Allambie Enterprises Limited

Allambie House

Inspection report

40-42 Coundon Road
Coventry
West Midlands
CV1 4AW

Tel: 02476525011

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21 July 2017
21 August 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Allambie House is registered to provide accommodation and personal care for up to 30 older people. This can be people who have a learning disability, physical disability, dementia or sensory impairment. At the time of our inspection visit there were 26 people living in the home.

The inspection visit took place on 19, 21 July and 21 August 2017. The first and third day of the inspection was unannounced and the second day, announced.

During our last inspection on 4 October 2016 we found there were improvements needed in three areas, these being, Effective, Responsive and Well led. We rated the service 'requires improvement' overall. During this inspection we found there had not been sufficient improvements made to improve the ratings. We also found additional areas needing improvement. We have rated this service 'Requires Improvement' three areas and 'Inadequate' in Safe and Well Led.

The registered person (provider) had been in post since June 2016. The manager had been in post for approximately 11 months but had not registered with us. The provider had not taken the necessary action to ensure the manager had applied for registration with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health were not effectively managed to ensure people remained safe. Risk assessments were not always accurate or easily accessible to staff to ensure they used them to manage risks safely. The provider's health and safety risk assessments had not identified risks associated with the environment such as unprotected hot surfaces and access to stair wells. Where risks had been identified, there had been delayed action to address them and audit checks to monitor the quality and safety had not always identified areas needing improvement.

People told us they sometimes felt safe living at the home and we saw people shared positive interactions with staff when supported. Staff were clear about the different kinds of potential abuse and had completed training so they knew how to protect people from harm. They knew about the procedures to follow if they had any concerns about people's safety which included reporting them to the provider. However, we found the provider had not always followed safeguarding procedures by forwarding the required notifications to the Local Authority and us, so that we could be assured people were protected.

The provider had not ensured they carried out their responsibilities to comply with the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people could not always make decisions themselves, mental capacity assessments had not been completed. Some staff had not received training in MCA and DoLS so that they understood how to apply the principles of this when delivering care.

Staffing arrangements at the home were not always effective to ensure people's needs were met and people, staff and relatives commented there were times when there were not enough staff available to support people. Recruitment checks carried out by the provider were not sufficiently robust to make sure staff employed to work at the home were safe and suitable to work with people. New staff were provided with an induction to the home and completed training to prepare them for their role. Refresher training was provided to all staff on an ongoing basis but there were gaps in some training. Training linked to people's needs such as medicines and dementia care was not routinely provided to ensure staff updated their knowledge and skills to meet people's needs.

Each person had a care plan that contained information about their needs, but these were not always up-to-date or sufficiently detailed to guide staff in providing consistent care. In addition, care staff had limited access to the care plans. Staff told us they relied on handover meetings at the beginning of their shift to be told about changes in people's needs. We attended one of the meetings and information shared was basic with many people being reported to be "fine, no concerns". Staff handed over information about anyone who had received personal care or had been unsettled during the night.

Medicines we checked for some people were not managed safely in relation to the administration, storage and recording of medicines. Some people did not receive their medicines as prescribed.

Staff were caring in their approach towards people and aimed to provide care in accordance with people's choices and preferences. People were provided with a choice of meals and drinks but some people felt meals could be improved. People were supported with some social activities within the home and spoke positively of activities staff.

Some staff told us they felt supported to carry out their role and were positive in their comments of working at the home. Other staff members told us they did not feel supported management staff. Relatives spoke positively of the care staff and management staff at the home. They told us they felt at ease to approach the manager or provider if they were not happy and wished to raise a concern. There was a complaint procedure available to people on who to contact should they have any concerns. This was accessible to people in their rooms. There were some audit checks undertaken to monitor the quality of the service and to plan improvements to ensure people received the quality of care and services they expected.

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

The 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always feel safe living at the home and risks associated with people's care were not consistently managed to keep people safe. Staff knew what to do if they suspected abuse but safeguarding procedures were not followed by the provider. Staff recruitment procedures were not sufficient to check staff were suitable to work with people at the home. Medicines were not consistently managed and administered safely. Staffing arrangements were not always effective to ensure people's needs were met.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was provided but there were gaps in essential training that needed to be addressed. Action had not been taken to assess people's mental capacity and there were no current authorisations in place to deprive people of their liberty where this may have been in their best interests. People had a choice of food and drink but felt the food could be improved. Staff had some knowledge of people's nutritional needs and supported people who needed assistance to eat. Overall people had access to health professionals.

Is the service caring?

Requires Improvement

The service was caring.

People and their relatives were positive about the staff. People were supported by a staff team who were patient and respectful towards them. Overall people's privacy and dignity needs were met and staff treated people with kindness. Some people did not experience positive care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff aimed to be responsive to people's needs but this did not

always happen. Staff supported people to make some choices about their care and people had access to some social activities. Care plans required more information to help ensure people received personalised care in accordance with their preferences. People had some involvement in planning and reviewing their care. There was a complaints process in place. People felt confident to report any concerns and knew who to speak to.

Is the service well-led?

Inadequate

The service was not well led.

There was a manager in post but they were not registered with us and had been in post since June 2016. Staff gave mixed views about working at the home, some feeling supported and others not. Systems and processes to monitor the quality of care were not sufficiently effective to drive and sustain improvements. Processes to identify and manage risks to people's health and safety were not sufficient although the provider had taken some action to mitigate risks identified during our inspection.

Allambie House

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

This inspection took place over three days. This was on 19 and 21 July 2017 and also 21 August 2017. This was a comprehensive inspection. On the first day, the inspection visit was unannounced and on the second day announced. The first day of the inspection was attended by two inspectors and an expert by experience. An expert by experience is a person who has experience of using this type of service themselves or caring for someone who used this type of service. On the second day, two inspectors returned to continue the inspection. As there had been a number of areas needing improvement identified during our inspection visits in July, we carried out a further visit on 21 August 2017. This was to check progress made in making the required improvements and in particular in regards to the safety of people.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care and spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They told us they were working with the provider in regard to some areas that needed improvement.

