Four Seasons 2000 Limited

Copper Beeches

Inspection report

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Ratings

Overall rating for this service	Inadequate
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

Overall summary

This inspection took place on 12 December 2014 and was unannounced. We returned for a second day on 16 December 2014 and this was announced. Copper Beeches is a care home providing accommodation, personal care and nursing care for up to 36 older people who maybe living with dementia. Accommodation is provided over two floors accessed by a shaft lift. The home is located in a residential area and is close to public transport links.

For those people who were able to tell us about their experiences at the home they told us they felt safe. There was a mixed response from relatives that we spoke with, but the majority thought their relative was safe at the home. One said they hoped this was the case; and two said they had some concerns that they were still waiting for the manager to address.

The service should have a registered manager. 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 a legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run. The

Summary of findings

former deputy manager had been appointed as the new manager in September 2014; she told us that she had started the process of applying to register with the Care Quality Commission.

Our observations and discussions with staff showed that they had a compassionate, kind and respectful attitude towards the people they supported; but our inspection found that the home was not always, safe, effective, caring, responsive, or well led.

Some incidents including safeguarding incidents had not been reported to the Care Quality Commission (CQC). Notifications about important events which the provider is required by law to send to CQC including expected deaths were not consistently sent to us.

The level of staffing within the home was insufficient to enable people to have a genuine choice about whether they left their room or not during the day. If people were to leave their bedrooms there were not enough appropriate chairs for them to use in the lounges. Staff did not have the time to supervise people who could eat independently but needed encouragement. Many people had lost weight in the home. The home looked clean but infection control was not well managed and there was an odour throughout the home.

The majority of staff training was up to date. This was provided as on line training and had to be completed in staff's own time. There were concerns that nursing staff, that were senior to care staff, had not been given suitable training to provide this lead role in a number of areas of people's care, including palliative care, dementia care, and wound care/pressure ulcer care.

Staff performance monitoring through supervision and appraisal was infrequent. The new manager was reintroducing regular timescales for this. She had also re-introduced staff meetings to provide opportunities for staff to express their concerns resolve issues and hear about changes.

People's care plans were not personalised, and staff did not have clear guidance about individual preferences to ensure care was provided consistently. Communication between staff and between staff and the manager was not good, with some staff unaware of some important information about the people they cared for. Some people's anxieties led to them expressing this through behaviour that could harm themselves or others. Staff had not received appropriate training to understand or deal with this, and they were not provided with strategies to ensure they responded in a consistent way.

There was a lack of stimulation for people who spent long periods in their bedrooms. Records showed relatives made minor complaints on a regular basis but because these were not deemed formal complaints they were not recorded in the complaints record. It was unclear how these were being handled and whether relatives were satisfied with the manager's response.

Audits of documentation were undertaken but actions taken as a result of issues highlighted were unclear. The provider representative undertook regular monitoring visits to the home but these had not picked up the shortfalls that we found.

The premises were well maintained and all safety checks were in place. Arrangements for the administration of medicines to people were safe.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Staff received training to understand abuse and how to report concerns but did not put this into practice. Some incidents and accidents had not been reported to CQC.

There were insufficient staff to support people to lead a full and inclusive life and to meet their needs. Infection control was not well managed and placed people and staff at risk.

Appropriate checks were made for new staff to ensure they were fit to undertake their roles. The premises were well maintained and all safety checks and tests were undertaken. Arrangements for the management of medicines were satisfactory.

Is the service effective?

Inadequate

The service was not effective

Staff had not all completed essential training and some staff lacked key skills to support people's specific health needs. Staff were not supervised and appraised on a regular basis.

Systems to monitor the behaviour of some people were in place but staff were not given guidelines to support those people in a consistent manner. People liked the food but many had lost weight. Those at risk did not have adequate support to encourage them to eat and drink and records about dietary needs were unclear.

People's health was monitored and referrals were made to health professionals as required, but specific guidance for staff on supporting identified health needs was not in place.

Is the service caring?

Requires Improvement

The service was not always caring. People's privacy and dignity was sometimes compromised.

Staff were caring, compassionate and respectful towards the people they supported.

People spoke positively about the contacts they had with staff; and relatives said they felt staff kept them informed about things to do with the care of their relative.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

Care plans were not personalised and often incomplete, so people's preferences around support were not clear for staff.

The activities programme did not provide meaningful activities for most people who required appropriate and individualised activities suitable for people with dementia.

There was a complaints procedure that was not in a suitable format for the needs of all the people in the home.

Is the service well-led?

Inadequate

The service was not well led.

Systems to record and analyse accidents and incidents or notify significant events to other agencies were not used effectively. Communication between staff was not good and care could be provided inconsistently as a result.

Systems to monitor service quality were in place but records of actions taken to address shortfalls were not made clear. People who used the service and their relatives were not routinely asked to give their views about the service, but when they were, they received no feedback about this.

The manager had a vision for the development of the service to provide quality care and deliver good outcomes for people. From discussion with staff there was some evidence of learning from incidents that had taken place and how changes to practice influenced the way staff worked with people. The manager had re-instated staff meetings to share information with staff and hear their views. The new manager was making an application to register with CQC to become the registered manager.

Copper Beeches

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.

We undertook an unannounced inspection of this service on 12 December 2014; we made a further visit on 16 December 2014 which was announced, to ensure that in the absence of the manager, a senior person was available to talk with us and enable access to some records usually kept by the manager. The inspection was undertaken by an inspector, a nurse specialist (a specialist advisor is someone who has clinical experience and knowledge of working with people with nursing needs who are living with dementia), and an expert by experience. The expert by experience had experience of nursing homes and services for people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

This inspection was undertaken in response to concerns received from the local authority. Because of this the provider had not been requested to complete a Provider Information Return. 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, before the inspection we looked at other information we hold about the service in the form of notifications and complaints and previous reports. A notification is information about important events which the provider is required to tell us about by law.

