Portsmouth City Council

Hilsea Lodge

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**

Summary of findings

Overall summary

Hilsea Lodge provides accommodation for up to 35 older people living with dementia. Single room accommodation is arranged on one level in four separate units, each unit having its own dining and lounge area. There was an enclosed garden. At the time of inspection 27 people were living in the home.

The inspection was unannounced and took place on 15 and 21 November 2017. There was a registered manager in place. 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.

At our last inspection, on 30 June and 4 July 2016, we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Areas in the home were of disrepair which could affect people's safety. There were also areas of malodour. The provider had taken the required action in relation to the concerns raised during that inspection. However, we found other concerns which led to a continuing breach of this Regulation. There were also breaches of Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The quality assurance system had not been robust and staff had not received appropriate training or supervision. At this inspection we found continued breaches of Regulation 17 and Regulation 18, together with other concerns.

Risks to people were not always managed effectively. Clear plans and records were not in place for people at risk of pressure injuries, falls and behaviour that challenges. Accidents, incidents and falls were not analysed to prevent further accidents from happening.

People's care plans were not always up to date and did not always reflect people's current needs. Staff relied heavily on the information they were given at handover. This meant we could not be assured people were receiving care in line with their needs and preferences.

Some risks associated with the management of medicines and people's care and treatment had not been identified because effective checks were not undertaken.

The quality assurance system in place was ineffective. Audits to assess the quality of service provision were not completed regularly and were ineffective in identifying improvements needed. Action plans were not developed to ensure improvements were made. Feedback from people was sought to improve the service but was not always responded to. Records showed concerns raised by staff were also not addressed

Allegations of abuse were not always reported to the relevant authorities or investigated by management.

Risks posed by the environment were not managed appropriately and some fire safety checks had not been completed. There was a lack of fire evacuation training which meant staff would not know what actions to

take in the event of an emergency.

A shortage of domestic staff meant that the set daily cleaning schedules could not always be completed. Records of weekly and monthly cleaning were not complete and we could not be assured these cleaning tasks were always undertaken. There were areas of malodour in the home and some areas were not clean.

There were not enough staff to ensure people's safety or provide personalised care. The provider was unable to provide the rationale for the current staffing levels and the service often relied on agency staff. Supervisions and appraisals were not taking place regularly which meant staff were not always appropriately supported in their role.

Not all staff had completed training in line with the provider's policy and staff did not receive an appropriate induction into their role. Staff were not always knowledgeable about pressure area care, mental capacity or medicine storage requirements. The provider had no effective systems to monitor when refresher or further training was expected.

People were not supported to have maximum choice and control of their lives because the policies and systems in the service did not support this practice. Whilst staff sought verbal consent from people, before providing support, they did not always follow legislation designed to protect people's rights when making decisions on their behalf. Care plans did not have mental capacity assessments in place.

Staff had not always notified CQC of significant events that occurred in the home. Neither had they followed legislation that required them to act in an open and transparent way when people came to harm.

People were supported to access other healthcare services when needed. They enjoyed the meals provided, however people did not have their food and fluid intake adequately monitored and a lack of nutritional care plans and assessments put people at risk of malnutrition and dehydration.

People were complimentary about the staff. Most interactions we observed between staff and people were positive although, on occasions, staff did not treat people with consideration and their dignity and privacy were not always protected. Staff encouraged people to remain as independent as possible.

Some beneficial activities were provided to people, however we noted more were needed to ensure the wellbeing of people.

Due to the concerns we found we made referrals to the local authority and the fire service. We told the provider to take immediate action. Following the inspection we received an action plan from the provider detailing how they would address the immediate risks to people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was very unsafe.

People were placed at risk of harm because individual risks to people had not been identified or assessed. In addition, measures had not been taken to minimise the risks for people.

Medicines were not always managed safely. Where people were prescribed 'as required' medicines to help with pain and anxieties, there were no clear systems in place to ensure these were given appropriately.

People were not protected from the risk of abuse as allegations of abuse were not always reported to the relevant authorities or investigated.