We analysed information such as statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at three care plan records in detail and other associated documentation such as people's risk assessments and medicine records. We looked at the complaints information, staff training records, accidents and incident records and quality monitoring information.

We spoke with 11 people who lived at the home, five relatives, seven staff (including care staff, the cook and

the activities co-ordinator), the manager and the two owners of the home (provider). We also spent time observing how staff interacted with people as some people were not able to talk with us in detail about their care due to them living with dementia.

Inadequate

Is the service safe?

Our findings

The provider's safeguarding procedures were to notify the local authority of any safeguarding concerns, and to keep them informed of any investigations into safeguarding concerns. However, the provider had not always followed their own procedures, or informed CQC of safeguarding concerns at the home as they were required to do by law. For example, on one occasion, a person who lacked the capacity to make decisions about risks to their safety and their movements, were being restricted at the home and had left the home without staff knowledge. The person had been found walking alone in the local community, and paramedics were called by a member of the public to assist them. This had not been reported to the CQC.

Safeguarding incidents had not been reported to us when required. This meant we had not been able to check sufficient actions had been taken at the time of these incidents to ensure risks were managed to prevent them happening again. The provider told us that following incidents where people had left the home without staff knowledge, they had made the home more secure by introducing extra locks to the door where the person had exited the building. These were fire safety approved locks. However, when we asked the provider to demonstrate how the door would be opened by staff, people or visitors in the event of a fire, the provider could not open one of the two exit doors that had been fitted with extra locks. They advised they would address this with immediate effect. This was actioned on the second day of our inspection visit. At our third visit a notice had been placed on the door so that staff would know what to do to exit the building in an emergency situation.

Accident and incident notifications showed one person had unexplained bruising. This had not been referred to the local safeguarding team as required for them to determine if any further actions were needed. Nor had not been identified by the manager or provider from audits of the accident records. This meant any potential abuse would not have been identified and acted upon to keep the person safe.

Risks associated with people's health were not always managed to ensure people's needs were met and they were protected from harm. For example, one person was at high risk of developing sore areas on their skin because of lying on one side and being reluctant to reposition themselves when in bed. A staff member told us, "I noticed they were getting pressure sores down one side. I told the senior but I have not heard anything. I was just told to log it down in the log sheets and have been putting cream on it so it does not break." We asked them if the person had any sore skin areas, they told us, at the moment it's not broken but sometimes it can be inflamed. There was no skin care plan available for this person to guide staff on how to manage the risk and prevent further skin damage.

We made the manager aware of this and they accepted no skin care plan was available and that this would be addressed straight away. When we visited the home on the third day on 21 August, there continued to be no skin care plan in place. The manager told us nobody in the home had any skin damage such as sores where they would require dressings, including this person. However, following discussions with staff, we established this person had developed a sore on their hip. We checked health professional visit records to establish when this had developed. This had been seen and dressed by a district nurse on 15 August 2017. We noted from records the person had been found in a wet bed and was in need of personal care. The lack

of effective systems to identify, monitor, record and treat people with skin break down put people at risk.

One person needed to use a frame to assist them with their mobility to prevent the risk of them falling. The person was able to move independently, so was moving around their room during the day. We observed the person sitting in their bedroom during the first day of our inspection visit. We passed by their room during the day several times. The person did not have their walking frame in their bedroom so that it was available for them to use and walk around safely. We told staff about this and on the second day of our inspection visit, the frame had been 'found' and placed in the person's room next to their chair where they were sitting. The manager told us, "I'm not sure why the frame was not in their room."

We observed one person on the first floor walking around the home independently partially clothed carrying three items in their arms. They had walked down stairs to the fire exit and back up again as stairwells in the home were open and easily accessed. They dropped an item and bent down to pick it up balancing the other two items in their arms to retrieve it. Upon reviewing this person's care we found they were supposed to walk with a walking frame but would not use it. To manage this risk there were instructions in their care plan for two staff to support the person when walking. Staff knew the person walked around the home unsupervised and their failure to monitor this person's whereabouts, placed the person at risk of falling. Staff in the home were working on the ground floor so were unaware this person was walking around unaided. They told us, "They are a wanderer and they sometimes go up the stairs if you are not keeping an eye on them." It was evident despite this known risk, action was not being taken to ensure the person remained safe at all times.

One person had been discharged from hospital with an infection that could be transferred to other people and staff at the home. There was no risk assessment in place, or care plan, to instruct staff on how other people and staff should be protected from the spread of the infection. The manager told us staff knew people well, and this information did not need to be in the care records. However, agency staff (staff obtained from a recruitment agency) were brought in at the home regularly and we did not see records that ensured they would be made aware of this. The manager showed us at our third visit to the home a risk assessment had been put in place.

People's risk assessments, had not been completed accurately. For example, a moving and handling risk assessment had a score to denote the level of risk. The scores showed one person had "normal weight bearing" (able take their own weight when standing). However, staff told us the person could not stand and take their own weight which meant the scoring was not correct. The falls risk assessment for the same person indicated they were "fully mobile" which was not the case. As the risk assessments were not accurate there was a risk this person's care may not be consistently managed safely although staff told us the person was cared for in bed. During our third visit to the home we found the provider had not updated the risk assessments to make sure care and support provided reflected a person's changing condition.

We looked at how medicines were managed to make sure people received them as prescribed. We found some staff who administered prescribed medicines were not trained to do this safely. For example, applying medicated creams. The senior care staff member told us staff who applied creams informed the medicines trained staff they had been applied. It was the trained staff member who then signed the medication administration record (MAR) to confirm the creams had been applied. This was not good safe practice as the senior care staff member had not evidenced the creams being applied, or to the correct area, so they could be assured this had been applied correctly. Records did not consistently show where creams were to be applied or the quantities to use so it was not clear if creams were applied safely as prescribed.

