Gilead Care Services Ltd

Gilead House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Gilead House is registered to provide accommodation and personal care for up to 22 people. There were two people living at the service at the time of our inspection.

People's experience of using this service:

The recruitment of staff was not robust which left people at risk. Risk assessments were not always up to date or accurate. People's evacuation plans contained a lack of information about the needs of people. Safeguarding concerns were not always investigated or reported to the Local Authority.

There were however good infection control procedures in place and people received their medicines in a safe way.

Although people's weights were being monitored, staff were not always aware of the dietary needs of people. People were not always offered snacks in between meals when they said they were hungry. There were aspects to the environment that required improvements.

There were times during the inspection where staff could have been more attentive, caring and dignified towards people. We did see occasions where staff acted in a kind way and relatives fed back that staff were considerate to their loved ones.

Activities needed to be more person centred and outings were not happening as often as people would have liked. Care plans were not always detailed around the needs of people particularly those with health care conditions. End of life care planning needed to be more detailed.

There had been a lack of leadership at the service. The provider had failed to have robust oversight of the service. Quality assurance was not effective in identifying shortfalls. Where shortfalls had been identified there were insufficient actions plans in place to address this.
Staff told us that they felt supported and valued. We saw that they had undertaken training and had one to one discussion with their manager.

Rating at last inspection:
At the last inspection the service was rated Requires Improvement (the report was published on the 5 July 2018). This latest inspection was partly prompted by an incident which had a serious impact on a person using the service and that this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. Prior to the inspection we also received concerns that related to the safety of care at the service. We wanted to follow up on breaches of regulation that were identified at the previous inspection.

Enforcement:
We have identified breaches in relation to the safety of care provided to people, the recruitment of staff, how records are kept and the lack of robust oversight.

Follow up:
We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

Please see the 'action we have told the provider to take' section towards the end 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 always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Gilead House

Detailed findings

Background to this inspection

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

Inspection team:
● Our inspection was completed by two inspectors and an inspection manager who was there to support the inspection.

Service and service type:
●This service is a care home that provides personal care to older people some of whom are living with dementia. Gilead House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
● On the day of the inspection there was a manager that had submitted an application to the Care Quality Commission to be registered. Once registered this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
● Our inspection was unannounced.
● The inspection took place on the 29 April 2019.

What we did:
●Our inspection was informed by evidence we already held about the service including feedback we received from members of the public and local authorities. We checked records held by Companies House.
● We reviewed the Provider Information Return. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

● We briefly spoke with two people who used the service and observed care that staff provided to them.
● We spoke with the manager and four members of staff.
● We reviewed two people's care records, medicine records, audits, recruitment records for three staff and other records about the management of the service.
● We requested additional evidence to be sent to us after our inspection that related to policies used at the service. This was received, and the information was used as part of our inspection.
●After the inspection we spoke with two relatives of people.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment:

- The provider was not operating an effective and safe recruitment practice when employing new staff. There were gaps in staff employment that had not been explained. In one recruitment file there was no work history for a member of staff. This was despite the providers recruitment policy stating, "Check work history, note and investigate all periods of no work." There was no evidence that this had been done in five of the recruitment files that we looked at.
- References for staff were not robust. For example, one member of staff only had one reference, and this was from their family member. One member of staff's background checks were not undertaken for more than a year after working at the service.
- Disclosure and Barring Services checks were carried out on all other staff to confirm whether prospective new staff had a criminal record or were barred from working with people.

As the recruitment procedures to ensure that staff employed were fit and proper were not robust this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were not always enough qualified and experienced numbers of staff on duty at night. We were told by the manager and staff that at night there needed to be one waking member of staff and one asleep that could be called upon to provide care in an emergency. However, we saw from the rotas that the 'sleep in' was often a member of staff that was not trained to provide care. A senior carer told us, "I didn't know they [the sleep in] would have to be a trained carer." After the inspection the manager sent us rotas to show that the providers were going to provide the sleep-in cover.
- During the day we found that there were enough staff to provide support to people. This included two carers and a member of staff doing the maintenance and cleaning. One relative said, "There are always two staff there when I visit, and this is more than enough." Throughout the day staff were available to attend to the needs of people living there. One member of staff said, "We have enough staff to meet people's needs."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong:

