Mr & Mrs R S Rai

Kingsley Cottage

Inspection report

40 Uxbridge Street
Hednesford
Cannock
Staffordshire
WS12 1DB

Tel: 01543422763

Date of inspection visit:
07 February 2017

Date of publication:
27 March 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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 7 February 2017 and was unannounced.

Kingsley Cottage provides accommodation for up to 17 people who require accommodation and or personal care. On the day of our inspection visit, there were 17 people living at the home, some of who were living with dementia.

We had previously inspected the home on 24 March 2016 and rated the home as requires improvement overall with specific concerns about the safety of the home's environment, how the staff supported people who needed help with decision making and the effectiveness of the systems used to assess, monitor and improve the quality and safety of the service. We received an action plan from the provider which said the improvements would be made by July 2016. At this inspection we found the provider had not made all of the improvements they told us they would make. We also found improvements were needed in other areas including the administration and management of people's medicines and the risks associated with people's care.

We saw that some improvements had been made to the home's environment but we identified ongoing concerns regarding the management of the service. There was a lack of effective governance and managerial oversight of the service. Steps to ensure the health and safety of people and others were not always considered and risk assessments had not been developed for all areas of identified risk. The registered manager had introduced audits for medicines, but these had not been effective in identifying the concerns we found with the storage and administration of medicines.

Risks associated with people's care had been assessed but management plans were not always followed to ensure any identified risks were minimised. People felt safe at the home and sufficient numbers of suitably recruited staff were available to meet people's needs. Staff understood their responsibilities to keep people safe from the risk of abuse. Staff received training and support to meet people's needs and felt supported by the registered manager.

Further improvements were required to ensure the provider and registered manager consistently followed the requirements of the Mental Capacity Act 2005 where people were unable to make certain decisions for themselves. Staff sought people's consent and encouraged people to make choices about their daily routine to promote their independence. People accessed the support of other health professionals when needed.

Staff treated people in a kind and compassionate manner but at times, they did not always treat people with dignity and respect. People were not always supported to have an enjoyable mealtime experience and some people's individual needs were not met.

People were not always offered opportunities to join in social activities and follow their hobbies and

interests. People were encouraged to maintain important relationships and visitors were made welcome.

People knew how to raise any concerns and complaints and were kept informed about things that were happening in the service. However, the provider did not routinely seek people's views on how the service could be improved.

The provider was not meeting some of the requirements of their registration with us. They had not displayed their performance rating as required and had failed to notify us about a safeguarding concern referred to the local safeguarding team.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

The provider had not made the required improvements to ensure the home's environment was assessed, monitored and maintained to ensure people's safety and wellbeing. Further improvements were needed to ensure people's medicines were managed safely. Risks associated with people's care had been assessed but management plans were not always followed to ensure any identified risks were minimised. Sufficient numbers of suitably recruited staff were available to meet people's needs. Staff understood their responsibilities to keep people safe from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered manager had made applications to ensure people had the correct legal authorisations in place where people were deprived of their liberty to keep them safe. However, further improvements were needed to ensure people were supported to make decisions where they lacked the capacity to do so for themselves. People were not always supported to have an enjoyable mealtime experience and some people's individual needs were not met. Staff were trained and supported to meet people's needs. People were supported to access health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw that staff were kind and caring but at times people were not treated with dignity and respect. Staff had a good rapport with people and encouraged people to make choices about their daily routine and be as independent as possible. Visitors were made welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care. Some activities were available for people, but the provider had not ensured that people could follow their hobbies and interests to ensure their social needs were met. There was a complaints procedure in place and people knew how to raise concerns and complaints but had not felt the need to do so.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not made the required improvements following the last inspection and did not have effective governance arrangements in place to continually monitor and improve the service, and ensure the home's environment was safe for people. The provider had failed to display their performance rating and had not ensured that notifications were sent in relation to safeguarding concerns. There was no evidence that the provider had taken people's views into account in the planning of the service.

Kingsley Cottage

Detailed findings

Background to this inspection

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

This inspection took place on 7 February 2017 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we had received from the public and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We spoke with the service commissioners who are responsible for finding appropriate care and support services for people, which are paid for by the local authority. On this occasion, we had not asked the provider to complete a Provider Information Return (PIR). 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. However, we offered the provider the opportunity to share information they felt was relevant with us

We spoke with seven people who used the service, three relatives, and three members of the care staff, the cook, two visiting health care professionals, the deputy manager, and the provider. We did this to gain views about the care and to ensure that the required standards were being met.