We identified one person had a skin rash and was at risk of skin breakdown, there was no clear information

about where the creams should be applied and no information to say the person had been prescribed creams for their rash stating how they should be used. The provider told us during our third visit to the home, that in some cases family members had brought creams into the home for people to use. They said action was in progress to advise family members not to do this or to let staff know if any creams were brought into the home so they could ensure safe procedures were followed.

We saw people had creams for their skin stored in their bedrooms. We found one cream not labelled and others had no date of opening recorded so that it was clear they were still 'in date' and effective. The risks around storing creams in people's rooms had not been assessed. For example, risks to those people who were living with dementia, who could overuse creams, or potentially swallow them. Some of the creams should only have been administered by staff who had completed medicines training. During our third visit, we were informed that medicated creams had been removed from rooms and were stored in the medicine trolley. However, we found a cream in a person's room not dated which meant we could not be confident sufficient action had been taken to address the issue around recording dates of opening.

Night staff did not administer medicines and the manager told us they had not been assessed as competent to do this. This meant they were not able to administer medicines safely at night if people needed medicine. One staff member told us, "They give us a key but I don't know which key is for the drugs cupboard." Another staff member told us, "They leave paracetamol on top of the trolley if they (people) need it." However, without the necessary training, there was a risk the medicines may not be managed safely. At our third visit the manager stated actions had been taken for senior care staff to receive further training. There continued to be no trained staff on duty at night who could administer medicines.

We were informed nobody in the home self-medicated, but found one person had an inhaler in their room under their pillow. There was conflicting information about how this person's inhaler was to be managed. The person's 'daily support plan' stated "keeps a reliever inhaler on them at all times" the records stated the person did not always use it correctly. The manager told us the person was not supposed to be self managing their inhaler because they had been told this by a health professional. Although we found at the third visit to the home the inhaler had been removed from the person, we could not be assured their systems continually checked to ensure medicines were given as directed or in line with professional advice.

MARs showed people did not always receive their medicines as prescribed. One person should have stopped receiving folic acid on 30 June 2017, but they had continued to be given this until 8 July 2017. This had not been identified during any medicine checks.

Another person's MAR showed they had been given three times the amount of an inhaler medicine they should have been. We also found a prescribed inhaler was not available to give them. We asked the staff member who managed the medicines to make contact with the GP and Pharmacist to ensure there would be no detrimental effect to the person and to ensure the inhaler they needed was made available to them. The staff member confirmed contact had been made and during our third visit, we found action had been taken to ensure the person had the correct inhalers. Although this issue was resolved, the provider or staff had not identified this potential risk.

When we checked a pain relief medicine for one person, there was a discrepancy in relation to the amount available on the records and those available in the box. We could not be assured the medicine had been given as prescribed. Records were not sufficiently clear to check how this had been managed.

One person had received a medication review by their GP in June 2017. The person was prescribed food supplements, as they required additional nutrition to maintain their weight and health. We saw on the

review their prescribed food supplements had been changed to a different product, as the person disliked the taste and refused to take them. We saw the person looked frail and underweight, and checked what food supplements they were taking to help increase their calorie intake. We noted the previously prescribed supplements were still in stock at the home, and were being given to the person, instead of their new prescription. Staff told us they had been given advice by a different health professional to use existing supplements before starting the new ones, to save wastage. Staff were not following the advice of the prescriber to minimise the risk of further weight loss. Due to the person being in discomfort when they were moved, staff had been unable to monitor the person's weight other than taking arm measurements. However, there was no recognised tool to assess what the arm measurements meant. We discussed the risks associated with this person's nutritional needs with management staff so that clarification could be sought about how the supplements were to be managed. On the third day of our visit we found the prescribed supplements were now being given.

Another person had been prescribed a medicine to assist them with bowel movements, the prescription stated they should have this once daily. This helped prevent the person experiencing discomfort. However, staff were only administering this when the person had not had a bowel movement.

We found one person had been given their medicines at the wrong time of day. They had been prescribed a medicine to control stomach acid. It was important the medicine was given around half an hour before food. The person had been given the medicine after breakfast each day which meant it would not have been fully effective.

Due to the timings of the medicine rounds, we could not be confident there was a sufficient gap between rounds to make sure people did not receive too much medicine in a short period of time. For example, staff told us the morning medicine round took place at approximately 8.30 to 9.45am, the second medicines round of the day took place at 12.00 noon. Some people received medicine that required a 4-6 hour gap between doses. Specific times were not recorded when this was different to that indicated on the MAR to enable this to be checked. Staff told us they had not considered a time gap needed to be left between some types of medicines. No medication audit had identified this as a concern.

Medicines were not always stored safely. For example, some medicines were stored in the fridge and there was a procedure to monitor the temperature of the fridge but we found the temperature monitoring equipment showed varying results which questioned whether it was not working correctly. This meant the effectiveness of the medicine may be compromised. We brought this to the attention of the provider on the first day of our inspection visit. They had changed the temperature gauges by the second day of our inspection. However, during our third visit the provider had noted it was the fridge that was the problem and this had been replaced.

The provider advised us following our inspection visit, that medicine training had been booked for all senior care staff. The manager told us a medicine review and audit had been requested by the local clinical commissioning group and during our third visit told us this had taken place. They had been provided with an audit form to enable the manager to effectively audit medicines and identify any errors.

We checked safe procedures were in place to recruit staff. Staff recruitment files showed a Disclosure and Barring Service (DBS) check had been obtained for each staff member prior to their employment to check for any criminal convictions. However, where concerning information had been identified, there was no record to show this had been discussed with the person at their interview. There was no risk assessment in place to show how concerns identified would be managed to protect people from potential risk. References had been obtained. In one case, there was only one character reference that had been obtained and not the

required two in line with the provider's recruitment policy. We also found the manager had not signed copies of identification documents to confirm they had checked the originals (although they assured us they had checked them). The lack of robust checks meant the provider could not assure themselves staff had been recruited safely to support people. The provider has subsequently advised action has been taken to ensure recruitment records and risk assessments linked to recruitment had been carried out to ensure risks were minimised.