There were not enough staff deployed to ensure people's needs were met and they were safe.

Recruitment practices ensured staff were safe to work with vulnerable adults.

Is the service effective?

Inadequate

The service was very ineffective.

Staff training was not up to date and some staff lacked essential knowledge to enable them to support people effectively.

Staff did not always follow legislation designed to protect people's rights.

Staff were not appropriately supported in their role through regular supervisions or annual appraisals.

People were supported to eat and drink enough; however, food and fluid intake was not adequately monitored.

People were supported to access other healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives said staff treated them well.

Staffing levels did not ensure staff were able to provide personalised care and support.

Whilst most interactions between staff and people were positive, we observed that staff did not always treat people in a way that protected their privacy and dignity.

People were encouraged to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were not always up to date and staff did not always respond promptly to people's individual needs.

There was a complaints procedure in place and complaints were investigated and resolved.

Some activities were provided but we observed more were needed to ensure people's social and emotional needs were met.

Is the service well-led?

Inadequate

The service was not at all well-led.

An effective quality assurance system was not in place. This had led to breaches of multiple regulations. Audits conducted had not been robust and action plans were not in place to drive continuous improvements to the service.

The provider had not notified CQC of all significant events.

Staff did not always act in an open and transparent way when people came to harm.

Hilsea Lodge

Detailed findings

Background to this inspection

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

The inspection was unannounced and was carried out on 15 and 21 November 2017 by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in caring for older people with dementia.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Following the last inspection on 30 June and 4 July 2016, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, safe, effective and well-led to at least good. We found the provider had not made the required improvements and our detailed findings are described under the relevant key questions below.

We spoke with twenty people and nine relatives of people living at the home. We spoke with four members of the care staff, one agency care worker, a chef, a housekeeper, an administrator, the registered manager and the provider's representative. We also spoke with a community matron. We observed care and support being delivered to people in the communal area of the home.

We looked at care plans and associated records for seven people using the service, staff duty records and other records related to the running of the service, including staff recruitment and training records, accidents and incidents, policies and procedures and quality assurance records.

We asked for some information to be sent to us after the visit. This information was received.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 30 June and 4 July 2016 we rated the provider as 'requires improvement' under the key question of 'Is the service safe?' We found at this inspection that the extent to which people were being kept safe by the service had deteriorated.

Risks to people from falls had not been assessed to ensure such risks were identified and that preventative measures were put in place, for example; records showed that two people had fallen and these incidents had led to a hospital admission. However, these people did not have plans in place to guide staff on how to manage their risk of falls. Whilst daily communication records stated a person had been identified as 'unsteady on their feet' and that they 'kept leaving their walking frame behind', this risk had not been assessed so that staff were clear on the actions required to support this person safely. The registered manager told us about another person who was at risk of falls and this usually happened at teatime. There was no risk assessment or actions identified to manage this risk and prevent the person from falling.

Records identified that the provider's falls recording and observation tools were not being used effectively to mitigate the risk of falls and falls guidance for staff was limited. Staff had not been trained in how to reduce the risk of falls for people. People were not being protected against risks from falls and action had not been taken to prevent potential harm.

People were not protected against the risk of skin damage. The risks associated with pressure sores had not been assessed for any of the people living at Hilsea Lodge. When we discussed this with the registered manager, they told us that skin risk assessment tools were not used in the home. Staff had not received training in relation to skin integrity. This meant that people were at risk of developing pressure related injuries.

The registered manager told us that one person had a pressure sore and guidance had been sought from the community nurses. The nurse's notes stated they had agreed with the registered manager and staff that the person should be regularly repositioned. Not all staff we spoke with were aware of this. One staff member told us "We don't turn as the mattress does it", another staff member told us "The pressure sore has healed so we don't need to turn them", and a third staff member told us "We do turn them but sometimes they decline". The lack of clear guidance and staff understanding of how to support the person meant they could be at risk of deterioration in their condition.