There were no outstanding concerns highlighted in the previous report. We last inspected Copper Beeches on 22 May 2014 where no concerns were identified.

During the inspection we spoke with the new manager, who was not currently registered with the Care Quality Commission. We also talked with three registered nurses, five care staff, four members of administrative staff, domestic and maintenance teams. We also spoke with a care manager and a contract monitoring officer from the local authority, and also a member of the continuing care team who fund a number of placements at the home; all were visiting the home at the time of inspection. We visited all areas of the home. We met and spoke with approximately eighteen people who lived there and also spoke with eight of their relatives.

Most people were unable to tell us directly about their day to day experiences, and we spent time throughout the inspection undertaking short observations. We also used a Short Observational Framework for Inspection (SOFI) tool. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We reviewed a range of records. These included three care plans and associated risk information; six people's room files; environmental risk information; recruitment information for three staff; records of training and supervision provided to the staff team; staff rotas for two weeks; records of accidents and incidents over the preceding two months; behaviour monitoring records for one person; complaints information; records of equipment servicing and premises maintenance information. We also viewed a sample of policies and procedures; medicine records and medicine returns information, and quality monitoring audits undertaken by the manager and the provider.

Detailed findings

After the inspection we asked the home to send us some information that was not available on the day of inspection and would help inform our judgement. This included information about when people with low weights were referred to health professionals, the qualifications of registered nurses employed at the home and copies of some maintenance certificates. The home subsequently provided all of this information.

Inadequate

Is the service safe?

Our findings

All the people who were able to said that they felt safe.

Of the relatives we spoke with, five said that their loved ones were safe, but two who visited a parent who had been resident for 18 months, were 'not a 100% happy'. They said "(Our relative) has had a few falls, and we are not sure how they happened". They also mentioned 'allegations about a member of staff and bruising, but said, "They have not yet got back to us about this". They said "The new manager seems very 'on the ball', we've been to see her". Another relative said they hoped their husband was safe there.

We spoke with care staff who had received training in how to recognise and report abuse of people they cared for. In discussion with them they showed an understanding of the types of abuse that people might experience. Staff understood the reporting process and their responsibility to report their concerns through their organisation or to other agencies if needed. However, when we tracked one particular person and also viewed incident records for the previous three months, the records highlighted at least three incidents had not been reported to the manager, and had not been raised as safeguarding alerts to the local authority.

The Care Quality Commission had not been notified of these events. Incidents had not been reported properly to the manager by the staff. Staff had not followed the homes and the local authority's procedures for reporting. Appropriate strategies that would help staff establish ways of working with people to reduce such incidents had not been developed. This was a breach of Regulation 11 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Individual risks relating to people's nutrition, skin integrity, and mobility needs were in place and were kept updated. Risks around behaviour were not made clear. People's individual risk information was not sufficiently personalised to inform staff of how best to support people in these areas, leading to a risk of staff giving inconsistent support. One person's moving and handling assessment stated that they needed to be moved by two staff using a hoist and slide sheet. An update to this then said the person was now walking but still needed the support of two staff. While we were reading this assessment, the person entered the office independently followed a little later by a staff member.

When we asked whether the person needed two staff to supervise them at all times they reported that 'No, this was not the case' and that the person was an independent walker.

This was not the only example of gaps in the knowledge of senior staff responsible for updating people's records. There was a risk that staff were confused amongst themselves about the level of support people needed they could be placed at risk of harm or pose a risk to others from either too little support or could be overly restricted.

Staffing levels did not allow for people to be appropriately monitored and the balance between protection of people from risk and enabling them to be as independent as possible was sometimes unclear. People who were mobile and had a tendency to wander due to their condition, were able to walk the corridors unescorted, and into the lounge areas. There had been incidents when people had entered other residents' bedrooms. During our inspection a gentleman was found undressing in a lady's room, while she was present. Staff came to help straightaway when informed. Another man was seen opening the laundry bins in the corridor, and a lady was seen eating someone else's half eaten biscuit. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider used a dependency tool to work out how much support people needed and what staffing levels were required. Our observations and discussions with staff showed that the staffing levels identified did not take account of the additional support people with complex needs required, to ensure a good quality of support beyond their basic care needs being attended to.

Our observations showed that people had limited opportunities to get out of bed each day because the levels of staff did not allow for staff to spend time with individuals, who might require extra staff support and encouragement in some aspects of their care., On the first day of the inspection there were only two care staff available on the ground floor.

There were usually three staff to offer support to 14 people, eight of whom we were told required two staff to assist them. One of these two staff on duty was on light duties due to a health issue and felt that their health and safety needs had not been taken fully into account. Later an

Is the service safe?

agency staff member joined the shift. The manager said they always tried to find cover for gaps in the rota but at short notice this was not always easy; where possible agency staff used were familiar with the service.

A review of the staff rota for the previous two weeks showed that out of 14 days the ground floor had operated on eight days with only two care staff and one nurse instead of three care staff and a nurse. The rota also revealed a high level of sickness amongst staff. There had been 22 staff days lost to sickness in a two week period.

Only a small number of people used the lounge, many people were in their beds all day and records viewed provided no indication that this was their choice or that their health needs required this. If they left their bedrooms there were not enough comfortable chairs for them to use, with only nine armchairs in the ground floor lounge for 14 people. For those people who wished to leave their room but needed more support than a standard armchair, specialist seating was not available for them to use. This is a breach of Regulation 16 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we asked a staff member about one person they told us that the person enjoyed being out of the bed and up in the lounge. However, due to the person's fear of the hoist it took staff a long time to persuade them to use it so they could be transferred to a wheelchair.

Staff were busy most of the time and had little opportunity to monitor the movements of people who paced the corridors sometimes going into other people's rooms. This posed a risk to frail people who were unable to raise the alarm or to protect themselves if others went into their rooms. There was a risk of more unwitnessed incidents because staff were not available.