Equipment checks and health and safety checks were no effective in minimising risks to people. We saw bathrooms were small and there would be insufficient space to use hoists and wheelchairs safely and easily in these areas. One person told us, "I can't have a shower because the bathroom is not safe for me to have a shower." The bathroom on the middle floor had tiles missing from the wall which meant this area could not be cleaned properly and was an infection control risk. The provider told us they were in the process of installing a new bathroom with more space.

When we checked some of the hot water taps in some bedrooms, the water was very hot to touch which meant there was a potential scald risk. We also found radiators in three bedrooms next to people's beds had no covers. There were unprotected pipes in rooms under the wash-hand basins that were hot to touch when the hot water was in use. There was a risk if people fell against these they could potentially burn themselves. The provider had not undertaken a sufficient risk assessment of the environment to identify areas of risk. The provider subsequently advised as an interim measure beds had been moved away from the radiators. During our third visit to the home the provider told us they had identified 11 radiators that needed covers fitting. Eight had been fitted and a further three were due to be fitted the day following our visit.

Some of the carpets in the home were worn, stained and threadbare. This included stair carpets that were torn in places. This posed a risk, especially when we saw a person who was supposed to use a walking aid with staff support use the stairs unsupported and without equipment. We were aware from accident records this person had fallen in the home. In two bedrooms we saw the floor covering was in need of attention due to it being ripped or raised where there was a seam creating a trip risk. During our third visit to the home, the provider advised flooring would be replaced in bedrooms as a matter of priority and they were sourcing a contractor to do this. We saw new flooring had been obtained and the provider told us this would be fitted to three rooms identified as a priority.

One person liked to have their bedroom open and used a chair to prop it open, this meant in the event of a fire the door would not automatically close. When we asked the manager and provider about this, they told us, "We know [person] does this in their room, and we keep moving the chair out of the doorway." Arrangements had not been made to ensure the person could safely leave their door open by fitting an appropriate door retaining device that would automatically release in the event of a fire.

We checked the arrangements in place to manage an emergency situation. We saw evacuation plans contained details about people's mobility, and any special equipment that may be required to assist them to move around. However, we could not be sure they were accurate and this information was kept in people's individual care files as opposed to being in a central easily accessible location to present to emergency service staff. A staff member spoken with was not aware these were in place. They told us, "I have not been told about them." By our third visit, the manager told us they had all been reviewed and these were in a central file.

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

People and their relatives did not feel there were always sufficient numbers of staff to support them. One person told us they did not feel safe because there were not enough staff. They told us, "Safe, I don't know if I do (feel safe) to be honest. I don't think there are enough staff." A relative told us, "There are not enough carers in general, staff are great but just not enough. I can't always find them, especially when trying to get out of the home. I don't know what they would do if there was a fire." We found staffing arrangements were not always effective to keep people safe. The layout of the building impacted on staffing arrangements. For example, stairwells to each of the three floors were open and some people living with dementia were known to walk around during the night when there were only two staff on duty.

A staff member told us, "We have three (care staff) on in the morning and afternoon and two at night. I don't find three in the morning enough. If we have a really busy shift and all the buzzers are going off and we need to get them up washed and ready, it is a struggle." Another staff member told us, "To be quite honest I think we could do with a 'floater' (a staff member who could work flexibly). It would be nice if that one person could answer call bells, that's just my opinion." Staff they told us that out of the 26 people living in the home, there were nine people who needed two staff to assist them which meant there would be times when staff were not available to observe and support other people. The provider and manager told us they did not use a dependency tool to assess people's needs and the number of staff required. They told us staff had not raised concerns with them about staffing levels.

One person said they did very little during the day. They told us, "If I press my call button they usually come between five and ten minutes. Once they wash me, they put me in this chair and this is where I stay all day." We asked if they ever went out and they told us, "There isn't enough staff to take me out."

One person told us they were at risk of falling so spent "all day" in bed. They told us staff assisted them with their frame when they needed access the toilet. However, this person's curtains were still closed at 10.10am and when we asked if that was their choice, they replied, "No the staff haven't been in yet to wash me and draw the curtains".

We saw from viewing the duty rota there were three care staff plus a senior member of care staff on duty during the day and two care staff on duty at night. Duty rotas did not state the shifts worked by staff so that it was clear sufficient staff hours were provided to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

There were some risks that had been considered and acted upon. For example, one person's relative told us, "[Person] has a history of falls and has had a couple since coming here. They have lowered their bed, [person] has a mat (that sets off an alarm when touched) next to their bed too."

We had identified from records one person had fallen on more than one occasion. Their relative told us, "[Person] was on the top floor they are now on a nearer floor so they can monitor them more, they have moved the bed around, they have done everything they can to minimise the falls."

Some people told us they felt safe living at Allambie House. Comments included, "Yes I am safe, never felt frightened living here" and, "Safe, yes because staff keep me safe." A relative told us, "I am very, very happy [person] is safe."

All staff were clear about the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. Each staff member knew what action they should take if they

suspected abuse. All staff said if they saw anything of concern, they would tell the manager.

It was clear staff had received training in how to 'whistle-blow' and raise their concerns with the Care Quality Commission (CQC), as prior to our inspection visit we had received concerns from staff. We spoke with the provider about some of the concerns that had been raised with us, as this impacted on people's safety at the home. They told us they would take action to address these.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found the manager and provider were not working within the requirements of the MCA. The manager and provider had not received training in the MCA and DoLS and were unaware of the current guidance for care homes. The manager told us that not all staff at the home had received training in MCA and DoLS. We found this had resulted in unnecessary restrictions on people's freedoms and liberties.

