable people were protected.

The National Institute for Health and Clinical Excellence (NICE) guidelines state that because pressure wounds once developed, can be very painful, take an extended period to heal and may present a risk of infection, the emphasis must always be on their prevention. Due to a person developing severe pressure wounds at the service, we looked at how staff were following these guidelines.

We met with four people who were assessed as being at high risk of pressure damage. People's risk of pressure damage was not reduced because staff were not following guidelines on reduction of risk. One person had a risk assessment relating to their high risk of pressure damage. It had not been reviewed since 5 July 2017. They did not have information on any of their care files about how their risk was to be reduced. We asked staff about the person's risk but they could not tell us about planned interventions to reduce the person's risk. Another person's care plan documented they were at high risk of pressure damage and

needed to be observed because of this. The person was not able to move themselves independently and spent most of the three days of inspection sitting in a chair. Risk of pressure damage does not reduce when a person is sitting out in a chair. The person's plan did not outline how their risk of pressure damage was to be reduced. We asked staff about how they reduced the person's risk. They told us they had not been told about supporting the person regularly when sitting out in their chair. A third person's plan only stated they had dry skin and about creams they needed applying, with no further information on how their risk was to be reduced. A fourth person had a care plan which stated their risk of pressure damage was high. One member of staff told us the person was mobile, so they did not currently need any interventions. We asked about regular monitoring of the person's skin but the member of staff said this did not take place. None of the care workers we spoke with said they had been trained in how to reduce people's risk of pressure damage. Although a person had sustained complex pressure wounds in the service, systems had not been put in place to reduce risk to other people. We discussed this with the home manager. By the end of the inspection, they had started introducing some measures to reduce people's risk of pressure damage.

The service was not always ensuring they acted appropriately when people had an infection. One person's relative told us their relative was prone to urine infections. They said staff had not always responded appropriately when their relative showed signs and symptoms of a urine infection. We looked at the person's plan. It did not include any reference to checking their urine if they showed changes in their how they were. We met with a different person who was showing signs of distress. We asked staff if they had checked to see if the person had a urine infection. They said they had not. Staff performed a check, the result was positive and the person's GP was contacted, they prescribed an antibiotic. The person was much calmer and did not show signs of distress on the second and third day of the inspection.

The service was also not ensuring risk of infection to people was reduced when they used urinary catheters. The National Institute for Health and Care Excellence (NICE) set out guidelines on the use of such appliances. These guidelines identify a risk of infection to the person who uses these appliances unless safe procedures are followed. Leg bags for catheters need to be changed at the frequency set out in manufacturers' instructions to reduce infection risk, generally every 5-7 days. We met with three people who had urinary catheters. A member of staff told us one of these people experienced frequent urine infections. These people's care plans did not document how often their leg bag was to be changed. We asked four members of staff about this. We received a range of replies about when people's leg bags were changed, including one member of staff who said they did not know. None of the information given us by staff agreed with the only record which was available for one of the three people about when their leg bag had last been changed. One of these people became wet from urine because their catheter bag had not been managed correctly. None of the care workers we spoke with said they had been trained in catheter care. As there was no clear information about the changing of catheter leg bags, particularly as the service were using a range of agency care workers who would not know about such information, they were not ensuring people's risk of infection was reduced. By the third day of the inspection, the home manager had begun to introduce a documentation system about this.

The service was not consistently ensuring all people were given their medicines in a safe way. At lunchtime on the first day of the inspection, we saw a person who had been left with three tablets in a pot. The registered nurse said the person always asked for this to take place because they preferred to take their tablets when they wanted. The person had no information on their file about this, including a self-medication risk assessment. The service used agency registered nurses at times. They would not have had information about the person's preferences or if they had been assessed as safe to self-medicate. A person had a medicine prescribed to be given in an emergency if their diabetes was unstable. The instructions only stated it was to be given depending on their blood sugar levels, with no information about how low their blood sugar levels should be when it was given. Two people were prescribed pain killers. They did not have

instructions, including an 'as required' (PRN) protocol about when they needed support with pain relief, or a pain chart so staff could make accurate assessments if the person's pain.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, people raised a range of comments with us about staffing levels. We continued to receive comments from people at this inspection. One person told us, "They don't answer calls when I fall," another "They're not at full strength," and another, "They do come, if they have the time." An external professional told us it would "be great to have more trained staff." Staff gave us mixed comments about staffing levels. One member of staff told us their concerns related to staffing levels on nights, another member of staff told us they could not take their breaks because they were too busy and another "I think we need more" about staff. However other staff did not echo this, one member of staff told us, "The majority of the time it's good" about staffing and another said they thought there were "enough staff."

