Parkcare Homes Limited

# Lickey Hills

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 30 August 2017 and was unannounced, on the subsequent dates 31 August and 1 September 2017. This inspection was in response to information of concern received, and raised by members of the public, relatives, health and social service professionals.

The provider of Lickey Hills is registered to provide accommodation with personal and nursing care for up to 82 people. Care and support is provided to people with dementia, personal and nursing care needs. Bedrooms, bathrooms and toilets are situated over two floors with stairs and passenger lift access to each of them. People have use of communal areas including lounges and dining rooms. At the time of this inspection 63 people lived at the home.

There was a registered manager in post who was present during the three days of our inspection. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspection in May 2017 we found two breaches in regulation 9 Person Centred Care and regulation 17 Good Governance. At this inspection we found the provider had not made significant and sustained improvements. Therefore there were continuations in breaches Regulation 9 and Regulation 17.

People's daily records were not completed promptly. They did not monitor people's fluid intake to ensure they were not at risk of dehydration. People were not always given a choice of food. The monitoring of people's fluid and food intake was not always completed in a timely manner. Relatives were concerned their family member did not have sufficient drinks offered throughout the day.

We found medicines were not being managed safely. We found medicines not stored securely and left in a corridor which could put people at significant risk of harm. Although medicines were stored in medicine trolleys we found on two occasions either the door was left open or the medicine keys were left on top of the trolley so anyone could have accessed them.

Staff reported accidents and incidents to the office however; the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again.

Accurate records of people's care were not always maintained. People's care plans did not contain the detail needed to keep people safe including guidance for staff about how to reduce the risk of pressure sores. photographs of the wounds had not been taken to record the healing progress.

People were not supported to maintain their hobbies and interests. There was a lack of specialist activities available for people living with dementia.

People were asked for their consent for care and were provided with care that protected their freedom and promoted their rights. Staff asked people for their permission before care was provided. Staff were well meaning and had good relationships with those they supported. However interactions were largely based around the completion of tasks.

Care plans did not provide sufficient guidance to staff on people's needs. We identified gaps in how people's needs were monitored in order to help people maintain their health and wellbeing.

People were kept safe from potential abuse and harm by staff who understood how to identify the various types of abuse and knew who to report any concerns. Although these incidents had been reported to the local authority the provider had failed to notify safeguarding incidents to the Care Quality Commission.

Auditing systems in place to monitor the quality of services provided were not robust and effective.

The provider had failed to ensure there was sufficient and sustained improvement following our last inspection. During this inspection we found significant shortfalls in the quality of the care being provided. We found the registered provider to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections 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 expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five questions it will no longer be in special measures.

## 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.

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Medicines were not managed safely putting people at significant risk.

Risks to people were not always assessed and plans were not always in place to manage the risk and minimise safeguarding issues.

There were systems in place to check on staff suitability prior to starting their employment.

### Is the service effective?

**Inadequate**

The service was not always effective.

Relatives were concerned their family members were not given enough to drink.

People's daily fluid intake charts were not always completed promptly. .

Staff were not always supported through regular supervision and staff meetings.

People were supported in line with the principles of the Mental Capacity Act 2005.

### Is the service caring?

**Requires Improvement**

This service was not always caring.

People's right to confidentiality was not always up held.

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Staff were well meaning but interactions with people were based on tasks.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive

Care plans were not sufficiently detailed and did not give the staff the information they needed to care for people in the way they liked.

People had limited access to activities.

## Is the service well-led?

**Inadequate**

The service was not well-led

The provider had not reported safeguarding notifications to Care Quality Commission.

Systems to ensure the provider had an oversight of the quality of the service were not effective.

Audits were not driving or sustaining improvement to reduce risks to people.

# Lickey Hills

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30, 31 August and 1 September 2017 by two inspectors. The first day of our inspection was unannounced and included a Specialist Advisor in general nursing care for people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.  The inspection team consisted of two inspectors on the subsequent two days.