The manager told us all the people who lived at the home had medical conditions that could affect their capacity to make certain decisions. We found that mental capacity assessments had not been completed to show where people could not make decisions for themselves. The manager did not have an available mental capacity assessment document to conduct mental capacity assessments for people when needed. Before we left on the first day of our inspection visit, the manager had obtained a mental capacity assessment document and had begun the process of completing the form for one person at the home. They told us documents would be in place for everyone who needed mental capacity assessments within one month of our inspection visit.

The manager had reviewed each person's care needs to assess whether people were being deprived of their liberties. DoLS applications had been made to the local authority in accordance with the legislation. However, mental capacity assessments had not been completed before the applications had been made to the local authority to review. No-one at the home had a current authorised DoLS in place. Information about restrictions placed on people was not detailed in their care records to make sure there was a consistent approach by staff in managing these. For example, all people were subject to a restriction of not being allowed to freely enter or leave the home as all doors were securely locked.

On the third day of our inspection visit, MCA assessments had been completed but we found there continued to be a lack of understanding around MCA by the manager and provider. For example, an inhaler had been removed from one person and it was not clear if the person lacked capacity and if they were involved and had agreed to this decision. The manager told us no meeting had taken place to determine what was in the person's best interests. Whilst DoLS applications had been made for some people, they had not been completed for all those people who we were told could not leave the building unattended due to reasons related to their mental health. This showed there continued to be a lack of understanding around the MCA and DoLS.

Where people had been asked to sign records to consent to their care and treatment, these records had not been regularly reviewed to make sure people's decisions remained unchanged. For example, one person had signed to consent to certain aspects of their care being completed by staff in 2010. Where people could not make decisions for themselves, records did not show who had been involved in making decisions for people. They did not show decisions had been made in their 'best interests' in consultation with people who were important to them and health professionals. The manager agreed further training was needed in regards to MCA and this needed to be arranged.

This was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for Consent

CCTV was in use in communal areas of the home including lounges, corridors and staff areas without evidence of good reason. People had not been consulted about its use nor their consent obtained. There were no signs to say CCTV was in use. The provider turned this off during our visit and advised us this would not be used again without good reason.

We saw that sometimes people were asked for their consent before providing care which showed staff had some understanding of the importance to involve people in decisions. They told us, "They are likely to ask me what I want doing rather than telling me."

Overall, people were positive about the support they received from staff. People commented, "I am quite happy with the staff and they do know how to look after me" and "The staff are lovely, there was one that didn't seem to want to help and I told another member of staff. I haven't seen them since." A third person told us, "Staff are kind and respectful and know what they are doing." A relative told us they felt the staff were competent in supporting their family member and told us, "Staff seem well trained."

Staff told us they had received an induction to the home when they started to help ensure they understood their roles and responsibilities. One staff member told us they had shadowed other experienced staff for one shift before they worked as part of the shift numbers. We asked them how they got to know about people's needs and how to support them. They told us, "I read some of the care plans myself but the other staff told me their needs. I have done manual handling training and I am meant to do some more training." We saw training certificates were signed by the manager to confirm completion.

The provider forwarded a copy of their staff training matrix to us following our visit. This showed training was provided on an ongoing basis but there were gaps in training that needed to be addressed. For example, fire training and health and safety training. We had also identified a training need in regards to medicine management and dementia care. It was not clear that dates had been identified for all training updates to ensure staff skills and knowledge was updated.

Staff had not received effective training on catheter care. The manager said this had been difficult to source. When we spoke to a staff member about how they managed a person's catheter they knew to empty the catheter bag when it reached a certain level but were not sure how often the catheter bag should be changed or how long it could be used for. They told us the bag was not dated so they did not know how long it had been in use. They stated information on the frequency of changing the bag had not been made available to them. This was important to make sure the person was not placed at risk of infection and demonstrated a training need. We noted during our inspection that catheter bags had not been appropriately positioned to prevent the risk of infection. Although the manager had taken action to seek advice in regards to this, we noted during our third visit there continued to be a problem in the positioning of a catheter bag.

The manager told us staff supervision meetings took place every three to four months or when needed. This was so issues related to staff's roles could be discussed as well as any concerns or development needs. They added all supervision meetings scheduled with staff were up to date. However, this was not clear from supervision records provided as dates were not detailed and some staff told us these had not regularly taken place.

We asked people if they enjoyed the meals at the home and we received mixed feedback. One person told us, "The food is not great, but I don't have a great appetite." We asked if staff offered them a choice of food and if an alternative was offered if they did not like what was on offer. They replied, "They don't ask me what I want." A second person told us, "The food is alright but there is a different cook on a Sunday who uses a lot of herbs and I don't like herbs." A third person told us, "The food is passable, I am fussy but they do give you a choice and you can ask for something else if you don't like what is on offer. Never have fresh fruit or snacks, but cake sometimes."

We saw staff asked people what they wanted for lunch before it was served. They also asked people what they would like for their evening meal, which was usually sandwiches and soup. Staff did not use visual references to help people understand the choices on offer which is considered to be good practice. There was no menu on display to assist people to remember what meals were available to them. This did not support people to make independent and informed choices.

People who needed assistance to eat were assisted in a way that supported them. A staff member engaged well with one person and offered food at a pace and portion size acceptable to the person. When the meal was over the staff member asked the person if they would like a drink and offered a beaker into the person's hands so they could drink independently.

We observed how lunch was managed in the communal dining areas. Staff served people their chosen meal. The manager and activities co-ordinator joined care staff during the lunchtime period to assist people to eat. People who asked for more food or different food options were provided with these. For example, one person asked for second and third helpings of food which was provided to them. Another person ate toast for their lunch, and a third person had salad instead of a hot meal which was their choice.