During the inspection, we observed one frail person assisting a person who was even frailer than themselves to stand up from their chair, because they had asked for assistance. This could have put them both at risk. There were no staff available in the area to support either person. Calls bells were ringing a lot of the time throughout all three days of the inspection. Staff explained the call bell system rang throughout the building, not just on the floor where the person was requesting assistance. They said this could mean some call bells were missed because staff did not know about them. The home manager said they had contacted the call bell supplier to see if this situation could be rectified. They also said they thought some of the issues related to staff not responding promptly when people used their call bells, which they were working on at present, showing us this had been brought up in a recent staff meeting. They hoped the situation would improve as they reduced their reliance on agency workers. They said had performed night inspections to assess the situation at night because of issues raised and had not identified any issues for action. The provider used a dependency tool to assess the numbers of staff needed. A review of staffing levels showed the service were working at levels consistent with this tool. As at the last inspection, people felt they were not always being listened to seriously about their concerns about staffing levels.

Although some people had felt they did not feel safeguarded, others said they felt safeguarded in certain areas. One person told us, "I feel very safe here," a person's relative told us their relative used to fall a lot when they were at home and they were "safe here." All of the staff we spoke with, including ancillary workers as well as care staff and registered nurses, were very aware of their responsibilities for safeguarding vulnerable people. One member of staff told us if they found out about any matter which concerned them, "I'd go and tell the manager," they said they "always" reported matters so they were "looked into at once." Another member of staff told us they would report any matter first to a senior care worker, then the manager, if not satisfied, they would go on to the provider's head office and the local safeguarding team. One member of staff told us there was a chart in the staff rest room which clearly set out what they needed to do and they would follow that if they had any concerns. One newer member of staff told us about how they safeguarded vulnerable people, including who to go to outside the service if necessary.

The provider was ensuring people's safety in other areas. All medicines were securely locked away. There were records of medicines received into the service, given to people and disposed of from the service. On the first day of the inspection, we observed some medicines administration rounds took a very long time. We discussed this with the deputy manager and action had been taken to address this by the second day of the inspection. Equipment used to support people, including hoists to support people's mobility, were regularly serviced. The maintenance worker regularly checked the functioning of the hot water systems and took action when necessary to rectify any matters. There were regular checks on the safety of the fire prevention

systems. The service's laundry was clean throughout, including hard to reach areas like behind the machines. New staff were safely recruited. We looked at records of six staff who had recently been employed. These showed prospective staff were assessed for their suitability. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service.

Requires Improvement

Is the service effective?

Our findings

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. 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.

The service's 're-audit action plan' of 11 October 2017 stated there was evidence that people's consent to care and treatment was regularly assessed and where appropriate recorded. Four of the people we met with were living with dementia. One of these people was very frail and found it difficult to communicate verbally, or in any other way. Three of these people had no mental capacity assessment on file although they had lived at the service for a while. One of the people did have a mental capacity assessment. This assessment stated they could make simple decisions such as what they would like to wear but was unable to make more complex decisions. This person used an appliance for their safety in connection with a medical condition, which could also have restricted their liberty. They had no best interest decision on file about use of this appliance or evidence their next of kin, who held power of attorney, had been included in any best interest decision about its use. We discussed mental capacity assessments with the home manager. They told us when they came in post in July 2017, they had identified that some work was needed to ensure all appropriate persons had mental capacity assessments. They agreed that not all work on this had been addressed. They showed us the Deprivation of Liberty Safeguards which had been put in place for the fourth person in relation to their living at the service. It was dated January 2017 and did not include reference to the appliance the person wore. It also did not document that the person's power of attorney had been involved or notified about the DoLS application.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not feel staff had been trained in all relevant areas. One person told us, "Not all staff know what they're doing." One person's relative told us, "The training's not there" for staff. People and their relatives said the service frequently used agency staff and they felt some agency staff did not have the right skills to meet people's needs. An external healthcare professional told us they felt "Wound care knowledge was very limited" among staff.

We looked at the records of two people who had pressure wounds and discussed their needs with staff. One external professional told us one of the people's wounds had deteriorated over time. They told us they found the people's records difficult to follow, this included their not being able to find the person's dressing plan to see what staff were doing. They also said wound evaluations often did not document how the person's wound was when the dressing was changed. We looked at these two people's records and found

this to be the case. Some records documented what dressing had been used, but others did not. From the records, it was not clear if wounds were improving or deteriorating. There was limited documentation about the size and depth of the wounds and type of liquid coming from the wounds.