The inspection was prompted in by information and concerns received from the local authorities, health professionals and relatives of people who lived at the home. We looked at the information we held about the provider. This included statutory notification's received from the provider about deaths, accidents and safeguarding incidents. A notification is information about important events which the provider is required to send us by law.

We spoke with 11 people who lived at the home and spent time looking at the care people received in the communal areas of the home  Many people lived with dementia and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living at the home. We also spoke with nine relatives of people who lived at the home by speaking with them when they visited their family member. We did this to gain people's views about the care and to check standards of care were being met.

We spoke with the registered manager, the deputy manager, the Quality Lead, the Clinical Lead, two registered nurses, two agency registered nurses, three care staff, one activities co-ordinator, senior housekeeper, the provider's Operations Director, the provider's Managing Director and the provider's Group Director in Performance and Regulation.

Inadequate

# Is the service safe?

## Our findings

At this inspection we found that people living at the home were at risk of harm. This was because risks had not been identified and appropriate actions had not been put in place to reduce these risks and to protect people.

We observed the medicine rounds on each of the three units throughout the inspection and found nursing staff were not always following best practice. For example, we observed that on three separate occasions medicines were left unsecured and unattended by staff members. On the first day of our inspection we found 463 tablets left in unsecured returns bags in a hallway outside the clinic room on the Cofton Unit. This meant these medicines could be removed inappropriately by a person living at the home, a visitor or a member of staff. There was the potential for someone living with dementia to take these medicines in error and so potentially cause significant risk to their health and wellbeing. We immediately reported our findings to the registered manager and provider's Quality Lead, so the medication could be stored securely.

On the same day on the Cofton Unit, we saw an agency nurse leave the keys to the medicines on top of the trolley, whilst they went to administer a person's medication. Again this meant people living at the home, any visitors or staff could have accessed people's medication.

On the third day of our inspection we noticed at lunchtime on the Cofton Unit a registered nurse, had left the medicine trolley with one of the doors left open and with the keys still in the lock. The contents of the medicine trolley were clearly visible and could have been accessed by unauthorised persons.

We saw an agency nurse administer medicines for people. They had recorded a dot to the Medication Administration Records (MARs) and told us they were going to sign them having completed the medicine round. This meant they were signing the records retrospectively. Good practice suggests staff administering medicines should sign the MAR record straight after administering them.

Where people were prescribed 'as required' (PRN) medicines there were not sufficiently detailed protocols in place to guide staff as to when the medicine may be required. Recording of when PRN medicines were offered was not consistent. We could not therefore be sure people were receiving their medicines appropriately or when they were needed. For example we saw one person been given their PRN medication several days running by the same member of staff. However another nurse told us they felt the person's anxiety could be managed without the need for PRN medicine by giving the person their favourite doll which provided them comfort.

Where risks to people had been identified records did not always include actions staff should take to mitigate these risks and keep people safe. For example, some people's records had highlighted a risk of their skin being damaged. However, there were not always records to show what staff should do to help reduce the risk, or photographs of the wounds, to monitor the progress of the healing process. We found nursing staff were unable to describe the progress made with the healing. On discussion with senior members of staff, we found a lack of knowledge as to which people may have skin care problems and were receiving

treatment. We found inaccurate records in peoples risk assessments for example crash mat risk assessments showed they were not in place when they were.

Some people had special mattresses in place to help alleviate pressure on their skin and reduce the risk of the skin becoming sore. However some people's records did not always show what settings the mattress needed to be set at, to maintain healthy skin. We checked the dates when the equipment was last serviced and found service dates were either overdue or not recorded. We brought this to the attention of the senior management who assured us servicing would be completed as soon as possible.

Staff did not always act to keep people safe from risks relating to the environment. Doors to some rooms including those containing potentially hazardous material or equipment were left unlocked. For example, sluice rooms. A stationary cupboard had a bucket of cleaning products in it. All these rooms had locks on them, but were left open. People living in the home had opportunity to walk around the building and potentially access these areas, so putting them at risk.