We spent time observing care in the communal areas to see how the staff interacted with the people who used the service. Some of the people living in the home were unable to speak with us in any detail about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

We looked at the care records for five people to see if they accurately reflected the way people were cared for. We also looked at records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements were needed to ensure the provider carried out effective checks to ensure the home's environment was safe for people. At this inspection, we noted that some steps had been taken to make improvements, for example, a new bathroom was being installed and the provider had sourced a company to test the hot water system for legionella bacteria. However, no checks had been carried out at the time of our inspection which meant the provider could not be sure that any risks were being minimised. The provider had not addressed other potential risks identified at the last inspection. For example they had not fitted a lock to the cylinder cupboard in the first floor bathroom, which meant people could access the area. We saw that items such as a toolbox were being stored there which could cause people harm. We found that no checks were being carried out to ensure the water temperatures on the washbasins, showers and baths were at a safe temperature. This meant the provider could not be sure the temperature regulation systems were effective in protecting people from the risk of scalding or burns.

We found further areas of disrepair in the home. The flooring in one of the corridors was very uneven and presented a trip hazard. We saw two toilet frames in the ground floor toilets were rusty and posed a risk of cross infection. A badly fitting toilet frame was being used as a temporary toilet seat in the staff bathroom. Staff told us the seat had been broken for a few days, which was a concern as people were being showered in this bathroom whilst the new bathroom was being installed and meant it was not be safe for use. The action plan submitted to us following our last inspection stated that there was a log for staff to record any faults or repairs, which would be audited on a monthly basis to review the status of any required improvements. None of these issues were recorded and there was no action plan in place to make the improvements. This showed the provider had not improved their systems to ensure they could identify and address environmental and equipment issues which would affect the care and safety of people who used the service.

We found the provider did not have a suitable approach to the assessment of risks relating to emergencies that could occur in the home. We saw they had carried out individual assessments to ensure that people could be safely evacuated in the event of an emergency such as a fire. However, since the Fire Safety Officer had visited in 2011, they had not carried out an annual fire risk assessment to ensure the control measures in place remained effective. We saw that the provider had maintenance contracts in place and the fire alarm and emergency lighting systems were serviced on an annual basis. However, there was no evidence that the provider carried out checks on an ongoing basis to ensure that any faults could be reported and repaired promptly. We saw the lift was inspected on an annual basis. However, the last two reports showed that the contractor had recommended the need for improvements and repairs, some of which made reference to Health and Safety Regulations, for example installing safety barriers and emergency lighting in the event of a power failure. The provider told us these were only recommendations and they had addressed these with their insurance company. However, they had not contacted the Health and Safety Executive to check that their actions were sufficient and met their regulations to ensure the lift was safe for people.

These issues are a continued breach of Regulation 12 (1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we asked the provider to make improvements to the storage of medicines and to ensure staff had appropriate guidance when people were prescribed medicines on an 'as and when required' or PRN basis. At this inspection, we found some improvements had been made but found new concerns which meant action was still required. We found that the provider had made improvements and introduced PRN protocols to enable them to support people who received PRN medicines. However, these were not sufficiently detailed, for example they did not provide the information staff would need to identify that a person was in pain. Whilst discussions with staff demonstrated they knew people well and understood their body language, improvements were needed to ensure staff who did not know people well understood their needs

We observed the deputy manager administering medicines and saw that they locked the medicine cabinets and office at all times to prevent people accessing them. However, not all medicines were being stored in the medicines cabinets. We found a supply of insulin and sharps had been left in the care plan cupboard which was not locked. We found that appropriate action had not been taken when the medicines fridge became faulty. The records showed that the fridge had been faulty for four days. Although a replacement had been ordered, the deputy manager told us that they had not considered the need to destroy and reorder the medicines being stored, which included insulin and eye drops as a precautionary measure. This meant people were not being protected from the risks of medicines that had not been stored in accordance with the manufacturer's recommendations.

This is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who could tell us their views were happy that they received their medicines when needed. We saw the member of staff administering medicines spent time with people to ensure they had taken their medicine before leaving them. Staff received annual training to administer medicines and had their competence checked periodically by the registered manager.