We noted most people were able to eat independently in the dining room. Where people found it difficult to eat independently there was no adapted cutlery and plate guards for them to use. . Adapted cutlery can help people to get a better grip, plate guards help people to eat their meal without food falling onto table, clothes and floor. The provider has told us this has since been purchased. At the end of the meal staff asked, "Does anyone want tea?" Whilst this would have been a question some people fully understood and could respond to, there were others who did not comprehend what was being offered. This suggested staff were not fully familiar with the care needs of those people living with dementia.

We noted when we visited people in bedrooms that were cared for in bed, a number of them did not have drinks within their reach. We advised the manager about this so that it could be addressed. However at our third visit to the home, drinks continued to be out of people's reach.

People had access to health professionals and records confirmed when health professionals had been involved in their care. However, one person felt their access to a chiropodist was not effectively managed. They told us, "You just ask and you can see a doctor, but a chiropodist, they don't seem to be on top of that."

Requires Improvement

Is the service caring?

Our findings

People were supported to maintain relationships with those who were important to them. Relatives were welcomed into the home and we saw them visiting people during the day.

Relatives spoke positively about the staff team. They said staff knew people well and understood their needs. One relative told us, "I can't praise the home and staff enough. No-one is in a hurry with [Person], they chat to them." Another relative told us their family member had settled into the home very quickly after coming out of hospital. They told us they had mentioned to staff the person liked a particular food product every day and this had been purchased and provided to them the next day.

Relatives felt communication with the home had been effective and they were kept informed of concerns when needed. One told us, "They have called me when [person] has had a fall and hospital admission and had friendly chats as to how they are getting on."

We asked staff how they developed relationships with people. One staff member told us, "By talking to them, mostly asking about families." When we asked how they knew about people's wishes and preferences when providing care they gave an example of how they knew what food they liked. They told us, "A lot of them when you give them food, they don't want it, we ask them 'Don't you like that?' We ask them if they want something else." Staff told us they knew it was important to support people's independence. Care plans contained some information about what people could do independently to assist staff. For example, one care plan stated, "Encourage to wash his hands and face himself to promote independence."

We saw staff had a kind and caring approach towards people however, we saw some people did not always have positive experiences. For example, when we visited a person in their bedroom there was a very strong unpleasant odour. There was a used urine bottle on the floor which had not been emptied. This person had a mattress on the floor alongside their bed to protect them if they fell. This meant the table with their drinks and call bell was placed on the other side of the mattress and they were unable to reach their drinks or call bell to alert staff. Consideration had not been given as to how the person could access them as the person would not have been able to move independently to do this themselves. This meant the person was left in a vulnerable position if they needed assistance. Another person asked us to hand them the remote control as the table that was beside their bed had not been positioned in a way they could reach them.

Where people had specific cultural or religious requirements, these were not always being met. We asked one person if the home supported them to maintain links with their religion. They told us, "The home does not support me with my religion and I have no family members close by." It was clear through conversation this was an aspect of their life they missed. For others we were told a vicar/priest came into the home to give religious support which meant there was an inconsistent approach to meeting people's cultural or faith needs. We made the manager aware of this so that action could be taken to support them.

We saw positive interactions between people and the activities co-ordinator who knew people very well. They knew what games people enjoyed participating in and chatted with people about things of interest to

them. One person told us, "[Activities co-ordinator name] is lovely." During the day the activities co-ordinator put a comedy film on the television to try and make people laugh and lift their spirits.

People told us staff were respectful towards them and we saw that most of the time people's dignity was maintained. One person told us, "Staff are kind and they do respect my privacy and dignity." A relative told us, "I believe the staff do protect mums privacy and dignity." Staff knew what was required of them to maintain people's privacy and dignity. One staff member told us, "Always close the door when you go in, I just treat them like I would my mum or dad. Make sure if they have got any problems you don't discuss it in the hallway."

There was one incident we discussed with the provider relating to a person walking around the home partially dressed.

Requires Improvement

Is the service responsive?

Our findings

From people's comments and the care we saw delivered, staff provided task based care and we could not be confident staff responded to meet people's needs. On occasions, staff were reactive in their response, rather than identifying when people needed help before requests were made. One person told us, "Staff do pop in morning and night to make sure I am alright." We saw examples where staff responded well to support people. For example, when one person commented to people in the lounge they had cold legs, the activities co-ordinator immediately got up and went to see whether they wanted a blanket, one was obtained straight away. However, we saw another person had bare legs and were also complaining of being cold which was not initially identified by staff. We asked staff about this and were told the person had run out of stockings. After we advised staff the person was cold, a blanket was brought for them but staff had not identified this and responded to this themselves.

We asked people if they were able to maintain their independence or do things of interest to them so they were socially stimulated. Comments included, "I dust my room and change my bed myself." and "We don't really go out. I just sit here at weekends." Some people felt their social care needs were not met.

Some of the people who were cared for in bed, only engaged with staff when personal care tasks were carried out. One person who was in bed had their curtains drawn but the television was on with no sound. The person told us they spent all day in bed and we asked them if they wanted the volume turned up. They told us they did and said the television was the only interest they had but they had been unable to hear it. We asked if staff had been in to support them with personal care, they said "I think they have," but it was clear their hair had not been brushed.

Social activities were provided at the home by an activities co-ordinator who worked from Monday to Friday from 8am to 2pm. They told us activities were regularly provided to engage people. This included crafts, Scrabble, newspapers, baking and taking some people for walks around the park. We observed some group activities taking place at the home on both days of our inspection visit. Notes of a resident meeting showed some people enjoyed the activities provided.

The activities co-ordinator had a folder for each person at the home describing some of the things they enjoyed doing. They told us they planned activities with people and asked them about their lives, their likes and dislikes. They said they spoke with family members when they visited and kept a record of what people enjoyed doing, so they could plan ahead. There was a two weekly plan of activities which included some of the activities they had described.