On 9 October 2017, we met with a person who had a dressing visible on a limb. The dressing was not dated. Its condition showed there was or had been loss of stained liquid from the wound under the dressing's surface. The person was not able to tell us what had caused the wound, how long it had been there or when the dressing was last changed. On 18 October 2017, we looked at the person's files; there was no information about the person having a wound, what it was to be dressed with or any other information relating to its management. We discussed this with a registered nurse, who told us they did not know anything about this person's dressing or wound. They then dressed the wound. They told us they had found when they did the dressing that the person's wound was losing coloured liquid and needed care and treatment; they would refer it to the tissue viability nurse.

We asked the deputy manager about the training of registered nurses and senior care workers in wound care. They said they had plans to progress this in the future. We asked the home manager about how they audited people's wounds. They said they did not currently have an overview of which people had wounds and how they were progressing under treatment. After the inspection they sent us a copy of an audit tool which they said they would use for this in the future.

This was not the only clinical area where staff were not aware of relevant action to take to ensure the stability of people's medical conditions. Several of the people were living with diabetes. They also did not have clear information about how they were to be supported with their diabetes. One person had a medicines plan which gave the blood sugar ranges they needed to be within in before breakfast and supper. Their records showed their blood sugar levels were not always recorded as directed and several of the records, for example on 28 September 2017, were outside the range specified on their medicines care plan. They also had a care plan about their diabetes which stated they were at risk of high and low blood sugar levels. Their care plan only documented symptoms for low blood sugar levels, not high blood sugar levels, although the person's records showed they often experienced high blood sugar levels. The care plan did state their GP was to be informed if they had high blood sugar levels but did not state the level their GP wanted to be informed about. It did not state what actions staff were to take when the person was outside their expected ranges, such as making further checks or supporting the person in drinking additional water. The person's records did not show their incidents of high blood sugar levels had been reported to their GP, despite what was documented in their care plan. One registered nurse told us the person always preferred to use the same site for insulin injections. Over-use of one site for insulin injections can damage underlying skin tissue and affect the up-take of insulin. There was no information about regularly checking the person's preferred site for injections to observe for tissue damage. Another person was also living with diabetes. They also had no care plan about actions to take when their blood sugar levels were high.

None of the staff we met with had been recently trained in supporting people who were living with diabetes. Care workers did not know about how having a high blood sugar level might affect how a person was feeling or some of the common effects on a person's health from living with high blood sugar levels. We asked the deputy manager about staff training in supporting people who were living with diabetes. They said this was an area which they were planning to progress.

We received mixed comments about the meals. One person told us "I just don't like the food," and another "Food's the biggest issue, it is improving." On the first day of the inspection people were sitting in one of the dining rooms waiting for their meal from 12:00, by 1:00pm seven people were still waiting for their meal. When the meal started the food was cold, so staff re-heated it. They did not have a probe available to them

so they could assess it if was hot enough. We discussed our findings with the home manager and she took action to ensure people did not experience this during the next two inspection days. On the first inspection day, where people needed soft diets, we observed staff chopping up people's vegetables finely, so they could make the vegetables fork-mashable. We discussed this with the home manager and by the next two days of inspection all people on soft diets had pureed vegetables. On the third inspection day we observed one person who was on a soft diet had been given a dessert which contained some food items which had not been softened. A care worker promptly noticed this and appropriately supported the person before they put themselves at risk of choking. Although action was taken by the home manager, these are factors which should have been identified and addressed before they were observed during an inspection, to ensure effective care for people.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff worked hard to make meals a sociable time for people. At lunchtime, we noticed in several dining rooms care workers supported people in conversing with each other. Care workers offered people a selection of different drinks throughout the day and at meal times. Where people needed support from staff to eat their meals, staff sat down with them, engaging them in conversation and also carefully observing them to check they were swallowing safely. Staff consistently asked people if they were ready for their next mouthful and did not rush them in any way. One care worker told us about a person who was at risk of choking. They gently supported the person in a safe way to ensure they were not at risk. On the floor where people were living with dementia, a senior care worker was introducing systems to support people with memory loss to choose what they wanted to eat including showing them the meal choices at the mealtime. The chef showed a detailed individual knowledge of people and their dietary needs, for example they told us about a person who was a vegetarian who also did not eat fish or eggs. They said the provider's systems for buying in foods meant they could cater for all people's individual needs and preferences. The chef told us the kitchen made all their own soups and cakes up from raw ingredients. He told us how much catering staff liked serving people their meals so they could get direct feedback from people at the mealtime.

People had assessments for dietary risk. Where people were assessed as being at risk they had a care plan to outline how their risk was to be reduced. We met with an agency care worker. They told us about a person who had swallowing difficulties. They said because of information given to them they knew how the person needed to be supported to ensure they ate what they needed and wanted, in a safe way. Where people needed support with drinking enough, fluid charts recorded the amount they had drunk. However these were generally not totalled every 24 hours to enable assessment of whether people were drinking sufficient fluids over time.