Two relatives said, "There's a lack of staff here sometimes. Last week we were on our own in here for quite a while with five residents, which was worrying". They also mentioned 'a lack of continuity among the staff', blaming this for problems such as their loved one being left with drinks with no lids when they had repeatedly requested that lids be used for safety reasons.

One relative was more positive, and said of the staff numbers, "They cope, even if they need more staff, and there's usually enough." Another relative said, "The staff can be a bit sparse at times".

On the second day of inspection we spent time observing people in the lounge who could not easily call for staff to assess their mood and level of interaction and stimulation. There was a period of twenty minutes when no staff were present, and there were six people in the room, one of whom was at high risk of falls. The lack of sufficient staffing levels e to meet the needs of people on a day to day basis to maintain their health, safety and welfare is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Systems were in place for recording accidents and incidents but these were not used consistently. Incident and accident data was transferred from paper records to an electronic datix record system (this is an electronic record for recording incidents and accidents in the home). We viewed data for the two months before the inspection. These showed that staff were reporting many incidents and accidents that happened. However, we found examples where incidents had occurred that were recorded on people's ABC charts. (These are charts used for monitoring the antecedents or triggers to behaviour, the behaviour itself and the consequences of the behaviour), but had not been transferred to the incident reporting system.

Similarly an incident noted on the datix report had not been alerted to the manager and to other agencies as a safeguarding referral. This indicated that the systems used within the home were not cross referenced with each other and there was a risk of incidents not being reported which we have addressed within other breaches of regulations within this report.

The home was visibly clean but there was an underlying urine odour throughout the home. One en- suite floor was quite dirty. A domestic staff was cleaning the rooms in the relevant corridor. The general layout of the home meant that smells from the laundry and sluice areas were present in the corridor.

The sluice on the first floor had a strong unpleasant smell. There were hoist slings on the bedpan washer, these are used for specific individuals in conjunction with a hoist to help with transferring the person between their bed and a commode or chair, there is therefore a risk of cross infection if they are placed in a sluice area. There was no yellow waste bag in the bin to enable staff to dispose of any clinical waste appropriately. The cleaning trolley was

stored in the sluice room, and there were cleaning chemicals in the sink, so it was not possible to access the sink due to the amount of equipment in the way, impeding hand washing.

The ground floor sluice room also had a strong odour. The bedpan washer was not on, the yellow bag for waste continence products was overfilled and the linen skips were located in this room along with the hoover. The floor was dirty and there was no evidence of disposable aprons for staff to use. These shortfalls indicated that good infection control practices were not being maintained in the home and could place people and staff at risk from infection.

The laundry had one sink which was used for hand washing and had numerous mugs and a jug of milk on the draining board. The sink had no tiled splash back, exposing flaky plaster. The sink was used to pour out all the dirty water from domestic cleaning in the home as well as water that was used to soak clothes in. Soiled laundry was contained within red alginate bags and transferred to the washing machines, however this was wheeled through a clean area and ironing was also conducted in the same area. On discussion with a staff member it was clear they had received training in infection control and the control of hazardous substances (COSHH), and had an understanding of the risks posed by having dirty and clean clothes in the same area. They said they had raised concerns with a previous manager that had not been addressed and so they 'no longer bothered to do so'.

From discussion with the maintenance man we established that the industrial washing machines had not been serviced and had not had the water temperature checked for some time. An outside company who supplied them was contacted and confirmed that this had not taken place. There was a risk that the washing cycles used for disinfecting soiled laundry might not be at the required temperatures to do so effectively.

We spoke with domestic staff who confirmed they worked to cleaning schedules but when we viewed records we saw that only the kitchen and bathroom areas were included. Cleaning schedules to ensure the robust cleaning of individual rooms and communal hallways, dining and lounge areas were not in place. There was a rolling programme of carpet shampooing for individual rooms and there was evidence of reactive cleaning to incidents. However there was no record of the frequency of cleaning for carpets and general cleaning in dining and lounge areas. It was a breach of regulation for the provider not to ensure that appropriate systems were in place to maintain standards of cleanliness and hygiene at all times. This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

We viewed recruitment folders for staff in different roles, these showed that the provider operated a thorough recruitment process that required application forms to be completed and applicants to attend for interview. Records also showed that important checks were made of people's character and background through contacts with previous employers or people able to provide a character reference. A disclosure and barring check was completed to check any previous criminal record, and applicants were also asked about their health status. All these checks were made prior to new staff starting work at the home. We noted some references received were not always the same as those recorded on application forms, in discussion with the manager and administrator we understood the reasons for this but this was not always made clear in staff recruitment records.

Records showed that safety checks, including servicing of gas and electricity installations, had been undertaken. People's portable electrical appliances had been checked and equipment used for the care of people in the home was visually checked and serviced. Discussion with the maintenance man provided assurances that systems were in place to ensure that regular checks and tests of air mattress settings, water temperatures, bed rails, beds, nurse call systems and fire drill practices were conducted. Records viewed confirmed these checks were being undertaken regularly.

The ground floor lounge had a conservatory that had a view over the garden and car park. This area was cold and not safe for use because it was used for the storage of a broken table, plastic greenhouse and other items which could have been hazardous to people. This was separated off from the rest of the lounge by heavy curtains that discouraged people to use this area. This was a pleasant area that people could have used.

Generic environmental risk assessments had been developed for a range of areas and these were in date. An updated fire risk assessment had been completed and records showed that staff had received fire training and had practiced an evacuation in regular fire drills. The fire alarm

Inadequate

Is the service safe?

and fire equipment had been serviced and records showed that regular tests and checks of the alarm system emergency lighting and fire extinguishers were carried out. Personal evacuation plans to inform staff of the support that people needed in the event of an emergency evacuation were not in place in records we viewed.