- Risks to people had not always been considered and there was a lack of detailed actions in place to mitigate them. For example, one person was at high risk of falls. Their care plan did not contain a risk assessment in relation to this. There was a record in place from their optician that the person needed to wear their glasses to reduce the risk of falling however they were not wearing them on the day of the inspection.
- Another person had a medical condition that meant their diet had to be carefully monitored. There was no risk assessment in place to state actions staff had to take to reduce the risks of them becoming unwell. Staff were also not familiar with what this medical condition was. Another person had a mental health diagnosis.

There was no risk assessment that related to this condition or guidance for staff on how best to reduce the risks of the person's mental health affecting them.
● People's personal evacuation plans (PEEPs) did not reflect people's complete needs. They stated that both people were living with dementia, and that staff should speak in one person's left ear as they had a hearing aid however, the person had hearing aids for both ears. There was no additional information about either of their needs. The service policy stated, "Where assistance is required, a plan will be developed to specify how the Service User is to be assisted in the event of the need for evacuation." However, we found that the PEEPs were lacking this detail.
● Accidents and incidents were not always recorded. Where they were recorded there was not always detail on what actions had been taken to reduce further risks. For example, one person's daily notes stated that they had hurt their head and leg on a piano. Although the dressing had been applied to the leg wound there was no information included around how this could be avoided in the future.
● The service policy stated, "An accident/incident form should be completed and immediately submitted to [the provider], who, after reviewing the facts, will take those actions necessary to minimise danger of the same accident/incident in future." We found that this was not always happening.

As the risks associated with people's care were not always appropriately assessed and actions taken to reduce risks this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects of the risks around care that were appropriate. We saw that a risk had been identified around the use of using paraffin creams on people's skin. There were management plans in place that stated that the person should avoid being around a naked flame and that their clothes needed to be regularly laundered. A relative told us, "She [their family member] is mobile but staff make sure they are there to support her so she doesn't fall."
● There was a 'Business continuity plan' that detailed what staff needed to do in the event of an emergency such as a flood or a fire. We saw that staff received fire safety training and that regular fire drills took place.

Systems and processes to safeguard people from the risk of abuse:
● People were not always being protected from the risk of abuse or neglect. For example, we saw from one person's daily notes that there was an unexplained bruise on the person's leg. This was not reported to the Local Authority safeguarding team and there was no evidence that this had been investigated by staff at the service.
● Staff were not always able to tell us what safeguarding people meant. One member of staff told us that they had not had training in this. Other staff were able to tell us what they would do if they suspected abuse. One told us, "I know that if I notice any abuse I will tell the manager, if they don't take action I will call the council or CQC immediately." However, we found that they were not always putting this into practice.

As people were not always being protected against the risk of abuse or neglect this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:
● People were protected against the spread of infection within the service. One relative said, "It's always kept clean." Another said, "It's always so neat and tidy. Her room is always clean." The service was clean and tidy, and staff understood what they needed to do to reduce the risk of spreading infection. One member of staff said, "We wear aprons and gloves during personal care."
● Regular infection control audits took place to ensure that staff were adhering to the correct procedures. We saw that these checked to ensure that there was sufficient equipment and that this was all in date.

Using medicines safely:

● Medicines were managed in a safe way and people told us that they received their medicines when needed. One relative said, "She gets her meds and they always make sure she takes them."

● People's medicines were recorded in Medicine Administration Records (MAR) with a photo of the person and details of allergies. One MAR stated that the person's pulse rate had to be checked before the medicine was given and we saw this being done.

● There were medicines prescribed on an 'as required' (PRN) basis and these had guidelines in place for their use.

● Where topical creams needed to be applied there were body maps in place so that staff knew where this needed to be administered.

● Medicine competency checks took place to ensure that staff were appropriately administering medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Adapting service, design, decoration to meet people's needs:
● There were aspects to the environment that required improvement. We noted that the garden at the service was unkempt and the grass was overgrown. It was not suitable for people to sit out and enjoy.
● There were signs of damp on the wall in one bedroom that required painting and during the inspection there was a damp smell through the corridor. Staff could not identify where the smell was coming from.
● There was adapted equipment in the bathroom to assist when people wanted a bath or a shower.
● The manager contacted us after the inspection and told us that the garden had now been maintained. We will check this at the next inspection.