Some people displayed behaviours that challenged. On one person's records it stated they had been punching other people and grabbing their arms. There was no risk assessment in place and no plans to reduce these risks had been developed. A staff member told us another person displayed behaviours that challenged which included physical assault and they were completing a challenging behaviour record. Although they had sought the advice of the community psychiatric nurse, there was no assessment of the risk of physical assaults by the person, how these could be prevented and what to do if they arose.

A staff member told us another person could be verbally and physically abusive towards staff and other

people for which there was no apparent trigger. An entry on the person's daily living communication record confirmed they had slapped another person around the face. Furthermore, this person had absconded and left the home unnoticed on a recent occasion. When the person was found by a staff member, the person tried to attack them with a sharp object. The registered manager and a staff member told us this person had left the building before and it was a known risk. However, this risk had not been assessed and a plan had not been developed to guide staff on how to reduce or manage this behaviour.

Staff had not received training in supporting people whose behaviour may challenge. This meant they did not always have the skills or knowledge on how to deal with behaviours which presented a challenge. Techniques used to diffuse incidents of behaviours were ineffective and daily notes confirmed this, for example where there had been incidences of behaviour which presented a challenge, staff had frequently recorded 'I told the person their behaviour was unacceptable'. The lack of assessment, planning and training to ensure staff had the guidance and skills they needed to recognise and support these behaviours meant people had been exposed to harm.

We saw that the service used bowel charts universally rather than being personalised for the people that needed them. There was nothing recorded to say why the person needed a bowel chart in place or how risks associated with bowels were to be managed. For example, at what point the person may require medicine or other treatment due to constipation. Records showed that a person who was unable to communicate their needs had not had a bowel movement for five days. A staff member told us it was normal for the person to go without a bowel movement for three to four days. There was no information in the records to inform staff when to offer their prescribed laxative and this had not been administered until day six. Another person had also gone for six days without a bowel movement. Whilst staff had recorded on their bowel chart at day four they had not had a bowel movement, a laxative was not administered until day six. The lack of clear guidance on how to support people appropriately from risks associated with constipation meant people could be at risk of deterioration in their health.

The failure to ensure risks relating to the safety and welfare of people using the services are assessed and managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may not have been protected from harm or potential abuse because safeguarding concerns were not always reported or investigated in line with national policy. Staff did not always report incidents when they occurred. For example, when staff had documented in people's daily records about incidents of behaviour that had caused harm to others, there was nothing to indicate if the incidents had been reported formally, either internally or to the relevant external authorities. We informed the registered manager about some of the entries in people's records and they were unaware of the incidents and these had not been reported to the local safeguarding authority or to the CQC. When we spoke to a senior staff member, they told us they did not know they had to report these formally. It is a requirement of the Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Adults Multi-Agency Policy that providers disclose and raise safeguarding concerns with the relevant local authority.

A failure to establish and operate effective systems and processes to prevent abuse of people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being protected against risks associated with the premises. The provider had assessed the premises for risks from fire in June 2016. We reviewed the recommendations from this assessment and associated action plan. This had not been fully completed to evidence the urgent actions required or those to be completed within six months of the assessment having been undertaken. These recommendations are

made to reduce the risks to people from fire. Following our inspection the provider has sent us evidence to confirm all actions had been taken.

Personal Emergency Evacuation Plans (PEEPs) describe the support and assistance that people require to reach a place of safety when they are unable to do so unaided in an emergency. These documents are used by the provider, staff and emergency services to ensure appropriate support is available and provided in an emergency situation. At the time of our inspection the PEEPs available were not up to date for all people living in the home. There were seven people without a PEEP and with the exception of one record all others had been completed in April 2017 and had not been reviewed to reflect people's changed needs where required. For example, where a person now stayed in bed, the level of staff required and equipment needed to support people to evacuate the building safely had not been fully assessed. This meant people were at risk in the event of an emergency evacuation. Following our inspection the provider completed the PEEPs for all people living in the home.