Staff told us they were trained and felt supported so they could meet people's needs. One new member of staff described their induction as "Very thorough." They said they shadowed a "good deal" and had been given time to "find their feet." One of the permanent staff told us ,"Here you get all sorts of training opportunities." A different member of staff said they had been trained in all "Necessary areas," including dementia care. A domestic worker described their training in infection control and management of potentially hazardous substances. Staff confirmed they received regular supervision. One member of staff told us their supervisor liked to "make sure everyone's happy." Senior staff also supervised people during the course of their duties. One registered nurse promptly observed and took action when a care worker did not support a person to stand up from their chair in a safe way.

The deputy manager told us much of the training was on-line so staff could access it flexibly. They said some staff had fed-back that they did not like on-line training and they were accessing support for face to face

training. There was a training plan which included key areas such as safe moving and handling, fire safety and infection control. The plan enabled easy audit to see who was due for which training. The plan did not yet include all areas relevant to meeting the needs of people living at the service such as diabetes, catheter care, prevention of pressure damage and wound care. The provider followed national guidelines on the induction of new staff and there were clear records available. There was also a supervision plan and the deputy manager said they were also using group supervision because some staff preferred this. They showed us the notes of a recent group supervision which included discussions on accurate recording.

Staff called in external professionals to support people as needed. We met with a paramedic who told us staff were supportive and had given them the information they needed. We saw several people were visited by their GPs, following requests by staff. People had records of visits by external professionals. They also had records about relevant clinical treatments. Several of the people had urinary catheters. Records showed registered nurses were changing these at the frequency recommended by manufacturers and all required relevant records relating to areas such as appliance numbers were kept.

Requires Improvement

Is the service caring?

Our findings

Before the inspection, we received information that the service did not always meet people's needs at the end of their lives. We met with three people who had a diagnosis which meant they currently needed or would be likely to need end of life care. One of these people had been admitted to the service for end of life care. There was a lack of empathy shown to the person. The person found it difficult to communicate verbally or in other ways, they were also living with memory loss so could not always recall experience of pain. The service did not use a pain chart to support the person in management of their pain. There were no directives in their care plan about when pain relief should be used or increased. An external professional who was involved in their care stated the person needed strong pain relief before they were turned in bed, due to their pain, records showed this did not happen until it was identified during the inspection. There was no evidence that the service was meeting the person's other needs such as mouth care or support such as whether they wished to be on their own or wanted someone with them or music or other ways of supporting them.

Another person was documented as needing end of life care. They also had no guidance on when they needed to be given pain relief. A third person had a diagnosis about a major condition which would end their life. This was confirmed by the person's relative. This person had no end of life care plan and they had not had a review of their care plan since July 2017 to assess their current and on-going needs.

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

Some people told us the service was not caring. One person told us they did not like the way they had to "tell the carers how to care." One person's relative told us, "I don't expect anything anymore," about the care provided. A different person's relative told us "I'm worried about the care here" describing their relative's dirty underwear being left in their ensuite. Another relative told us the issues were "Small things, not important, but not what I expected" such as the person's toilet not being checked to see if it had been flushed after use. Another person's relative told us, "We're paying a lot of money for this, you expect the basics to be done."

Several people and relatives told us their concerns about care related in part to the numbers of different staff caring for them and said some staff did not know about them and their needs. One person told us they felt safe with the permanent staff but not with the agency staff because agency staff did not know them. Another person told us there were "A lot of agency staff, it can be all deserted of the people [staff] we know," a different person told us they did not receive continuity of care because "Most of the agency change all the time." One person's relative told us the agency staff did not always know what to do to care for people. Another person's relative told us they visited frequently because, "I can't rely on them" about the staff. Another person's relative told us they often supported their relative with their personal care because their relative said they did not like having different staff supporting them with this.

We saw the use of agency workers could have affected people's care. We asked an agency care worker the

name of the person who was sitting opposite them at lunchtime because the person showed clear signs of bruising. The agency worker gave us the name of a different person. We asked a different agency care worker during the late morning how a frail person was that day. They said they were not able tell us because they had not worked at the service recently. At lunchtime, we observed one agency care worker calling out loudly to permanent staff to find out which people needed softened meals. On 9 October 2017, there were five agency care workers working on the floor where people who lived with dementia were cared for, two of whom were supporting people who were assessed as needing one to one care. We looked for staff in the late afternoon on another floor. We spoke with two staff, one of whom said they were working their first shift at the service, another of whom said their English was not good enough to tell us about what we wanted to know.