Only registered nurses (RN'S) undertook medicines administration. Arrangements for the ordering and receipt of medicines were satisfactory. We spoke with both RNs on duty to check they had received updated training and records showed that their competency had also been assessed.

We observed an RN administering medication to two residents, and this was done safely. We undertook random sampling of Medicine Administration Records (MAR), and these were completed appropriately. We checked some people's medicines to ensure the correct number of tablets were in place and correct.

People's records showed that medicine reviews had been carried out by the pharmacist and the GP and as a result some people's medicines had been changed or had had their dosages reduced to make sure the dose was right for them.

We checked that the arrangements for the storage of medicines were appropriate and that Controlled, and end of life drugs storage, administration, and recording was undertaken correctly. Medicine cupboards and trolleys were locked when an RN was not present.

We noted that the container for the Destruction Of Old Medicines (DOOM) kit had medication in it but had not been activated. (A 'DOOM' kit is used to destroy controlled drugs by making them ineffective). This would pose a safety issue as the drugs could easily be accessed and the medicines removed or exchanged .The RN's spoken with had not realised that this was a risk.

We recommend that the provider reviews NICE guidance in respect of the management of medicines in Nursing homes and in particular the disposal of controlled drugs and other prescribed medicines.

Inadequate

Is the service effective?

Our findings

Staff training records showed that there was a range of essential training that staff must complete, and a selection of specialist training that they could choose to do. We looked at the training records for the whole staff team including registered nurses, care staff, domestic, kitchen staff and maintenance personnel.

The Mental Capacity Act 2005 had not been included as an essential training course for all care and nursing staff, and was considered only optional. We raised this issue and were informed that this had been an oversight and the subject would be incorporated into the essential training for all staff immediately. Electronic records viewed later during the inspection showed that this had been done.

Care and nursing staff told us that their training was up to date, and that they had completed all their training on-line and were expected to complete this in their own time. Staff were given timescales for achieving their essential training, and there was evidence that the provider monitored staff performance around the completion of training. However training records viewed showed that some essential training had not been completed by everyone in the staff team with some courses showing that less than 50% of staff had completed them, these included fire safety, first aid, food hygiene, and health and safety.

A number of people experienced anxieties that they expressed in behaviour that could be challenging to staff and other people, and could harm the person or others. Records showed that staff had received no training to work with people with these needs and behaviours, and strategies for managing this type of behaviour were not in place to guide staff and ensure they responded in a consistent manner.

Some training that we would expect to find as essential, for the nurses, was optional. Of seven nurses, three had not completed palliative care training, five had not completed allergen training to comply with a recent European ruling around awareness of allergens and the requirement to tell people about things that could cause allergic reactions to them.

Two registered nurses had not completed anaphylaxis training in the event that someone had a violent allergic reaction. Two nurses had not completed training for the prevention of pressure ulcers, two had not completed basic first aid and another basic life support, and there was one registered nurse who had not completed any essential training at all. Many of the people were cared for in bed and needed intensive general nursing.

There was a risk that in the event of a serious incident some nursing staff may not have the skills to deal with it. We spoke with two RN's about emergency procedures such as what to do if somebody was choking and what to do if somebody stopped breathing, neither had the level of knowledge expected of senior nursing staff. Only a senior care staff member was able to give accurate answers on how to handle these emergencies. It was a breach of regulation 23 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The RNs on duty during the inspection were both Registered Mental Nurses and did not have experience or knowledge of some of the general nursing that they might be required to support people with. However, the manager explained that usually they would rota nurses so that at least one on every shift would be a registered general nurse. The manager was also a registered general nurse and was available for the nurses to talk to for advice. The RNs stated that they felt supported by the two senior nurses who were registered general nurses and clinical leads, and that the manager always listened to them.

Staff told us that when they started work at the home they had an induction and familiarisation with the home's routines and people's needs. Induction booklets were completed and these were signed off by the manager at a supervisor meeting to confirm that the staff had satisfactorily completed and understood that area of work.

There were induction programmes for staff in different roles, including agency staff, registered nurse induction, and care staff. Induction booklets viewed had been completed and signed off although there was a concern that for one senior staff member who had been in post for more than three months the record of their induction was incomplete: the manager agreed to look into this

We looked at the staff supervision policy. This was in date and stated that all staff should receive face to face supervision with their supervisor a minimum of six times per year. This frequency had not been maintained for some time and supervision records showed that on average, nursing and care staff had received between one or two

supervisions since January 2014. This was an area the manager had identified in an action plan as needing improvement and there was evidence that she had already began to arrange and carry out supervisions for staff.

A staff member told us that they had found their recent supervision helpful and had discussed areas that they needed to work on without judgement being made. They told us that the home had become more 'homelier'. They said they felt supported by the manager, and felt the home had "come on in leaps and bounds" compared to how it had been. They said "The manager is supportive to all and is the right person for the job".

The manager told us that none of the staff had received an annual appraisal in the last twelve months. A staff member confirmed that they had not had an appraisal but were aware from a recent staff meeting that these would be happening. This was a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Nutritional assessments (these assess whether people may be at risk from not eating or drinking enough) were undertaken for each person to highlight any specific risks. People's food and drink preferences and any dietary requirements were recorded. Room files recorded the meals eaten by people and these showed a variety of healthy balanced food was provided. The amounts people ate at each sitting was not always recorded. This shortfall in recording had been identified by the present manager as a concern, and which staff had been reminded about at a recent staff meeting. Some people with very poor appetites had not been offered alternative options.

There was evidence that food supplements were being used, but for people who were recommended for 'boosting' diets their care plans did not contain information for staff about how this was to be supported. This was particularly important as 17 of the 35 people in the home had lost weight since admission, and some had lost significant amounts.