Regular fire drills were completed however; these did not include any evacuation practice. It is important for the provider to check their evacuation plan is safe and appropriate and for all staff to be aware of site specific evacuation procedures and people's support needs to ensure their safety. We referred our concerns about fire safety to the Hampshire Fire and Rescue Service who have visited the service and instructed the provider to carry out a practice drill to check people can be safely evacuated and staff know what to do. They will return to the service to carry out a fire safety audit and check the actions identified at their visit on 28 November 2017 have been taken.

The provider had failed to ensure equipment used to protect people was safe for such use. Regular checks such as monthly checks on fire extinguishers, emergency lighting and the weekly fire alarm tests were not up to date. Following our inspection, the provider confirmed tests of this equipment had now been carried out and a procedure is in place to check they are regularly completed.

At the time of our inspection refurbishment work was being completed in some areas of the home and the registered manager told us these had been underway for eight weeks. On the first day of our inspection we found these areas of the home were not safely managed. The areas were not secure and there were piles of items for rubbish collection, stationary and furniture in the main lounge and reception area which were safety hazards. The front door to the building was not in use due to these works and notices directed visitors to the side gate. On arrival at the home we found this gate was unlocked and we were able to walk through to people's rooms without challenge. A visitor told us this gate was usually unlocked. We spoke to the registered manager about this and they agreed it was not safe and told us a risk assessment had not been completed to address safety issues. Action was taken during our inspection to clear these areas and lock the gate. We were concerned that the provider had not carried out a risk assessment to identify and mitigate risks to people from these works and that the areas were not safely managed.

Other areas in the home were not secure and presented risks to people. This included unsafe storage such as, a cupboard containing cleaning fluid and dishwasher tablets was shut and bolted from the outside, although there was a key lock this was not used. Other storage areas were similarly unlocked and a person could enter and be at risk. Latex gloves were out in the corridor which could be a risk. The sluice room had other items stored in it. A bathroom with a condemned bath was open and used as a toilet. It also had other items in such as a sling, walking frame and a bar of soap and parts of wheelchairs. The last health and safety check we saw was carried out in June 2017. The meant the premises were not always managed to support people to stay safe and prevent the potential for harm.

The failure to identify, assess and do all that is reasonably practicable to mitigate and manage risks to

people from premises and equipment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons available to meet the needs of people using the service and keep them safe at all times. Five members of staff and the registered manager told us there were insufficient staff available at all times and this could leave people at risk. Incidents had occurred which placed people at risk of harm due to insufficient staff. These had included a person leaving the building undetected although they had been assessed as unsafe to do so alone, were living with dementia and experienced behaviours that challenged others including aggressive behaviour. This incident occurred in the late afternoon. Staff told us the staffing levels in the evening were not sufficient to manage people safely when they presented with behaviours that challenge. Staff told us people were more likely to display these behaviours later in the day and evening which is a known symptom of dementia. There were usually five staff on duty from 2pm-9.30pm.

The staff meeting minutes of 26 September 2017 recorded that staff were informed they must be aware of the whereabouts of residents at all times because of the building works. Staff had said they couldn't cope with this when short staffed. The registered manager had replied they would ensure there were always more than four staff on duty and would endeavour to have six throughout the day/evening shifts. The staffing rotas for the period 22 October to 18 November 2017 showed there were three occasions on 3, 10 and 11 November 2017 when only four staff were on duty and 21 occasions with 5 staff available in the afternoon/evening. Although staff had made the registered manager aware they could not keep people safe at the staffing level of four, the provider had failed to ensure this did not occur.

We observed there were not always enough staff appropriately deployed to keep people safe. We were concerned that people at risk of falls were not always sufficiently monitored by staff and one person fell in an unstaffed office during our inspection. Another person who was at risk of falls and had a urinary infection which can increase a risk of falls, was seen to be very unsteady in a communal lounge where no staff attended for a period of over 15 minutes. The registered manager confirmed there were insufficient staff to safely monitor the needs of a person with Parkinson's who regularly 'slipped' at around tea time. We saw one staff member supporting seven people with their lunch. One person was unable to settle to eat their lunch and repeatedly went to the hot food trolley when the staff member was distracted by serving others. There was a risk this person could be harmed.