People we spoke with told us they felt safe and were happy with how the staff supported them. One person said, "It's all alarmed here, everyone has to sign in to say who they are, you can't have just anybody strolling in". Relatives felt their family members were safe and well cared for. One relative told us, "I do feel [Name of person] is safe". Risks associated with people's care had been assessed and plans were in place to minimise any identified risks. Although staff understood people's individual risks, we found that on occasions these plans were not always followed. For example, where people were supported to move using wheelchairs, we saw that footplates were not always used by staff and for one person we had to intervene to ensure the person was moved safely.

Staff we spoke with told us that they received training in safeguarding and understood their responsibilities to protect people from harm. Staff recognised the different types of abuse and knew how to report abuse if they suspected it. All the staff we spoke with were confident that any concerns they raised would be acted on but told us they had the information they needed to escalate their concerns to the local safeguarding team if necessary. At the last inspection, we had concerns that the registered manager had not always understood their responsibility to report any concerns to the local safeguarding team to keep people safe from harm. At this inspection, we found they had made a referral to the local safeguarding team. However, we found this had not been reported to us as required by their registration with us. We have referred to this in the well led section of this report.

People and their relatives had no concerns about the staffing levels at the home. One person said, "I don't have to wait long for support and if I press my buzzer in my bedroom, staff come very quickly". A relative said, "There are plenty of staff, if people call, someone will always come". We saw there were enough staff available to meet people's needs. Most of the staff had been working at the service for some time and any additional cover for sickness and annual leave was generally provided by the staff who worked in the service. On the morning of our inspection, there was an emergency at the home and the deputy manager was busy with paramedics. The provider arranged for an additional member of staff to come in for a few hours to ensure people's needs were met. This showed staffing levels were kept under review to ensure they met people's needs at all times. At our last inspection we found that all the necessary recruitment checks had been carried out and no new staff had started working at the service since then. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, the provider was in breach of Regulations 11 and 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We found that the registered manager was not acting in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where decisions were being made on behalf of people in their best interests. The 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 people 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, some improvements had been made and people's capacity to make certain decisions had been assessed. However, this had not been done consistently and mental capacity assessments where not always in place where needed. For example, one person's relative had signed to consent for them to have a flu vaccination and another person's family had given consent for their relative to have a sensor mat in their bedroom. This was to alert staff when they got out of bed because they were at risk of falls. Capacity assessments had not been carried out to show that the people were unable to make the decisions for themselves and there was no information to demonstrate that the decision had been made in their best interest.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had made applications for approval where people were being restricted to the home's environment for their safety. However, capacity assessments were not always completed to confirm that people were unable to make the decision about their safety. Staff had received training in MCA and DoLS but they showed varying degrees of understanding of the legislation. For example, some staff demonstrated an understanding of how people were restricted from leaving the home because there was a DoLS in place but one member of staff confused a mental capacity assessment with a mental health assessment.

These issues demonstrated there was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified some staff did not fully understand MCA and DoLS, we found that staff received training and support to meet people's individual care needs. Staff told us and records confirmed that regular training was provided in areas that were relevant to the needs of people living in the home. The registered manager monitored training to ensure their skills and knowledge were kept up to date. There was an induction programme for new staff, which included shadowing experienced staff to get to know people and their needs. Staff told us they completed nationally recognised qualifications and were

encourage to develop their skills further. One member of staff told us, "The training here is so much better than in my previous job. We can do any subject we wish; I've done diabetes". Staff told us they had supervision with a senior member of staff or the registered manager at least every six months. One said, "We sit and talk over any problems; there's a checklist we cover which includes looking at any training we need.

We saw that some people were not supported to enjoy a positive mealtime experience because risks relating to their dietary needs were not always well managed. For example, one person was assessed to be at risk of choking. Their care plan stated that they should have a fork mashable diet, with any crusts removed from bread and to be seated upright whilst eating. They should also have thickened drinks. However, the person remained in their recliner chair throughout the day and was not supported to sit up during meals. At lunchtime, we saw their drink had been left in front of them for some time and the thickener had sunk to the bottom, which meant it was not suitable for them to drink. We had to draw a member of staff's attention to this to ensure they replaced it. At tea time the person was served a sandwich, with the crusts, and a packet of crisps. We saw that the person coughed repeatedly whilst eating and we had to ask staff to come to support them. The deputy manager told us the person's chair was broken but there was no record of any action taken to provide a more suitable replacement. Another person was asleep through the lunchtime service and was left with their meal in front of them for more than an hour. Staff tried to gently wake the person on a number of occasions. The deputy manager told us, "This is quite normal, [Name of person] usually just wakes up and starts eating". However, no consideration had been given to supporting the person to receive their meal at a different time.