We asked the manager for information as to how many people had been referred to dieticians and the home was able to provide this information to us after the inspection in regard to nine people. There were eight people that had lost weight but had not been referred to health professionals. It was a breach of Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

Fluid monitoring was undertaken but fluid charts did not make clear the ideal or target fluid levels people should be having, and fluid records were not always totalled. There was evidence that shortfalls in fluid monitoring were being highlighted to staff by the manager however there was no follow up of this to ensure future shortfalls were avoided. It was a breach of Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

People gave mainly positive comments about the food. People said, "It's been all right. I don't mind what comes." and "It's okay", with one saying, "It's not like you cook for yourself but yes, okay." Relatives were y more positive: One said, "The food looks filling and nutritious. She loves puddings and they give her plenty. "Another said, "She likes sweet food and needs feeding. They all know." The relative of a newly admitted person said that they had spoken to the cook about their relatives needs and was assured this was not a problem. They said "I do worry because he needs help and I'm not sure if he gets it when I'm not here".

In the dining room at lunchtime, there was a cheerful atmosphere, with music playing. Staff talked to people who were mostly eating well. The food trolley had a burning smell, and someone from the kitchen had to be called. It was dealt with appropriately, with no panic, and the maintenance man arrived promptly. There was a drinks dispenser in this room, which was used again to give people drinks in the afternoon.

Two people were observed being assisted with eating and drinking while they were in bed. This was done very well, with each person supported into a better position to eat, and then provided with a cover to protect their clothes before being assisted with their meal. The care staff spoke to the people about the food, adjusted their speed to suit them, and always said what they were doing. The atmosphere in each bedroom was calm. Pureed food was well presented and thoughtfully given to each resident being observed. One lady needed her fluids thickened and this was carefully carried out. One of the carers showed an excellent knowledge of the person, referring to her past and present during the meal.

Inadequate

Is the service effective?

Staff did their best to support each other during the mealtime. For example, one fetched the pudding for another, to save them leaving the person they were assisting, and in the dining room, the nurse praised the staff member who called for help from the kitchen. Drinks were available, including cups of tea and soft drinks. One relative commented, "There are always drinks here, and they prompt her to have some as she forgets".

One resident could recall 'a couple of choices' and another remembered, "I say if I like it or not, and they cook it".

Staff were asked to record incidents of behaviour on ABC charts (these are charts used for monitoring the triggers to behaviour, the behaviour itself and the consequences of the behaviour) for some people. For one person this had been happening for months and it was clear that assisting the person with personal care was a trigger to behaviour. No strategy or plan around this had been developed to help staff to cope. Some staff showed initiative and had really thought about the triggers that preceded some behaviour, and were testing personal theories about what seemed to work well. However, this was not shared and not recorded anywhere so that everyone worked with people consistently which could compound the confusion people experienced.

In discussion separately with a registered nurse (RN) and a member of the care staff about a person's behaviour, each gave different views of the frequency and severity of the behaviour shown by the person to staff and sometimes to other people. The carer told us that the occurrence of the behaviour was now much rarer, and the RN stated that they were unaware this person ever expressed behaviour of this type and had never seen it. This was a concern because care plans were updated by RN's and records showed there had been 26 incidents involving this particular person since October 2014.

There was a lack of recognition that this person presented on a frequent basis behaviour that challenged staff and others. Consequently strategies for helping staff to manage this had not been developed to ensure incidents were responded to in a safe, consistent, least restrictive and preferred manner. This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

People's Care plans included individual booklets that assessed people's ability to consent; this was called a 'consents rights and capacity' section and enabled staff to identify areas where the person was unable to make decisions for themselves. Records showed evidence of consultation with relatives to discuss these types of decisions, which included the use of bed rails, or flu vaccinations. A best interest checklist was completed and a mental capacity assessment was completed for to the use of bed rails.

There was clear evidence of the involvement of relatives in best interest decision discussions, and these also identified who had legal authority to represent people through Power Of Attorney (POA) authorisations. DNACPR (Do Not Attempt Cardiopulmonary resuscitation) forms which inform others about a person's wishes to be resuscitated or if that decision has been made on their behalf, were in place for the majority of people. We viewed three files and saw these forms had been completed appropriately and where possible, their relatives or other advocates had been consulted about the decision.

Those with bed rails in place had the organisation's bed rails policy either on their wall or in their folder. Staff were required to make regular checks of bed rails to ensure those people confined to bed were safe. A check of records showed that the frequency of checks was not always maintained.

The home's administrator showed us a recent piece of work to contact all representatives to seek evidence of their legal authority to make decisions on their relative's behalf. We saw copies of POA authorisations sent to the home to be placed on file. Some information was not clearly recorded. For example, on one person's file we saw that a referral to health professionals prompted by our visit, recorded that the person had been involved in this decision. However, on the same page it stated the person was unable to make any decisions for themselves.

The manager was aware of legislation and requirements of the Deprivation of Liberty Safeguards (DOLS) and said they would be completing appropriate applications for most of the people in the home. Mental Capacity Act (MCA) 2005 training had only been completed by three senior staff in the home. When we asked about this we were initially informed that MCA 2005 (this act provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular

Inadequate

Is the service effective?

decisions for themselves) was an optional course only, but during the course of the inspection the provider took action to ensure this was added to the essential training course list for all staff.

Although staff had not received MCA training and did not have a full understanding of what this meant for people, records showed that they were respectful of people's decisions to refuse support from staff, and there were examples of staff re-offering care at other times during the day when the person may be more responsive.

People were not really able to comment about their own health status. A person's relative said, "They had a doctor out to him once, I think". But some relatives were unsure if their loved one had been seen by a doctor at all. The manager told us that the doctor visited fortnightly unless there was a need for an earlier visit. A new pilot project called the 'Care Home Team' was now working with the home and this meant that two nurse prescribers visited weekly to check on residents' health needs.

People's records showed evidence of them being referred to different health professionals, for example, speech and language therapists, dieticians, and the mental health team; but records did not make clear any specific advice given by health professionals. One person was a diabetic, and their room file contained most of the daily documentation used by staff but contained no reference as to how this was to be managed on a day to day basis.