We were told there were no planned activities in the evenings or at weekends and people told us they did not know what was going to happen when the activities co-ordinator was away on holiday which was planned for the following two weeks. One person told us, "They haven't told us what will happen when she is on holiday. There is no list of activities, so we know. We don't go anywhere really."

The activities co-ordinator told us, "When I am here I make sure that I spend some time each day with

people in their rooms, for example, listening to music, chatting with them, providing them with reading materials like books and newspapers, hand massages. Sometimes I try and encourage them to colour and draw." We observed one person sitting in their room colouring and drawing which they clearly enjoyed. Another person was sitting in the upstairs lounge listening to music. They told us they were planning to play Scrabble later and liked to play.

The provider told us following our visit they had made contact with voluntary organisations to try and increase the level of activities provided alongside the activities co-ordinator.

People's needs had been assessed before they lived at Allambie House and details obtained during this assessment process had been transferred into individual care plans for people. Care plans contained some information about people's care needs and how they needed to be supported. However, care plans generally were not sufficiently detailed or personalised. We could not see that people were regularly involved in their care plan reviews and people could not recall being involved in care planning. One person told us, "No, not seen my care plan." Another said, "No, not been involved in any care plan."

When we looked at one person's care file it mentioned the names of three different people suggesting other people's care plans had been used to write the person's care plans. This meant information recorded was not accurate. One section of this person's care records asked staff to assess whether the person had any emotional or cultural needs. The person had lived at the home for a number of years and it was recorded they enjoyed socialising with people. However, records did not show consideration had been given to their emotional needs such as developing relationships with people and others in the wider community.

There were aspects of the environment that did not support people's needs such as small toilets and bathrooms. Whilst the provider had plans to improve these, people had not been able to access showers and baths in accordance with their choice. All of the people we spoke with said they had not had a bath or shower and instead had a wash provided by staff.

A number of people living at Allambie House were living with dementia. Staff did not always support people in a manner that took into account their diagnosis. For example, by using visual aids to assist them in making choices. There was limited signage around the home to support people to find their way around. There was no use of colour or tactile aids/sensory areas to help people reminisce and support people's differing needs.

People told us they would speak to the manager if they were unhappy about anything. One person told us, "I know the manager I would tell them." Another told us, "I would talk to the senior staff or manager." A relative told us, "Any concerns we would see the manager." They said they knew the manager and felt they were accessible if they needed to speak with them. There was a complaints log for any complaints to be recorded and this showed none had been received. The manager confirmed this.

Inadequate

Is the service well-led?

Our findings

Conversations with people identified they had varying experiences of living at Allambie House. Both people and their relatives did not always feel involved in decisions related to the quality of service provided. One relative told us, "I have not been involved in any quality assurance questionnaire or family / residents meetings." A person told us, "Not seen anything regarding residents meetings."

We saw and felt the atmosphere in the home varied throughout the day. There were periods of time when social activities were provided in the lounge area when people got involved and appeared to enjoy them. When people were assisted in their bedrooms, staff took the opportunity to engage with them and people responded positively. However, there were also long periods of time when people had no social interaction other than when staff provided care and support. A relative commented, "The atmosphere in the home is a bit remote, sometimes the lounge can feel like a waiting room." They told us their family member had also made this comment to them.

The management team consisted of the manager and the two owners (the provider) of the home. The manager had not yet applied to register, despite this being raised as an action as part of their condition of registration and needing priority at the previous inspection in October 2016. The manager had told us they planned to register but had been busy with tasks and improvements at the home and had been delayed in applying for the necessary checks in order for them to make the application required. The provider has subsequently confirmed these checks have been completed so that the application can be made.

Processes and quality assurance systems were not in place for the manager to ensure safe service delivery and to identify areas that required improvement. Audits such as medicine audits failed to identify the issues we found because there was no effective process to manage medicines safely. We were told medicine administration records (MAR) were checked by a senior member of care staff daily on each shift. The manager told us, "We count medicines at the end of each shift, and do a stock take." They added, "This practice comes from lessons we learned following a recent medicines error, the antibiotics count for one person was found to be one tablet over the amount that should have been present, but there were no gaps on the MAR chart." We asked to see a copy of the most recent medicines audit conducted by manager or staff, but were not shown this. However, any medicine audits that had been carried out had not been effective and failed to identify areas for improvement, nor had they identified the issues we found in relation to time critical medicines, safe medicine storage and quality of MAR completion.

The provider had not ensured staff had easy access to all the records they required to care for people safely as these were located in the manager's and provider office. Care staff told us they were not able to check them when they needed because they were in the manager's office and they did not feel they could keep asking for them. One staff member told us this was a problem and commented, "I would prefer it if they were here (staff office) like we have a new person coming in today, I would like to get the care plan and get to know everything about them." Staff had access to a summary care plan for each person but this was not sufficiently detailed for staff to be clear on people's needs and to know what was expected of them. Staff did not have access to some of the recent daily records completed for people so they could refer back to

them and check if people's health had improved or deteriorated. We were told that staff shared information at handover meetings at the beginning of each shift so they were made aware of any immediate changes and could manage these. However, we found communication systems were not always effective.

Through discussions with staff we established there were four people in the home with a sickness condition. Infection control procedures for managing this were not effective to ensure this was not spread to others including any visitors in that this information was not initially shared with us and the concerns had not been reported to the relevant authorities. This was subsequently reported to the local authority.

We found information about medical decisions made by health professionals was not kept with care plans and some advice was not followed. For example, 'Do Not Attempt Resuscitation' (DNAR) orders. There was a risk that staff may not know about them so they could ensure health professionals followed them. Staff told us they did not read the care plans, or care documents such as this, as they were not accessible to them. The manager told us they would put information about who had an advanced decision in a location where staff could easily access them. During the third day of our inspection, the manager told us the DNAR documents continued to be stored in the locked medicines room but a meeting had been arranged with the GP for these decisions to be discussed.