We looked at records to see if the people who were living with more complex needs, who needed one to one care, received continuity of care from the same group of care workers. The service did not maintain such a record. We looked at the service's records for use of agency workers. This showed high numbers of agency staff were being used. On 8 October 2017, 95.75 agency staff hours were used, and for that week the average was 63 hours agency staff a day. We asked the home manager about the use of agency care workers, they told us, "We are trying our best to work on the off-duty to reduce agency." They also said they were recruiting more staff to work at the service.

Some staff did not always support people in their independence, in making choices and ensuring their dignity. We saw a member of staff place a napkin round a person's neck at lunchtime, without asking them if they wanted them to do this. During the late morning, a person clearly said they wanted to get up for lunch, the care workers said they were not able to do this for a medical reason. We checked with the registered nurse who said there was no medical reason why the person could not get up. The registered nurse took action to ensure the person's wishes were responded to. Several of the people who used catheters had them clearly visible, including in public places like the communal rooms. Staff did not intervene to ensure these people's dignity was preserved. One of the people had a tendency to remove some of their clothing when they were in their room. Some staff ensured their bedroom door was always closed when they chose to do this but other staff would walk past their bedroom door and not close it to ensure the dignity of the person and for the benefit of other people who also lived on that corridor.

Some areas to ensure people's confidentiality required improvement on the first day of the inspection. Before the inspection, we were told by some people that they had concerns about people's confidential records being left out in sitting areas, because they could be viewed by anyone. On the first day of the inspection, we observed this happening on several occasions. For example at 11:55am some people's records had been left unattended on a small table in one of the sitting rooms, this room had easy access from the reception area of the service. We also observed the nurses' stations, where people's records were kept were not locked, with people's records being accessible within, either on the desk or the notes cupboards, which were also not locked. We brought this up with the home manager during the inspection. We did not see such occurrences on the second two days, and the nurses' stations were always locked.

Some people commented favourably on the caring nature of the staff. One person told us staff were, "always polite," another that staff were "jolly nice." A person pointed out a care worker to us and said, "She's lovely." Another person told us about a registered nurse and they were "absolutely excellent, I wish we had a rota of her." This was also echoed by some relatives. One person's relative told us "Staff are fine here." Another person's relative told us how they had been supported to choose their relative's room, together with the person. They said they liked its aspect and the way it was laid out. A member of staff told us "I do feel we have a person-centred approach, all have choice."

We met with a person who had their breakfast in front of them in the late morning. They said this was their choice because they liked a late breakfast and they appreciated how staff let them chose to do this. One person said they preferred to sit quietly in room and were pleased this was respected and staff did not try to make them come out to do things they did not want to go to.

We saw staff being kind and supportive to people. A person was showing anxiety about when their relative was going to visit. A member of staff talked with them about this in a quiet, gentle way. Another person became confused at lunchtime, insisting it was breakfast. The member of staff with them was very kindly and supportive, helping them to become less worried. We saw a member of staff finishing caring for a person in their room. They asked them if they wanted their light on or off and listened to what they said. One person rang their bell for assistance. The member of staff who came to them was very polite and supportive. They checked the person was comfortable before they left them, using their preferred name when they talked with them. One of the domestic workers went into a person's room, they were friendly and approachable to the person, chatting with them while they emptied bins and did other domestic work. One person said they did not want to eat at lunchtime. The care worker supporting them said that was fine, they would keep their meal warm and they could have it when they were ready. Two members of staff supported a person to move from their chair to a wheelchair, they were kindly and supportive, encouraging the person throughout the time they were with them. One of the agency care workers clearly knew the person they were supporting as an individual. They told us they enjoyed caring for the person and there was clear empathy between the person and the agency worker.

Requires Improvement

Is the service responsive?

Our findings

Some people told us they were not given care which was responsive to their needs. A person's relative told us "The standards of care are not what I would expect." Three different people's relatives, who also held power of attorney for their relative who was living with dementia, said they had not been consulted about their relative's care plan. The relative of one person told us they had given the service a plan of care when the person was admitted but staff did not keep to it; they did not know about the service's care planning system. We asked the home manager about this. They said this was an area they had identified when they came in post in July 2017 and were currently planning to make sure all relevant people were fully consulted by the end of November 2017. We asked a registered nurse about how they consulted with people and their relatives about people's care plans. They said when they came in post; they found this had not been taking place for any of the people living on the floor they managed. They had started rectifying this and had made an appointment with one person's relative. They would then move on to other people's relatives. They said this process might take time because of the availability of some people's relatives.

The provider had their own established systems for people's care plans, which they used across all of their services. These involved standard care plan documents which could then be added to, to reflect individual people's needs. These tended to be quite long, so the service also used 'care at a glance' plans which were either one or two page documents. These were placed in people's rooms. We asked staff about people's care plans. One registered nurse said they did not find the provider's care plans supportive and another said they were not easily accessible and they found them hard to read. We asked care workers how they knew about meeting people's needs. One care worker said people's care plans in the office were too big and they didn't have time to read them, another said they used the 'care at a glance' plans because they were much shorter and more accessible. We spoke with four agency care workers, they all confirmed they did not look at people's main care plans, all said they used verbal reports and the 'care at a glance' care plans in people's rooms to inform them about how to meet people's needs.