Requires Improvement

Is the service caring?

Our findings

A person commented on how she was looked after, saying, “They are fine at night. They give me the support I need. ”Another said, “I just tell them I want them. They soon come round.” Some people were not able to use a buzzer, but one person in their room, whose call bell was accessible but not in sight, was interested when we asked about it, saying, ‘Have I got a lead?’. The person recognised it when placed in their hand.

A number of people were lying on their backs in bed with radios or televisions on, even though some were asleep. Room’s records did not indicate if spending time in this position was their choice or was necessary. We asked one person if they would like to sit up and they said they would, they also said that they would like to be helped out of bed to go to the lounge. We later saw this person had been assisted to sit up for visitors who had arrived. Another person was unable to see the television that was on in their room although their room record stated they enjoyed watching films with music in them.

“I prefer to sit here in my room so I can watch my own programmes”, said one person in their room, before adding, “I love the view of the trees”. Another person said, “I don’t go to the lounge, they’re too old! I like this room. Some have no view at all”. He also said, “I have a bath if I want one”. It was less clear whether all the people in their rooms had expressed a preference to remain there, as their ‘my preference’ booklets had not been completed.

The bedroom doors throughout the home were mostly left open when people were in their rooms, When we asked a senior staff member about this they said there had to be a compromise between maintaining people’s privacy and also ensuring that those people who stayed in their rooms did not become isolated there. In passing a room door we noticed that one person’s clothing had moved due to their restless movements causing this to expose part of their body to passers-by. When we checked their room record briefly we saw nothing was recorded to inform staff this was a frequent issue and that they needed to ensure the person was checked more frequently to ensure their dignity was not compromised.

On passing another room we saw a staff member helping another person whose room door had been closed, in their attempt to leave the room the person had become wedged between the door and furniture with their Zimmer frame and had required the intervention and assistance of staff to exit the room.

Relatives gave some examples of the communication and involvement at the home. One said “They did ask me about his likes and dislikes and they phone me if they need to talk to me, and see me here”; and, “They phoned us to ask about the flu jab and if she runs out of toiletries.”

Staff talked respectfully to people. When a care staff offered a person more coffee at breakfast, she gained her attention, waited for a reply, and then gently reminded her that she usually preferred two sweeteners in her drinks. Another staff was observed sitting down at eye level to get the person’s attention before asking them what they would like to eat for breakfast.

One family said they had arrived to find their relative distressed, and said, “They dealt with it straight away”. Another family said they had called staff when their loved one was complaining of leg discomfort and “They came immediately, the nurse came and changed the dressing.” They also said, “They usually say what they are doing to her before they do it and the records are completed most of the time.”

Whilst it would be considered good practice for people to get up when they want and have flexible breakfast arrangements, it was unclear from the number of people still needing breakfast when we arrived and those still being assisted to get up at 09:30 if this was a personal choice or the impact of not having enough staff to get people up and dressed and ready for breakfast. Staff said they followed a relaxed routine and people got up when they wanted.

Care staff were observed supporting people with personal care discreetly, but privacy and dignity was not always supported. One person was in the lounge in the morning, wearing pyjamas but no socks or shoes. His relative noticed this when visiting, and was upset that the person’s dignity was compromised. The visitor attempted to assist the person with their socks. A care staff came quickly when asked and discussed this with the relative. The relative was also upset that the person’s new slippers were missing and the staff agreed to go to the laundry to look.

On looking around the premises and particularly people’s individual bedrooms we noticed how few people had

Is the service caring?

clocks or calendars or anything that could orientate them to the time and date. This was important so that people who were able to could tell the time and plan their day accordingly. We discussed this during the inspection with the manager who arranged that all rooms were immediately fitted with clocks. This included those people who had clocks that were no longer working.

Although staff were constantly busy they always tried to acknowledge those people in passing who sought their attention, but those that did not were seen only in accordance with the frequency of the checks they had been assessed for. We observed that some people called out constantly from their rooms and staff managed this by going into their rooms briefly but quite frequently to talk to them. One said she wanted to see 'her', gesturing to the Activities Coordinator who walked by, and, the staff member immediately came back to see them, spending time with them and soothing them.

Staff also showed knowledge of how to keep people safe; for example, they tried inventive ways to encourage a person to wear protective headgear that would keep them safe from injury, staff showed that they had developed an understanding of the signs that could indicate if the person was becoming unwell.

Care staff had formed positive relationships with people in the home. One care staff said "Christmas here is amazing"; and another was really looking forward to ensuring the people had the best Christmas day. Staff were keen to show the photos of a recent event where many had brought their own children in to see people.

The manager discussed ways in which she wanted to improve the signage and colour schemes in the home to guide people around the home better. One of the bathrooms had a bath sign outside even though it had been converted into a wet room. Improvements to the garden area were under way to make it easier to push wheelchairs and also to improve the security of the garden.

Care staff spoke kindly and compassionately with people. The response of some people to them showed that they felt well cared for. One person was spoken to with such skill that it calmed the person's anxieties down.

The staff showed that they knew the people they were caring for. When talking about one of the people who walked around for most of the day, one said, "He loves milk, he drinks lots. That must help with his strength". Another person had chosen to wear an Easter-type bonnet, covered with flowers and a care staff reassured her that the hat suited her, and reminded her of other hats she had worn.

We observed a person being supported using a hoist in the lounge before lunch by two care staff. They moved the person appropriately, making sufficient space first, and then talking to them, telling them what they were doing and reassuring them.

People who were able to answer agreed that staff were caring. One said, "Yes. They work very hard too", and another, "The staff are all right". A person in bed who was waiting for their breakfast was shouting cheerfully, and said "They are very kind to me. And I'm very grateful." This person had a wonderful philosophy for living in the home, and said, "You've got to either like it or lump it, and I don't lump very much!" Another person said, "I get on all right with this crowd. It has its moments!" A smiling person in her room, said, "They are good", and a person who was reading in their room said, "They are all right, I've no complaints".