In the action plan the provider sent us following our inspection in May 2017 it stated "It is now a requirement for a staff member to present at all times in all dining rooms overseeing and supporting with a positive dining experience." However on the first day of our inspection, we saw the hot food trolley was left unsupervised on the Cofton Unit with the door open and some hot food was left uncovered. We brought this to the attention of the senior management. They undertook to remind staff, that a staff member should remain in the dining room to ensure people did not burn themselves on the hot surface. They told us they would look into purchasing a protective cover for the trolley to reduce the surface temperature.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.

We asked people and their relatives if they thought there were enough staff to care for them. One relative told us, "The staffing levels are fine." When we asked staff if there were enough staff on duty to care for people, one staff member said "Staff on the nursing unit, want to do more for people but they can't do it. We have a lot of agency staff." The registered manager told us staffing levels were decided using a dependency tool. They told us they were in the process of recruiting and new staff who were due to start work in the near future. They said the use of agency nursing staff had been blocked booked, to try to get continuity of staff. This was so they understood people's needs. Permanent staff confirmed the nurses had visited the home frequently and classed them as locum nurses so they felt they knew the people they cared for.

We spoke with staff about how they made sure the people they provided support for were safe. They were able to tell us how they would respond to and report allegations or incidents of abuse. Staff could describe the different types of abuse people were at risk of and were able to explain the different agencies that they could report concerns to. One staff member told us, "I wouldn't hesitate to report it. If I ever saw anyone with any bruising, I'd always ask the nurse where it had come from." The registered manager was aware of the need to report safeguarding's to the Local Authority but had not notified the Care Quality Commission of such events..

We saw there were plans in place for responding to emergencies. The registered provider had an emergency fire evacuation plan in place. We saw each person had a personal emergency evacuation plan (PEEP). The plans outlined people's support needs should there be a need for them to be evacuated from the premises in an emergency.

We looked at the provider's recruitment procedures. Staff told us they had the required checks before they

were able to start work at the home. We checked three recruitment files and found references and a Disclosure and Barring Services (DBS) check had been performed to ensure potential staff members were of good character and suitable to work with people who lived at the home. Where nurses were employed checks were made with their professional body to show they were able to practice as a nurse.

Inadequate

# Is the service effective?

## Our findings

Prior to our inspection we received information about an incident which indicated potential concerns about the risk of dehydration. During our inspection additional concerns were raised to the inspection team by people's relatives. These people told us they did not feel their family member had enough to drink. A relative told us their family member "Always seems really thirsty." Another relative told us, "There never seem to be enough drinks". We were told family members visited regularly to ensure their family member was given sufficient drinks.

One relative commented, "People are not getting enough fluids". They added that they believed, "Staff did not record accurately the amount of fluids taken by people." Another relative stated they were continually bringing up concerns such as not having a jug of water in the bedroom. The relative said they were told by staff their family member would have a drink at breakfast, lunch and tea. Therefore the relative was concerned their family member would only have drinks at these times. We were told they did not see people given drinks and they had needed to provide people with drinks themselves because residents were thirsty. One relative said, "My [relative] says whenever they visit [daily], they find [person's name] seems really thirsty". Another relative told us, "There never seems to be enough drinks." A staff member told us, "Squash is usually available but it's very weak, so people don't like it."

Following our inspection in May 2017 the provider had sent us an action plan which stated by 31 August 2017 "Nutrition and fluid intake forms are completed for each resident to ensure there is a record of what each resident has eaten throughout the day. Staff have been formally reminded of the importance of keeping log of diet and fluid. This is regularly being monitored nursing staff and management at the home to ensure recordings are accurately detailed and appropriate action is taken when identified. Nutrition and fluid intake forms are completed for each resident to ensure there is a record of what each resident has eaten throughout the day. Nurse in charge on each unit to monitor the completion of the diet and fluid charts by care staff."