The 'care at a glance' care plans were brief and did not document all relevant matters. We met with a person who had lost a limb. They had no information on their 'care at a glance' plan to state this. There was also no information on it about how the person was to be supported with their mobility in the light of this. Over all three days of the inspection, we met with another person. For two of the days, they were supported to move using a wheelchair. On the other day, they walked with a care worker next to them. We asked staff how the person was meant to be supported to move about. Two members of staff said the person could only walk a few steps and could not get from their room to the sitting room without a wheelchair. Two other staff told us the person could walk slowly if supported by a member of staff who walked by their side, encouraging them. Their 'care at a glance' care plan in their room was dated 8 October 2017, stated they walked with a frame. We did not see the person using a frame to walk with and two members of staff said they would have a difficulty in using a frame because of their living with dementia. We looked on their main care plan about their mobility. This did not include any plan about supporting the person with maintaining their mobility or the use of a wheelchair. The service were not ensuring they were responding to the person's needs by putting a care plan in place which reflected their current needs and ensuring all staff followed this care plan.

We met with a person who was showing signs of agitation, who was living with dementia. We looked at their records, they had two care plans relating to different aspects of their dementia care needs, which stated differing matters. These care plans did not reflect what was documented in the person's 'care at a glance' care plan. We asked three care workers how they had been told how to support the person if they became distressed. They told us they supported the person in the way they needed at the time. None of them had been advised of a planned approach to supporting the person when they were agitated such as distraction, giving them a drink, taking them for a walk or sitting with them in a quiet place. The lack of a responsive care planning system meant the person was at risk of receiving inconsistent care which did not meet their needs.

One person's records showed they had a history of high blood pressure which could affect their health. The provider's standard care plan set out that the blood pressure range aimed for needed to be documented. The person's care plan did not document a range, and stated only one level. The person's care plan did not document what registered nurses needed to do if the person's readings fell outside the level documented. This had happened in June and September 2017. We asked registered nurses how they responded to the person when this had happened. They said they were not aware of those readings or of actions they were to take to respond to the person's needs.

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

We received mixed comments about how the service responded to complaints. One person told us, "It's no good complaining, they don't do anything about it," another said they "Never see the manager," so they could bring things up with them. Another person told us there had "been a few issues, I like to be up early in morning" but this did not always happen because agency staff did not know about this. One person's relative told us they had complained verbally to the home manager about a particular matter and had needed to chase them up to find out what was happening, they had not received a written response. Another person's relative told us, "You repeatedly have to follow things up to get them done." This was not echoed by other people. One person told us, "They do take notice of what you say", they told us they had complained about the food not being hot enough and "now it's almost too hot." Another person told us "The manager comes round, she's been quite a help."

One person told us they had a concern and they wanted to talk to the home manager about it. The home manager went to see the person, listened to what they said and took action on what the person told them about. Another person told us about an issue they had raised with staff. We looked at the service's complaints records. We saw the matter had been documented and there was clear evidence of relevant actions taken following the matter. The records in the complaints folder showed the manager had received complaints about a range of areas. They had responded to them in accordance with the provider's policy and had made an apology where relevant. They had also developed action plans to address issues. However, the complaints record showed that some matters where people felt they had raised matters had not been documented. This meant they had not been followed up by the home manager. This is an area that needs to be improved to ensure people's complaints were consistently listened to and action taken.

People gave us positive comments about the activities provided. One person told us how much they liked the sing-alongs. Another said they did enjoy watching "Strictly Come Dancing" together with other people on the large screen downstairs. Another said they missed the summer because of what they had been able to do outside in the garden. We observed people being supported with a wide range of activities, including large group, small group and individual activities. Activities lasted for different periods of time because some people had difficulties with concentrating for longer periods, while others did not. Activities staff were on duty seven days a week, so people continued to be supported at weekends. We watched one of the activities workers sitting quietly working on a puzzle with one person, supporting them with finding pieces and

concentrating with what they were doing. The person clearly enjoyed doing this activity. We observed a larger group where an external person had brought in a range of small animals for people to look at and handle. Several people said how much they had enjoyed this activity, including handling spiders and a snake.