Relatives, even those who had expressed some concerns, had good things to say of the care. One relative said "Everyone speaks to her very kindly and on the whole she is well cared for". "The staff on duty are very nice", before adding, "There's just not enough of them". Another relative said, "I'm very happy with his care. Can't fault it. They are lovely to him and he likes them very much." A relative talked of "The very helpful staff. . ..I think it's very good here". Another relative agreed, saying, "They are lovely staff here, they look after her well".

One family said "The staff have talked about her condition when we have asked", and most felt they could visit when they wanted to. Another relative stated, "We feel welcome here", and another said, "I visit every day. Having me here all the time makes it like his home. I'm very welcome here."

Requires Improvement

Is the service responsive?

Our findings

A review of people's Care plans showed that people's initial assessment on admission had been completed. An exception had been an emergency admission, which had left the staff without appropriate information over a weekend. Since then, the home manager explained they would not be willing to admit people for emergencies over a weekend unless it was someone they already knew.

We viewed people's individual care plans and the room files kept in their bedrooms. Care plans were not indexed so information was difficult for staff to find in a hurry. Care plan information was handwritten by registered nurses who recorded their assessment of the level of support each person needed. These records were not personalised and did not reflect people's preferences for how care should be delivered or what worked best for them.

In discussion with a staff member they said that a person disliked male carers. A review of records related to this person showed that they did not get the support they wanted and this had had a negative impact on them. On more than one occasion they had been supported by a male staff member and this had triggered behaviour that staff found challenging. Care plans did not show that a decision had been taken that the person would not receive support from male carers in future.

Room files that care staff used on a daily basis held a 'My preference' booklet that should be used by staff to give them information quickly about how people preferred to be supported. We saw these in every room visited and looked at seven which were mostly not filled in. When we asked a staff member about this they reported that information was collected about people and written up but the booklets became full as they contained monitoring information and were archived and replaced with new booklets. This meant that important information about people's preferences and choices was not transferred over and there was a risk people could receive inconsistent or inappropriate support. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw some people that were more able spent time with the activities co-ordinator on the days of inspection, these took the form of individual one to one time to play games, or complete a puzzle, or have a brief chat. We had mixed views from people about how meaningful some activities were. On the first day the activities coordinator took two people downstairs and they sat with her at a table looking on whilst she wrapped people's presents. Some of her conversations with them did not appear to take into account their condition. For example, she asked one person how many grandchildren they had, this was not a good question as the person had advanced dementia and had great difficulty recalling this kind of fine detail and struggled to respond. There were photos on notice boards of people during organised events and an activity planner displayed on the wall of the staircase but this was for November 2014.

Some effort had been made to provide people with open books and magazines, and one person was sat at a table with some jigsaws. A staff member helped her with these. There were collages on display in some people's rooms, and in the lounge. One person was reading in her room, and said, "I love to read". Another person, who was sitting up in bed, was using felt pens. His hands were covered in their colours, and later his relative helped to wash them. The staff said that he loved to use the pens, and his relative agreed. A person in the lounge told us, "There's not an awful lot to do."

Laundry staff encouraged one of the people to 'help' them to push the trolleys. One family said, "They do encourage her to join in". Relationships with families and friends were supported. A relative, told us about a special occasion that had been set up by the home for their family and friends to Similarly, personal photos were given pride of place in many of the bedrooms and one relative said, "They want to know us as well here." He added that a staff member sometimes came to read to his mother, who remained in bed.

On the second day of inspection we observed the activities co-ordinator engaging individually with five people in the top lounge. There were individual discussions and game playing that drew some laughter from the people playing, people looked relaxed and in positive moods, tapping their feet to music, chatting with other people or reading a book or paper.

The activities co-ordinator was relatively new, and had developed a weekly activities planner. There was an activities file which contained a small profile of each person and their previous interests and hobbies, so that they could try to personalise some of the activities offered.

Requires Improvement

Is the service responsive?

The complaints procedure was displayed in the entrance hall of the home. This was not provided in more accessible formats like large print or with pictures to support the text. The complaints procedure and policy were up to date. The complaints log showed only one complaint from this year, which was ongoing. The manager told us this was the only complaint received. However, when we looked at the minutes of a recent staff meeting the manager had pointed out to staff that there were regular complaints received from relatives about clothing and other items going missing. These were not formal complaints and so had not been recorded. It was therefore unclear how the home was dealing with relatives' concerns and complaints and whether they were happy with the outcomes. Some relatives told us they were satisfied with the resolution of their complaints.

We asked relatives whether they felt confident of using the complaints procedure. One relative said, "Once the skin on my relative's feet was dry and they sorted it out straight away". Another relative said "I'd talk first to the carers, they'd help, then the manager, then Head Office. Any complaints seem to be acted upon. I sent them a well done message recently." Another relative did not think he had met the manager, but clarified this with: "If I've got no complaints, I wouldn't need to, would I?" He added, "He couldn't be in a better place". Another relative said, "I would contact the manager downstairs if any problems". He added that "My relative needed shoes once and I had to stress that they needed to do it", and "I was a bit shocked when she was out of shampoo, but they are usually pretty good".

Two other relatives said "There was a strange incident recently when mum's granddaughter visited and was told that she could not stay long because dinner was nearly ready. We've been to see the manager about this', and they were still waiting for this to be resolved.

There was a 'Concerns Box' at reception, with a sign saying, 'If you have any concerns you wish the manager to address, please fill in a form and leave it here'. There were no forms, and the box, which was not a locking one, was empty.