People told us they enjoyed the food at the home and we saw they were offered a choice of meals and drinks. However, people were not always given the choice of adding seasoning to their meals. Tables were not laid up with condiments and a member of staff walked between the tables asking if people wanted salad cream. The deputy manager told us, "Most people would not understand that lots of salt isn't good for them". We saw that lunchtime was not a sociable experience. Where people received assistance to eat, staff did not always engage with them which meant their conversation was limited. We saw one member of staff continued to offer a person more food even though they had made it clear they'd had enough.

This is a breach of Regulation 14 the HSCA 2008 (Regulated Activities) Regulations 2014.

We saw that people accessed the support of other health professionals including the GP, district nurse and optician. We spoke with visiting professionals who were positive about the staff and told us they escalated any concerns to them to ensure people's changing needs were met. One said, "There is good communication. Staff know people well and know about actions to take". One person told us, "I see the specialist nurse for my condition regularly; the provider is taking me to an appointment today, they are really good like that". This showed people were supported to maintain good health.

Requires Improvement

Is the service caring?

Our findings

People who could give us their views told us the staff were kind and caring and treated them with respect. Comments included, "The staff are kind and treat us well", and "I'm happy with things". Relatives told us the staff knew people well and created a homely environment. One said, "It's a small home, the staff have time for people". Another said, "I'm happy with [Name of person's] care. It's lovely and cosy here and the staff are all great". However, we found that staff did not always respect people's dignity when they supported them. We saw that a person's dignity was not maintained when they were supported to transfer from the armchair to go to the bathroom. We saw the person was left in the middle of the lounge on the equipment and waited for five minutes for a member of staff to take them to the bathroom. Staff did not always support people to maintain their appearance to promote their dignity. People were not offered clothes protectors or napkins at mealtimes, although we saw they were available. One person was not positioned closely enough to the table and spilt their dessert down their clothes. We had to call a member of staff to ask them to assist the person to change their top as they became distressed.

At other times, we saw staff respected people's dignity and respected their privacy. We observed they knocked on people's bedroom doors before entering and asked people for their consent and explained what they were doing before supporting people. One person told us, "The staff always knock and they always take us to our rooms for personal care and cover us up to keep our dignity".

We saw staff had a good rapport with people. Staff acknowledged people when they came into the room, for example we heard a member of staff asking people how they had slept when they first came on duty. We saw staff looked comfortable in the company of staff and heard laughter and banter between them.

Staff encouraged people to have choice over how they spent their day. People told us they chose what time they got up and when they settled for bed. One person said, "I normally get up at about 6am as I've always been an early riser; the staff know that". People told us the staff encouraged them to be as independent as they wished. One said, "The staff encourage me to walk around the home as much as possible".

People were encouraged to maintain their important relationships. One person told us, "Visitors are made welcome, they get a cup of tea when they walk in". We saw staff chatted with people's visitors and knew them well. One relative told us, "I can visit whenever I want".

Requires Improvement

Is the service responsive?

Our findings

We found that people did not always receive person centred care that met their individual needs and preferences. People's needs had been assessed before they moved into the home and the information was used to draw up a care plan, which included information about their likes, dislikes and preferences. However, we saw that people's preferences were not always followed or when changes occurred, the care plans were not updated to reflect changes. For example, one person's care plan stated that they should be encouraged to walk using a frame to promote their independence. We saw that staff supported the person to move using a wheelchair which was too large for them. The deputy manager told us the person sometimes preferred not to walk but the registered manager had not sought advice, for example from an occupational therapist, to ensure they were being safely supported and their independence promoted. The person's family told us they were planning to purchase a smaller wheelchair which meant the service was not responsive to the person's individual needs .

Another person preferred not to follow the advice of the speech and language therapist to have thickener in their drinks to minimise the risk of them choking. The deputy manager told us they respected the person's wishes. Whilst this showed the staff were balancing the needs and safety of people with their rights and preferences, the person's care plan had not been updated to reflect their preferences for how they wanted to receive their care and ensure their safety had been considered.