We recommend that the provider ensures that the external and internal environment is maintained appropriately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support:
● Since the last inspection no new people had been admitted to the service. This meant that we did not need to look at pre-admission assessments.
● Communication needed to be improved upon between staff at the service. The 'communication' book where staff handed over information about people's needs was not always completed. For example, between the 26 January 2019 and 1 March 2019 it had only been completed on three occasions.
● Where health care professionals were providing up to date guidance about a person's needs this was not always shared with all of the staff. For example, one person previously required a low-fat diet due to a health condition. As the person was not eating sufficient amounts further guidance from a health care professional was provided stating that the person should now be given fortified meals. One member of senior staff was not aware of this updated guidance.
● People were not always provided snacks in between meals. We were aware that one person at the service was reluctant to eat and needed to be encouraged. We heard this person ask for a meal at 11.30 however a member of staff advised them that they needed to wait for lunch at 12.30. They did not offer the person a snack.
● People were offered a choice of drink at lunchtime. In the morning they had been asked what they would like for lunch. The meal looked appetising and people said that they enjoyed it.
● People's weights and hydration was monitored. If there was a concern, then a food and fluid chart was put in place to review what people had eaten and drunk. There was target information on the charts and we saw

that these targets were met. One relative said, "She wasn't eating or drinking before she moved in and now I have no worries at all."
● People's care records showed relevant health and social care professionals were involved with their care. Records showed involvement with GP, dietician and the Speech and Language Therapist (SaLT). Care records showed that people had regular annual eye checks and regular involvement of the chiropodist. One relative said, "They sort out her appointments with the chiropodist and then let me know."

The provider needs to ensure that staff communicate up to date information about people's needs and people are provided with sufficient levels of food throughout the day.

Staff support: induction, training, skills and experience:
● Staff had appropriate training and development for the role. One relative said, "They look after her so well." One member of staff said, "[The provider] said I have to do training here before I started the induction. I've done diabetes, end of life, stroke training."
● We checked the training matrix and found that staff had undertaken a wide range of training including dementia awareness, moving and handling and infection control.
● Staff received appropriate support that promoted their professional development. Regular one to one meetings took place with the staff and their manager.

Ensuring consent to care and treatment in line with law and guidance:

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Staff were aware of the principles of MCA. One told us, "It's whether the person has the capacity to make decisions. If they cannot consent, then we look to provide making decisions for them."
● Where people's capacity was in doubt MCA capacity assessments were completed and these were specific to the particular decisions that needed to be made. For example, in relation to receiving care, bed rails and sensor mats. We saw evidence of best interests' discussions that detailed the options considered including the least restrictive options.
● We saw where people were being restricted, in their best interests, applications had been submitted to the local authority for authorisation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People and their representatives were not always involved in decisions around their care. Staff were not always engaging with people in a meaningful way.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; equality and diversity:

- We received feedback from relatives that they had observed staff to be kind and caring towards their loved ones. One told us, "They [staff] are just so caring." Another told us, "I'm quite happy with the way staff are."
- Despite this feedback, through the inspection we found that in spite of the opportunities to do so staff were not always engaging with people in a meaningful way. For example, during the morning the only conversation staff had with people who were sat in the lounge was to ask them if they wanted a drink.
- During lunch a member of staff stood and watched people eat rather than sit with them. A senior carer came into the room and said, "You can sit at the table." The member of staff said that they did not want to. The senior carer said, "It looks nicer if you do." The member of staff then sat at the opposite end of the table with their arms folded observed by the senior carer who sat in the armchair at the side of the room.
- The member of staff that was sat with people during the day did not smile at people when they spoke with them and their approach when speaking with them was direct. For example, during a game of Bingo the member of staff said to the person, "[Persons name] mark it, check it. Pay attention."
- People were not always listened to. One person whilst sat in the lounge stated, "It's very quiet in here. I can even hear the clock ticking." The member of staff did not respond to this. One person told us, "It's nice to have a bit of music in the background." Again, the member of staff did not respond to this until we asked if they could put the music on.
- We did not see evidence that people and their families were involved in the reviews of their care. This was despite one person not having the capacity to make decisions where family involvement was important. The member of staff said, "I don't understand what you mean about including people in their reviews? Would we need to involve their families too?" However, people were able to decide when they wanted to get up and go to bed and whether they wanted a male or female carer. One person said, "I had breakfast in bed earlier."