During this inspection we saw there were continued inconsistencies in the recording of people's eating and drinking to support effective monitoring was taking place so people remained healthy. We saw gaps in the records and one staff member retrospectively completing the forms later in the day rather than when people had consumed their drink to ensure accurate records were maintained.

This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Act 2008.

On the Rednal Unit we saw people were given a choice of two meals at lunchtime. However people living at the home who required a soft diet were not given any choice. A relative told us, "[Person's name] always gets porridge for breakfast; you'd think they could do some tomatoes or something different? They always get the same menu it tastes diabolical…I've tried it."

At this inspection we found people continued to not always receive effective care based upon best practice. For example, we saw staff were called away to help other staff whilst assisting people to eat their meals. This

meant the person's meal time was interrupted and they had to wait until the staff member returned. A visitor told us their friend's meal "Had been left to go stone cold as they were unable to eat unassisted". The practice of interrupting people, to take their medicines whilst they were eating their meals continued. We saw for some people it distracted them away from eating their meal, as the nurse needed to encourage and support people with taking their medicines. This contradicted the action plan the provider sent us following our inspection in May 2017 which stated, "Nurses are now administering medication at a different time that does not clash with meal times to prevent residents being distracted during their meals"

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

Staff told us they had not received supervisions, so were not given the opportunity to reflect on their practice and discuss their training needs. We saw a memo from the registered manager dated in May 2017 apologising to staff there hadn't been a staff meeting, as it had been difficult to get staff together for a staff meeting. The registered manager told us staff supervisions were overdue and but since coming into post they had completed staff annual appraisals. The action plan sent to us from the provider following our last inspection indicated this process would have been completed by 31 August 2017.

We spoke with staff about the training they were received from the provider. New staff completed an induction period linked to the Care Certificate. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers. Staff told us they had training which was either classroom based or in the form of e-learning packages. One staff member told us they felt the induction they received "Had prepared them for their role." We checked the training records and found some staff training was due for a refresher and staff had been notified. The registered manager told us they had given staff a seven day deadline to complete all their training requirements. We saw further dates for staff manual handling training to be completed by the end of September 2017. Further specialist courses for staff in diabetes and dementia were being organised by the registered manager to ensure staff had the necessary skills and knowledge to care for people.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed how the registered manager had ensured people's freedom was not restricted. We found applications had been made to the local authority, we noted that two DoLS applications had been submitted to the local authority in retrospect after the people had been living at the home for several weeks.

We also reviewed how the registered manager had made a decision about the person's capacity to make decisions. Although we saw in people's care records some decisions had been made in a person's best interests, people, their relatives and health care professionals had been involved in the decision making process where appropriate.

A clinical lead had been employed by the provider to support people's wider health needs. People also had access to visiting GP who visited the home weekly. People also told us they had access to other health professionals as required in order to maintain their health and wellbeing.

Requires Improvement

# Is the service caring?

## Our findings

People's right to confidentiality was not always protected. On the first day of our inspection we found a person's supplementary care record left in the lounge on Cofton Unit. We also saw the door was open to the nurse's office on the Rednal unit and on the Cofton Unit throughout the inspection. They contained people's confidential information which was not locked away and notice boards containing information pertaining to people's care needs. This meant anyone in or visiting the home could look at peoples' confidential information. We saw in one of the staff handover files a record of staff absences and the reason as to why they staff member was off sick.

We saw one staff member assist a person with a cold. Rather than using a tissue, the staff member used some general cleaning paper to assist the person to wipe their nose. When we reported our findings to the senior management – they purchased some tissues for the home the following day.

We asked people and their relatives how they were involved with their care planning, when they came to live at the home. One relative told us about the care their family member received and said they were "Resentful that they had to tell the staff how to do this." They felt that the staff should have known what they were doing without them having to tell them. Although another relative told us, how their family member's had been assessed prior to coming to live at the home
and was pleased with the care and support the person received. They said, "It's better than the other place they were at."