Some people told us there wasn't enough to do. One person said, "I get fed up of sitting here". Another person said, "I feel restricted sometimes, I'd like to get out more". We saw that people's life history and their hobbies and interests had been recorded in their care plans but this information was not used to support them to engage in activities that met their preferences. For example, staff were aware that one person liked to listen to classical music but they were not supported to follow this interest. Another person's relative told us their relation grew up in the countryside, "They miss the fresh air". Although they told us the staff sometimes took them to the front door for some fresh air, they had not asked the person how they would like to be supported, for example if they would like to go into the garden at the home. People told us they sometimes played bingo and singers came to entertain them every couple of months. We saw that some people were having their nails done but for large parts of the day, there was little stimulation for people. The deputy manager told us they did not have an activities co-ordinator. Staff encouraged people to engage in activities when they had time but there was no set programme of activities. This showed people were not always supported to follow their hobbies and interests and engage in activities that met their individual preferences.

People told us they felt able to raise any concerns or complaints with the registered manager, staff or the provider but had not had cause to do so. We saw there was a complaints procedure in place and the deputy manager told us there had been no complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection, the provider was in breach of Regulation 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements to their quality assurance systems to ensure shortfalls were identified and improvements made where needed. There were no clear arrangements in place to determine the roles and responsibilities of the registered manager and provider. We found improvements were needed to the home's environment, to the management of medicines and to ensure records were well organised, and people's personal records were stored securely. Although the provider shared with us their action plan detailing how they would meet the regulatory requirements, we found the improvements they told us they would make had not been fully achieved. Where improvements had been made, these related to the introduction of weekly medicines audits, however these had not been effective in identifying the concerns we found with the storage and administration of medicines.

At this inspection, we found there was no consistent approach to ensuring the environment was safe for people and that equipment was maintained in good order and replaced when needed. The provider did not have a suitable approach to the assessment of potential emergencies at the home, for example fire, and recommendations for repairs to the lift had not been assessed and a risk management plan put in place to demonstrate that it remained safe for use. We were aware that the provider had failed to act on the recommendation to carry out a fire risk assessment following monitoring visits by the Local Authority in September and November 2016.

Improvements had not been made to monitor accidents and incidents for any patterns and trends to ensure action could be taken to prevent reoccurrence. We found that records were not always completed accurately, for example, details of investigations carried out and actions taken were not always recorded and did not always identify if referrals had been made to Local Authority safeguarding team or notified to ourselves. This meant we could not be sure that appropriate action had been taken.

The provider's action plan stated that weekly audits would be introduced to check the accuracy of people's care plans but we saw these had not been carried out. In addition, the provider had not taken action to ensure that people's care records were stored securely because they were in an unlocked room, which meant personal information was not being protected.

People were aware of the refurbishment work that had started at the home but we found the provider was not seeking people's views on how the service could be improved. For example there had not been any relatives or residents meetings recently. This meant there was no evidence to demonstrate that the provider was taking people's views into account in the planning of the service.

We discussed the lack of improvement with the provider. They told us the demands of the day-to-day running of the service had meant they did not always have time to focus on the management tasks to deliver the required improvements. They told us they would meet with the registered manager to discuss and agree

clear management arrangements. These issues demonstrate the provider had failed to effectively assess and monitor progress against their action plan to improve quality and safety for people. The provider and registered manager We remain concerned that the provider and registered manager have therefore failed to demonstrate a clear understanding of the principles of good quality assurance, to drive improvement. This is a continued breach of Regulation 17(2)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection, we found the provider and registered manager did not understand their responsibility to notify us about important events that occur at the home, in accordance with the requirements of registration with us. At this inspection, we found that the provider and registered manager had not ensured there was a consistent approach to making notifications to us and had failed to inform us about a safeguarding incident at the home. Whilst discussions with the provider and deputy manager demonstrated that appropriate action had been taken, we must be notified of such events so that where needed, we can take follow-up action.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

We saw that the provider had failed to display their performance rating following the last comprehensive inspection in March 2016, despite guidance being readily available on the CQC website. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

This is a breach of Regulation 20A of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke were positive about the support they received from the registered manager. One member of staff told us, "We all work well together, it's a nice place to work". Staff told us they had regular staff meetings with the registered manager and were asked for their views on how the service could be improved. However, one member of staff told us they regularly raised concerns with the provider about the need to invest in the home but resources were not always made available to ensure repairs were actioned promptly.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us about a safeguarding incident at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions for themselves was not being assessed where needed. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have systems and processes to ensure the premises and equipment were well maintained and safe for people. Regulation 12(1)(2)(d) The provider had not ensured the proper and safe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to make sure that people's assessed nutritional needs were met. Regulation 14(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and improved. Regulation 17(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed their performance rating at the service.