This is a breach of Regulation 19 (1) (2) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

A range of audits were taking place, and there was a system for the management of people's monies. Other audits did not show the action taken to address identified shortfalls. Audits conducted by the provider representative were premises focused and did not pick up the concerns the Care Quality Commission (CQC) found regarding poor infection control, or shortfalls in respect of staffing, care, and documentation. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Important information that the provider was required to inform CQC about including deaths; safeguarding or serious injury had not been consistently notified to CQC. We found in a two month period only three out of eight deaths had been notified to CQC. These are breaches of Regulations 16(3) and 18 (2) (a) (e) of the Care Quality Commission (Registration) Regulations 2009.

The manager had organised and held staff meetings with both the day and night staff, and records of these showed that there was some dissatisfaction within the staff team about how other staff worked and that poor practice was not being handled appropriately. There was no evidence of spot checks by the manager or other senior staff to monitor the delivery of care at night.

When we spoke with individual staff they said that they thought communication between staff and the manager was good , however this contradicted our findings which showed that reporting systems used to inform other staff and the manager were not being used effectively, to ensure everyone was kept informed and the manager could ensure that appropriate action was always taken.

There is not a registered manage in post but the former deputy manager has stepped into the manager role and is proceeding with an application to register with the commission, she has been provided with a mentor who is another experienced registered manager within the organisation to help with her development and understanding of the requirements of the role.

An electronic record for recording incidents and accidents in the home was maintained. This gave details of the types and number of accidents for the preceding two months and showed that out of 49 occurrences, 32 could be attributed to people experiencing falls. There was no analysis of this information to establish if there were emerging trends or patterns. Data viewed did not always make clear what action had been taken by staff other than the immediate intervention that would indicate learning from the situation. For example following a fall or another type of accident people's risk assessment were not reviewed, or a referral made, or their care plan updated, so as to try and reduce recurrence. There was an absence of quality monitoring of incident reporting which meant that issues regarding people's safety were not responded to appropriately.

Of the relatives spoken to, two mentioned they had been sent annual satisfaction surveys from the organisation and said, "Meetings are occasional, but they do happen". None of the other relatives had any recall of either meetings or questionnaires. There was no evidence of meetings or surveys of people in the home to ask for their feedback, or evidence of requests for feedback from professionals who visit the service. There was no clear frequency to the surveys that were conducted or evidence that this information was used to help develop the service. A system was not in place to inform those who contributed to surveys how their feedback information was used. It is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was mixed feedback from health and social care professionals present during the inspection. A care manager and a representative from the Local Authority commissioning team raised no concerns regarding the home and the delivery of care to people; however a health care professional expressed concern that they had not been kept informed of the deterioration of two people at the home, and that the relatives of one had not been happy with the way the person's illness had been handled.

Records showed that the manager was addressing shortfalls highlighted by the last environmental health service visit; this gave a food rating to the home of 4 stars. The rating was based on a number of factors including the condition of the kitchen and the processes for the storage, preparing and cooking of food and the records maintained of this. The highest rating that can be achieved is 5 stars and the manager was hopeful that the improvements implemented would help the home regain the higher rating.

The majority of staff spoken with said the new manager was supportive, popular, and listened and responded on

Inadequate

Is the service well-led?

day to day issues. However two staff for different reasons did not feel listened to or supported, with one commenting that they no longer bothered to raise issues with any manager because of this.

The manager told us that she was aware of issues around documentation and this was evidenced in staff meeting discussions held recently. She had developed an action plan of things that she had identified as needing improvement. She added to the action plan as the inspection progressed to ensure all areas were covered. She had identified a need to commission good quality face to face staff training in response to issues highlighted in this inspection, and had implemented this immediately by booking this training for the New Year. In response to our concerns regarding the lack of calendars, clocks, and the bathroom sign, the sign was immediately removed and clocks were provided for all rooms within two hours of this being highlighted. From discussion with staff and a review of meeting minutes there was evidence of some learning from a recent event and that the manager had implemented changes to staff practice as a result.

The provider had started working with a new service set up by the Clinical Commissioning Group (CCG) (this is a local group of GP surgeries that manage community health in the locality). It was called the Care Home Support Team. This service had a nurse prescriber or tissue viability nurse who attended the home weekly. They reported their findings back to the GP. The team had direct access to a consultant geriatrician and pharmacist. The provider had embraced this new service. In response to our concerns regarding one person the manager had taken immediate action to refer this person to the Care Home Support Team service for reassessment.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurs, and had not responded appropriately to incidents of abuse that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider had not ensured that appropriate systems were in place for appropriate standards of cleanliness and hygiene at all times and this placed service users at risk from infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment People were not provided with a sufficient number and range of comfortable chairs in lounges to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider had not taken appropriate steps to ensure that an effective system for the receipt, handling and response to all complaints made by the service users or the persons acting on their behalf, was in place.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider had failed to ensure that staff had appropriate training, supervision and appraisal to develop the skills necessary to carry out their role thereby ensuring people's health and welfare needs could be supported to an appropriate standard at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider had failed to ensure that all deaths occurring at the home were appropriately notified to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to ensure that serious incidents or allegations of abuse were notified to the Care Quality Commission

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against risks of inappropriate or unsafe care and treatment, because the assessment of needs and planning and delivery of care did not ensure their welfare and safety. Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
We served a warning notice which required the provider to meet this regulation by 25 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected against risks of inappropriate or unsafe care and treatment, because systems designed to regularly assess and monitor the quality of the services provided to identify, assess and manage risks relating to people's health, welfare and safety were not effective. They did not take account of people's complaints and comments made. Regulation 10(1)(a)(b), 10(2)(b)(i) and 10(2)(c)(i)

The enforcement action we took:
We served a warning notice which required the provider to meet this regulation by 25 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to safeguard people's health, safety and welfare. Regulation 22 of the

This section is primarily information for the provider

Enforcement actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which states:

The enforcement action we took:
We served a warning notice which required the provider to meet this regulation by 16 March 2015.