We saw caring interactions between staff and the people they cared for. One person told us, "Staff are kind and caring." Another person commented, "They [staff] are all wags; keep me going with all their laughing." We saw staff spoke kindly with people and took time to listen to what people were saying to them. Staff knew and used people's preferred names. We saw where people made their choices known to staff these were listened to and people were given time to respond. Staff we spoke with told us they enjoyed supporting people living there and were able to tell us about people's individual likes and dislikes. We saw staff used this knowledge when talking with people. A relative told us, "Staff are quite good. Nothing is too much trouble." They described how often their family member is found sat chatting to staff when they visited.

We saw staff had ensured people had their personal effects close to hand for example the ladies living on the Rednall and Blackwell Units had their handbags and wore their own personal jewellery. The cook told us how the home remembered people's birthdays and to help in the celebrations they made individual birthday cakes for the person.

We saw staff knocked on people's bedroom doors before they entered when checking whether people needed anything. We saw that people were treated with dignity and staff had a good understanding of what dignity meant for people. We saw staff discreetly assisted people who needed support to use the bathroom. Although we did see one person ask to go to the toilet but when the staff member spoke to them they asked the person if they would like to go to the bathroom. The change in terminology confused the person and

they started to become distressed.

People's rooms were large and decorated in the way they preferred, with their own personal belongings. People could use their own rooms to meet with visitors if they preferred. The home had gardens for people to use if they wanted, however a staff member told us in reality, people only got to use the gardens if their relatives took them outside.

Requires Improvement

# Is the service responsive?

## Our findings

We checked to see if any improvements had been made since out last inspection. An activities planner was displayed on the wall in the hallways in each of the units. However we found on the Cofton Unit activities advertised were for the previous week. The provider had employed two activities co-ordinators, but during the period of our inspection only one activities coordinator was present. The activities co-ordinator told us they found it difficult to provide activities for 63 people. Their first task when they came on duty was to circulate the 'Daily Sparkle' a provider's newsletter for people. They found this consumed a considerable amount of time and limited the time they were able to spend with people doing activities. One person told us, "They need another activities person here." Another person told us, they had to leave the Cofton Unit if they wanted to join in activities, they said, "If activities are happening I go downstairs to the floor below."

During the inspection days we saw little activities available for people and the activities co-ordinator told us there was little activity specifically designed for people who had dementia to engage in. Staff were busy throughout the three days of the inspection and were task orientated.

We asked staff how they met people's differing cultural needs. One staff member replied, "It could be better." They described how one person's family brought in food so the person could follow their cultural beliefs, because the person did not like a British diet, so did not eat the food provided.

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

People and their relatives were involved in planning and reviewing their care with staff. One relative said, "We've had several reviews, but they were thoroughly assessed before they came here from hospital" Handovers were completed between shifts and records were kept about any changes in people's care.

We saw meetings for people living at the home had been arranged but the last meeting had been cancelled, so people had not been able to express their opinions to give feedback on the service provided within the home. We saw relatives coming and going throughout the inspection. There was friendly chatter between staff, people and relatives, and it was evident relatives were made to feel welcome at the home.

When we looked at how the service managed complaints we saw that the registered manager logged any complaint made and these were saved in a complaints file and shared with the provider. We saw three people had left the home and had chosen not to return. The registered manager had not recorded the reason why, so missed an opportunity to learn if people had been dissatisfied with the service they received so any lessons could be learned.

Inadequate

# Is the service well-led?

## Our findings

We carried out this inspection as a result of concerns raised by the local authority safeguarding team, intelligence provided by relatives of people who use the service and a healthcare professional.

During the inspection we looked at the way the provider recorded and responded to incidents, accidents and safeguarding reporting. We found some details on the handwritten incident forms did not match the entry on the provider's computerised recording system. We also were unable to see what actions and any outcomes of the incidents, because they had not been recorded. We brought this to the attention of the senior management who assured us this would be addressed.