We met with two of the three activities workers. They were very enthusiastic in their roles and clearly knew people well. One of them told us about a person who could become anxious. They told us the person became calmer if the activities worker read poetry to them. They also told us about supporting a person who they had found liked stringing beads. This activity helped them with colour recognition and dexterity. They told us about a person who did not like loud noises, so they had to carefully plan which films they might want to watch on the big screen, so they did not become distressed. They knew about people's family circumstances and said they involved them as much as possible. They told us about a person whose family lived abroad and how they supported them by reading out weekly letters sent to them by a member of their family. They said they were aware some men might find some activities were too female based and were planning to start a 'men's' group in the near future.

The activities staff kept clear assessments of people's needs, which they updated as they found out more about people and what they liked to do. They recorded what activities people had been to and the benefit for them. For example a person told them they had enjoyed ballroom dancing in the past. Activities documented for them included activities which were dance-based. Their record documented which activities they had enjoyed and had been beneficial to them and which were not, so activities staff could more effectively target how they supported the person.

Inadequate

Is the service well-led?

Our findings

We received mixed comments about if the service was well-led. One person told us, "I've paid a lot of money to be here, I don't get value for money from it" and another, "In the main it's good, but I've been in better ones." A person's relative told us, "He's paying a lot for his care, he's paying premium rates, I'd like him to get premium care," and another described the provider as "complacent" and "apathetic." We also received mixed comments about the home manager. One person told us, "The manager is shut away and doesn't come out of her office" and another described the home manager as "defensive." This was not echoed by other people. One person told us, "It's more organised since the new manager came" and another described the home manager as a "competent person". A person's relative described the home manager as, "very good" and another described her as, "very approachable," they said they were pleased the home manager had "got plans" for making improvements to the service.

The home manager performed regular audits of the service and the service was also visited by a senior manager from the provider every month, who performed an audit and produced a report. Neither audit systems had been effective in identifying a wide range of areas which needed to be addressed. The provider's systems had not identified that NICE guidelines were not being followed in relation to prevention of pressure damage for people and changing people's catheter leg bags. Their systems also not identified that the service did not complete an audit of people's wounds so they could assess progress of treatment plans. They had not identified that care plans were not clear and were not being followed in a range of areas, including when people were at the end of their lives, living with diabetes and had mobility needs. The home manager did introduce a range of developments during and after the inspection to address some of the areas we identified, however the lack of identification or action on such matters before the inspection meant people could be at risk to their health and well-being.

The home manager told us they had identified that they needed to take action to ensure the Mental Capacity Act (2005) was followed and that all people were involved in developing their own care plans. However we found a wide range of cases where this had not taken place. None of these matters had been documented in either the provider or home manager's audits or clear action plans developed so the involvement of people could be ensured.

The service had been rated as requires improvement under the well-led domain the last inspection, and a number of issues identified, particularly people's concerns about staffing. During this inspection we again received a range of comments from people about staffing and response times to the call bell system. Despite this, there was no evidence in audits that this had been reviewed, or audited in an effective way, to assess if people felt improvements had been made, or plans put in place to address people's responses, if they felt improvements had not been made. The home manager confirmed the call bell system used in the service could give a print-out of times taken by staff to respond when people used their call bells. Despite this, responses to call bells were not included in their systems for audit, to identify issues and take action if relevant.

During the inspection we found a range of people's assessments and care plans had not been reviewed

when relevant and people's care plans which were not accurate. The home manager reported that such matters were audited during their 'resident of the day' reviews. These systems had not been effective in ensuring relevant action was taken. One person had a risk assessment dated 29 July 2017, which stated they were at high risk of falling. The provider's systems had not identified that this person's risk assessment had not been reviewed since that date and that there was nothing in the person's care plan to identify how their risk of falls was to be minimalised, while continuing to support their independence. Another person used an aid to ensure their safety. We saw staff support the person in wearing it in different ways during the inspection. The person's care plan did not document how the person needed their aid to be fitted so they wore it in the way intended by the manufacturer. The auditing systems had not identified that this person's care plan did not clearly set out how they were to be supported, until we identified the issue.

Some matters were not identified, or where they were, relevant actions to address were not taken. During the inspection, we identified a discrepancy in the controlled drugs record. This had not been identified by the service's systems of audit before we identified it. The deputy manager did perform a review after the inspection and sent us a report of actions taken. When we went into the laundry, there was a large receptacle of un-named clothes, there was also a large table-top with people's un-named closed piled on them. We looked at the audits and saw this matter had been identified during the last two audits. The systems used had not identified that the action to address the issue had not been effective in insuring people, particularly people who were living with dementia and may not recognise their own clothing, had their own belongings returned to them.