Respecting and promoting people's privacy, dignity and independence:

- There were times during the inspection where people were not always treated with respect. For example, a member of staff placed a clothing protector on a person without checking with them first if they wanted it on. On another occasion a member of staff poured gravy over the person's meal without asking if they wanted this.
- When a member of staff spoke with a person whilst the person was sat down they put both hands on the arm of the chair and leaned over them rather than stoop down to their level.

As people were not always treated in a caring way, were not always involved in their care planning and were not always treated with respect and dignity this is a breach of regulation 10 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● We did find elements of the care that was respectful and dignified. When personal care was provided this was done behind closed doors. One member of staff said, "We always maintain their privacy and dignity." When people chose to stay in their rooms staff respected this.
● We saw examples of people being supported to be independent. One relative said, "They [staff] let her do as much as she can for herself." We saw one person being encouraged to walk without staff imposing their help on them. One member of staff said, "We try and let them be as independent as possible."
● We saw that there were staff that greeted people when they walked in the room and spoke to people in a gentle and caring manner.
● People were supported with their appearance. One person's nails had been painted and they told us, "The staff do that for me." We saw from their care plan that, "[Person] likes to have her nails trimmed, filed and painted."
● Relatives told us that they always felt welcomed at the service. One told us, "They always ask me if I would like a drink." They told us that staff at times went above and beyond in showing that they care. They said, "On [member of staffs] day off she came in especially to wish [their family member] a happy birthday. It was so special."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's care plans did not always reflect their current needs. Improvements were needed with activities and outings.

At the previous inspection we recommended that the provider ensured that detailed care planning was in place around all of the needs of people including mental health, clinical needs and end of life care. At this inspection we found that this still needed to be addressed.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support:

- Care plans did not always contain the detailed guidance around the needs of people. For example, one person had a mental health condition. There was a lack of information in the care plan on what the person's mental health diagnosis was. There was a printout stating a list of conditions that would cause the symptoms that the person displayed however there was no information on what the person's condition was.
- Staff were not aware of the person's mental health diagnosis. One told us, "[Person] doesn't have a mental health diagnosis as far as I'm aware."
- Another person had a condition that impacted on how they digested food. However, their care plan had contradictory information on how best to provide care. Staff we spoke with also had conflicting information on what was best for the person to eat.
- Activities were not as person centred as they could have been, and people did not have the opportunities to go out as much as they liked. One person told us, "I don't get to go out much at all. Not even for a coffee every now and then. I'm here from the moment I wake up until I go to bed."
- We spoke to a senior staff member about activities and trips out. They told us, "They [people] go out once every three months for a coffee morning at Tesco's in Purley. [Person] prefers to go out to the station so we take her there. They only go out once every three months because they don't want to go other times. We record this." We checked the records and could not see evidence to support this.
- One person's care plan stated, "In the warmer weather, [person] enjoys spending time in the garden when it is sunny." The person was unable to sit in the garden as it was overgrown despite the fact that there had been some recent warm weather. We did not see the person being supported to set the table, water the plants of tidy up on the day of the inspection despite this being stated on their care plan that they liked to do.
- We noted on the day of the inspection that a game of Bingo was played and a balloon game. However, the member of staff playing the balloon game was not interacting with the person. When a senior member of staff asked this staff member to assist to lay the table (when there were other staff that could have assisted with this) the member of staff walked away from the balloon game without informing the person that the game had ended. The activities were limited to Bingo, balloon games, reading and movies.
- End of life care planning was not as detailed as it could have been. We saw from one person's care plan it

just stated that they wanted to be at the service at the end of their life. This had also not been reviewed since April 2018.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:
● Relatives told us that they knew how to complain and would not hesitate if they needed to. One told us, "I have no concerns. I would know what to do though."
● There was a suggestions and comments book next to the signing in book in reception for people and visitors. People and visitors also had access to the complaints policy.
● There had been no complaints at the service since the last inspection. One member of staff said, "When [people] complain about anything I will listen and ask a few questions. Then I would call [the provider] and let him know the complaint. Neither have complained to me since I've been here."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care:

● At the previous inspections in November 2017 and July 2018 we identified that notifications were not always being sent to the Care Quality Commission (CQC). Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. During this inspection we found that the provider was still not sending notifications to the CQC where it was appropriate to do so. This related to injuries to people and safeguarding concerns.

As notifications were not always being sent in to the CQC this is a continued breach of regulation 18 of the (Registration) Regulations 2009.

● Since the last inspection there had been inconsistent leadership at the service. The provider who is also the current registered manager did not have day to day oversight of the service. They had been making attempts to recruit a new registered manager however this had been unsuccessful up to the point of inspection. This was impacting on the day to management of the service. On the day of the inspection a new manager had started work at the service. Since the last inspection there had been four managers at the service.

● Staff told us that there had not been robust leadership. One told us, "Every two months the managers were changing." A relative said, "There have been a lot of changes in management. To be fair I just deal with the carers." Another said, "I don't know who the manager is."

● Records were not always being kept securely or accurately. When we arrived at the service a person's care plan had been left open in the lounge. We also found boxes and bags of people's personal records that were being stored in an empty unlocked bedroom. This was despite an external auditor raising this as a concern in March 2019.

● We found that training records were not always accurate. For example, in one member of staff's file there were certificates that stated they had completed a selection of training including health and safety, food hygiene and infection control. However, the member of staff confirmed with us that this training had not been provided. We found that the analysis of one person's weight had been recorded for future dates up to 29 May 2019.

● Although quality assurance was taking place this was not always identifying the shortfalls. For example, audits had not identified the gaps in the recruitment files.

● Where shortfalls had been identified, actions had not always taken place to address them. An external

auditor identified in March 2019 that there had been no audit or analysis of accidents and incidents since August 2018. This had still not been done. They also recommended that a health and safety audit be undertaken however this had not been done.

● The senior carer at the service agreed that audits had not always been effective. They said, "I agree, some of what we expected has not been done."

● There were staff at the service that were only legally allowed to work 20 hours or less during term times. However, we found that the provider had regularly scheduled them to work more hours than this. We have passed this information on to the appropriate authority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others:

● Due to there only being two people living at the service, rather than relatives' meetings, staff regularly spoke with relatives when they visited. One relative told us, "We get asked for feedback. As I am there every week we don't have formal meetings as such."

● We reviewed the minutes of these discussions with relatives and found that actions had not always been taken to address suggestions from relatives. In January 2019 one relative suggested that the hallway at the service was brightened up. The manager was to arrange for the hallway to be painted and for pictures to be purchased. This had not taken place.

● Relatives were asked to complete surveys to gain feedback on the quality of care. Overall, they were satisfied with the care. However, one relative did mention that activities could be improved upon and felt that more residents in the home could help with that. There was no action plan in place to improve upon activities.

● Staff did tell us that they felt valued. One told us, "I feel valued as a staff member. The management tell you you're doing a good job."

● Staff attended meetings however when we reviewed the minutes there was lack of management guidance and support. The notes consisted of highlighting staff shortfalls including mentioning one member of care staff in particular. There was no action plan in place to motivate staff.

● We could not see any evidence to show that the provider was working with external organisations to help drive improvements.

As there was a lack of leadership, records were not robust or kept securely and systems and processes were not established and operated effectively this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that notifications were being sent in to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided to meet people's individual and most current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people were always treated in a caring way, that they were involved in their care planning and were always treated with respect and dignity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people risks associated with people's care were always appropriately assessed and actions taken to reduce risks

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were always being protected against the risk of abuse or neglect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there was sufficient leadership, records were robust and kept securely and systems and processes were established and operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that recruitment procedures were robust to ensure that staff employed were fit and proper.