Care plans audits were not effective because they had not identified care plans contained inaccurate information. Care records were not consistently updated. For example, one person's care records were dated 2016, and it stated a review was to be done by March 2017. No review had been documented. Where people needed to have mobility aids or support to walk, insufficient checks were being made to make sure they had them. We saw staff did not consistently support people to mobilise with walking equipment at the home as instructed. One person was found not to have their mobility aid when we checked on the first day of our inspection.

Suitable arrangements were not in place to ensure people experienced person centred care. Our inspection process found that people's choices and preferences were not always followed or respected. For example, in regards to personal care and social care needs. The environment did not support people who were living with dementia and bathrooms and shower rooms were not accessible to some people with mobility needs.

Systems to monitor the quality of the service were not effective in that areas needing improvement were not consistently identified. The provider had not ensured the home was always effectively managed. There was minimal management oversight to manage shifts effectively and ensure people's needs were responded to and potential incidents and accidents avoided.

We found the manager and provider had not always notified us of important events when they should have such as injuries to people at the home and incidents that had involved the police. It is the registered person's legal duty to notify us of such events. Audit processes had failed to identify this which meant the provider was not always aware of potential issues within the home that affected people's care and experiences of living at Allambie House. The lack of statutory notifications being forwarded to us also meant we could not effectively monitor the service.

Accident and Incident records had not been completed clearly or consistently to enable the provider to carry out effective audit checks. For example, on some records there was no time of the accident recorded and sometimes it was not clear if the person had received any injuries. This information was important to identify patterns and trends so that appropriate action could be taken to minimise the risk of them happening again. We could not be confident that accidents were always recorded as required. For example, one person's care records stated the person had an accident on a date in May 2017. The records made

reference to a fall the previous night. However, there was no record of a fall the previous night in the accident records.

The manager had implemented a falls diary to help monitor those people who had fallen. However, this also was not sufficiently detailed for monitoring purposes. The time of the fall was not routinely recorded and the information requested was not always recorded. For example, there was a column for 'interventions required to minimise falls where in place at the time' but this was sometimes used to record any injuries instead. There was no specific column to record injuries to enable the provider to identify when they needed to act on this information and report them to us as required. We would expect a review of people's risk assessments to see whether people needed walking aids, alarm mats or other equipment to help keep them safe. A lack of checks and accurate records meant people may not receive the necessary support or medical interventions to reduce the possibility of further incidents from reoccurring.

There was no effective process to determine staffing levels in the home which took into account the dependencies of people and the layout of the building. Some people felt more staff were needed at certain times of day. During our visit we noted sometimes call bells took between five and ten minutes to be answered. We asked the manager whether they conducted call bell audits to check response times. They told us the system could produce these types of audits but they did not gather and use this data so they could be confident staffing levels met people's needs. On the third day of our visit the manager told us they needed a code to access the call bell response times and they were attempting to find out what this was.

Although health and safety checks were carried out, these had not always identified risks to ensure they were addressed in a timely manner. We had identified concerns relating to the flooring in the home, hot water taps and hot surfaces. From our observations, we could not be confident the provider took the necessary action to limit the risks to people, such as having effective safety checks to monitor water temperatures and to check radiators did not exceed safe temperature ranges. On the third day of our visit, we saw action had commenced to address hot surfaces, temperatures and flooring. The provider told us they had signed up to receive health and safety guidance tools and a risk assessment of the building was to take place to help ensure the home was fully compliant in meeting safety standards.

The provider had not ensured there were effective systems and processes in place so that people received the quality of care and support required to meet their needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Relatives were complimentary of the home. One told us, "I can't praise it (the home) enough, there is not one member of staff I have any reservations about at all." Another told us, "I would not change a thing. It is so much nicer than it used to be. They were also complimentary of the manager and provider and said they were approachable and easy to talk to. One told us, "The manager is great and always available, very good business people."

We received some positive comments from staff about the manager and a senior care staff member. One care staff member told us, "She (manager) is lovely, very nice and fair if you have done something wrong, she will take you to the side (to discuss it)". They also told us, "[senior care staff member] is lovely." They told us the provider always acknowledged staff and asked how they were getting on.

Some staff told us they felt valued by the management team and spoke positively of working at Allambie House. One staff member told us, "I find it really good ….all the staff are really helpful, we all work as a

team." Another told us, "I love it, its hard work but I love it". However, other staff told us they were not treated well and didn't feel they could raise concerns for fear of reprisals. We discussed this with the provider who was able to share information with us about plans to address this. The provider also told us they had an up to date whistle-blowing and grievance policy, so staff were able to raise any issues through these procedures. Staff had used the whistleblowing process to make contact with us prior to our visit.

The manager told us they had effective processes in place to communicate with staff. They told us staff meetings were held so that information about the home could be shared with staff. Staff told us these meetings were used to discuss what was expected of them during their shifts. For example, they told us, "Making sure we are all doing our jobs properly and all the fluid charts are being done, dietary charts. If a person is not eating right, to make sure they are okay." Staff told us they got to know about any poor practice through handover meetings which were carried out at the beginning of each shift.

The manager said they sent 'memos' to staff to tell them of any changes at the home, or any updates they had discussed at team meetings. The memos assisted staff, who had not been present at the meetings, to understand what decisions had been made.

The manager told us they had recently recruited a fourth senior member of care staff and hoped to organise some additional supernumerary hours for them. This was so they could assist the manager in addressing improvements needed related to the management of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place to ensure care and treatment was provided in accordance with people's consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably trained and competent staff were not always available to support people's care needs to maintain their health and safety.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their health, safety and welfare because risks were not fully assessed to ensure care and treatment was always provided in a safe way. This included medicines not being consistently managed or administered safely as prescribed.

The enforcement action we took:

Notice of Proposal to restrict admissions of people to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to manage risks, monitor the service and drive improvement were not sufficient to ensure the health, safety and welfare of people.

The enforcement action we took:

Notice of Proposal to restrict admissions of people to the home.