The home manager did perform a review of when people fell. We were given the audit for September and beginning of October. The audit was not accurate. A person had fallen in September and sustained a major injury which had required admission to hospital, however the September audit we were given did not include this person's fall. A person had fallen in early October, this person's injury was not included in the October falls audit. The audit did not include review of factors such as what time of day the accident or incident occurred to assess if people sustained injuries more commonly at certain times of the day. The home manager did not audit where people had sustained minor injuries such as skin tears and bruising. Due these factors the provider and home manager could not identify common themes or trends and use such information to reduce risk to people.

A person's relative described the service's documentation as "very poor." We found some records were not completed when needed. On 9 October 2017 a person had a dressing which needed attention on a limb. When we looked at their records on 18 October 2017, the person had no records about their wound or treatment needed. A person had fallen on 4 October 2017. On 9 October 2017, they had clearly visible bruising and some bruising was still visible on 18 October 2017. The person had no body map or other records in their file to show the progress of the person's bruising over time, so their condition could be monitored appropriately.

Other people's records were not completed at the time support was given, so may not have been accurate. On 17 October 2017, we looked at the records of a person whose condition was meant to be reported on every hour, they also had their fluid intake documented. At 12:10pm the last record in their records of support were for 8:00am and last drink at 7:00am. When we looked at their records at 3:00pm, a full record had been completed of the hourly interventions and fluids given throughout the morning. However as they were not documented when the person was supported there was a risk they may not have been fully accurate. On the 18 October 2017, the situation remained for the person's fluid intake record, although we had seen the person being supported to drink. On the first day of the inspection, we saw a person who had sustained a recent skin tear. There was no record of when this had happened. A record relating to this had been introduced for the person by the second day of the inspection but as it had not been completed at the

time it occurred, it may not have been accurate. Some other records were inaccurate. We observed a person who ate only a very small amount of their lunch. They told us they had not liked it. However their daily record stated they had eaten their lunch well.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The service currently did not have a registered manager. The current home manager told us they had been appointed in July 2017 and were in the process of applying to us to be the registered manager for the service. The home manager was supported by a deputy manager who had been in post since the service opened in February 2016. The home manager told us they were in the process of appointing registered nurses who would take on responsibility for each of the three floors of the service. Each registered nurse would be supported on each shift by one senior care worker or more. The service employed care workers, activities workers and ancillary workers, a team of catering workers and a maintenance worker, as well as administrative staff. The home manager was supported by an area manager. The previous area manager had left their post during the summer of 2017. There was a new regional manager who had recently been appointed. Because Caring Homes Healthcare Group Limited is a large provider, the home manager could also receive support from other departments within the provider including human resources, clinical management and facilities.

We asked staff about the culture of the service. We received mixed replies. One member of staff told us they had brought up issues about the situation at the service. They had been listened to but they felt nothing had happened after that. Two members of staff told us that when senior managers came from the provider they did not feel they were asked their opinions about what was happening in the service. Several members of staff told us one of the main issues about care provision was the high turnover in staff. None of the staff felt high turnover of staff related to anything specific do with the service, more a combination of the rates of pay all providers were currently able to pay, the hours some staff felt they needed to work to ensure their standard of living and because the work could be tiring at times. None of the staff we spoke with felt staff turnover related a lack of support for training and development from the provider. Several staff said they could bring issues up at supervision, and during staff meetings and felt they would be listened to. Two members of staff said if they could not attend staff meetings, minutes were made available so they could keep up to date with changes. The minutes of a recent staff meeting showed a representative from the provider's human resources department had attended to answer staff queries. The minutes also showed some staff meetings were held at a time when night staff could also attend and several of the night staff had done this.

The home manager had recently been successful in recruiting some experienced and very enthusiastic staff. One of them told us they were keep to develop a 'person-centred' approach to providing care. Another told us how much they were enjoying working in the service and found it pleasingly different from other areas they had worked in. They said they were enjoying the challenge and being part of a team. These staff also said they were keen to push forward improvements in the culture of the service to ensure people's individual wishes were known about and supported.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring the care and treatment of people was appropriate, met their needs, and reflected their preferences. This was because they were not carrying out, collaboratively with the relevant person, an assessment of the person's needs and preferences for care and treatment or designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's care and treatment was not being provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not being provided in a safe way because the provider was not doing all that is reasonably practicable to mitigate risks to people, ensuring that staff providing care or treatment to people users have the qualifications, competence, skills and experience to do so safely. They were also not ensuring the proper and safe management of medicines or assessing the risk of, and preventing, detecting and controlling the

spread of, infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment because the systems and processes to prevent abuse of people did not operate effectively and ensure, upon becoming aware of any allegation or evidence of such abuse, this was appropriately investigated according to their own policies.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems did not operate effectively to assess, monitor and improve the quality and safety of the services and monitor and mitigate risks relating to the health, safety and welfare of people who may be at risk. The provider was also not maintaining securely an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment.

The enforcement action we took:

Positive condition