Monitoring procedures did not effectively assess, monitor and mitigate risks to people including their health, safety and welfare. For example, where accidents and incidents were being recorded, no analysis had been undertaken to identify themes and recurring trends thereby limiting future occurrences. We found although quality assurance systems were in place to identify areas for improvement; these systems had failed to identify the issues we found during the inspection. For example providers are required by law to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. This includes notifying us of safeguarding incidents which been involving people living in the service. The registered manager told us they had not submitted any notifications to us in safeguarding incidents only the local authority.

All of the above constitutes a breach of Regulation 18 (Registration) CQC Regulations 2009. Notifications of other incidents.

An internal quality monitoring visit by the provider's Quality assurance team had been performed in August 2017. At the time of our inspection the outcomes of their visit was not available. We did have the opportunity to discuss out findings with the provider's senior management team who assured us, immediate action would be taken. Any serious incidents would be reviewed and notifications sent in to CQC in retrospect.

Staff described the difficulties they had experienced in recent months and the low morale due to the changes in management and the reliance on agency staff. They told us, "There are only four permanent care staff working and the agency staff don't always fill in the paperwork." A relative commented "They had concerns over lots of different managers". The added "The new management seem more approachable."

Staff told us they felt the home had a lot of management changes in the past year. Some staff said they did not always feel supported. One staff member told us, "If I see changes in a person I'm caring for I ask the nurse in charge, but it depends. Sometimes the nurse does not always do the observations when I thought someone was unwell." We had concerns about effective recording within the service. There were shortfalls in recording the assessment and care planning for people. Information was hard to track and obtain. The majority of up to date and key information was held in people's care files and other supplementary care files.

We found the recording of monitoring charts for fluid intake was inconsistent. Staff did not always 'total up' intake and output and there was no optimum amount of fluid indicated for care staff to encourage people to aim for. We saw staff completing these charts in retrospect, so could not be sure they were an accurate reflection. There were gaps in the charts for monitoring food and fluid intake and when clinical interventions should have been performed. For example we saw one person was supposed to have their blood sugars checked weekly for their diabetes, but when we found it had been missed for the last two weeks. We brought this to the attention of the registered nurse who confirmed this had been missed.

Following our inspection in May 2017 the provider sent us an action plan which stated "Management will continue to complete a daily walk around of the whole service and complete dining experience audits which indicate how the experience was and identify what improvements are required. These are then reviewed to ensure the actions are being implemented." During our inspection we could not see evidence that the improvements identified had been made.

Not maintaining accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

We saw the last meetings to be held for residents and relatives in order to gain their input and views of the quality of the service had been cancelled. A relative told us they were not always informed of the changes in management and when they expressed their views, and felt they were not always listened to. For example they told us they had raised concerns over the quality of the food especially for people who had pureed or soft diets. They told us nothing had changed. We saw a comment in the comments book left for people to complete in reception. We noted two comments further about the quality of food provided. One person had asked why people who are diabetic were only offered yoghurts for the sweet as "They are loaded with sugar" Another person had written "Tonight's soup was awful. Please can we have bread with soup (not sandwiches)?" When we discussed these comments with the registered manager they told us a new four weekly menu was being planned and implemented soon.

This was a continued breach of Regulation 9 of Health and Social Care Act (Regulated Activities) 2014 Person Centred Care.

The registered manager told us people who used the service, and their relatives had been sent questionnaires about their experience of the service and any improvements they would like. They told us they were waiting for the responses to be returned.

We fed back our concerns identified to the provider's senior management team. They gave us assurances that immediate action would be taken to secure and improve the management of the home.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not consistently receive person centred where their needs and personal preferences were met.. |

**The enforcement action we took:**

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure the proper and safe management of medicines |

**The enforcement action we took:**

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's quality checking arrangements did not consistently improve and sustain the quality of the experience of people who used the service. |

**The enforcement action we took:**

We imposed an urgent condition to restrict admissions to the home and reduced the number of people living at the service.