The provider did not have a systematic approach to determine the numbers of staff and range of skills required in order to meet the needs of people using the service and to keep them safe at all times. This meant staffing levels were not calculated according to people's needs and we could not be assured that sufficient staff were therefore available to meet people's needs or keep them safe. Following our inspection the provider has increased the staffing levels in the service and is completing an assessment of the staffing levels required to meet people's needs and keep them safe.

We found that people were not adequately protected against the risks associated with medicines. Safe practice was not consistently followed to ensure people's medicines were safely stored, monitored or always signed and dated when opened. The thermometer used to check the fridge temperature was not working and records were not available to evidence this was checked to ensure the safe storage of medicine requiring refrigeration. Medicines stored in cupboards on each unit of the home were not monitored for safe temperatures. We asked two assistant managers how they checked the temperature of this storage and they told us they "didn't know". We found a thermometer in one medicine cupboard on a unit and the reading appeared to be over the safe storage temperature (25 degrees) for some medicines in it. Some liquid medicines such as liquid anti biotic, liquid laxative and liquid pain relief were not dated when opened. The

expiry date of medicines can change when opened and liquid medicines can have a shorter expiry date than solid medicines. It is important to check medicines are stored correctly and in date to ensure medicines remain effective for their use.

Medicines for disposal were stored in a locked chest of drawers. The last collection of medicines for disposal was on 5 September 2017. Medicines awaiting disposal were not all recorded in the disposal book. This helps to reduce the risk of the diversion of medicines, as the contents of containers and what is in the disposal book should match. This was unsafe storage of medicines.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CDs). Providers are required to have procedures in place to ensure that CDs are safely managed and that staff follow these to keep people safe. We found a discrepancy in the records and stock of a person's CD medicines. A staff member told us the medicine had been administered by district nurses and they had not signed the CD register. There was no record made by staff in the CD register that the medicine was given to a visiting healthcare professional to administer. There was no record that these medicines had been checked as accurate since the 15 October 2017 when this medicine was administered. Incidents relating to CDs must be reported immediately to the manager and investigated and if a discrepancy is unexplained reported to a CD accountable officer, CQC and the police. A process was not in place to check, investigate and report discrepancies in CD medicines.

Other medicines were audited weekly and records showed that discrepancies had been found in the expected stock during this process. However, there was no information available about the action taken to investigate and address these anomalies. We could not be assured that medicine incidents and errors were effectively identified and acted on to protect people and ensure the safe management of their medicines.

Some medicines were prescribed to be taken 'when required' (PRN). These were used to treat short term medical conditions or long term conditions when people may experience 'flare ups' such as medicines to manage agitation, anxiety and behaviours that challenge others. Records showed that when people were prescribed these medicines information was sometimes available to guide staff as to what the medicine was for, when and how much to use. However, not all the people who were prescribed PRN medicines to help them manage their behaviours had this information available to staff. One person was prescribed a medicine with instruction to 'only use when really needed and avoid if possible' however, no information was available to guide staff as to the circumstances in which this should be given. Records showed this had been administered. Another person was regularly being administered a medicine prescribed to calm them. There was no detailed information about when this should be used or any other action that should be tried before using this medicine. Some staff recorded on the back of the MAR when and why this was given but not all staff did this. PRN medicines that are given regularly should be reviewed by the prescriber to consider if their treatment needs to be altered. Without clear guidance and records of PRN medicines people could be at risk of the inappropriate use of these medicines.

Some people, who were living with dementia, were unable to tell staff when they were in pain. Indicators of pain were not included within their care plans to help staff identify when pain relief might be needed. A pain assessment tool was not being used to enable staff to assess the level of people's pain and the effectiveness of any pain relief that was given. The registered manager told us she would look into this.

The failure to fully protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People's finances were managed safely. Records were kept to account for all monies held and spent on

behalf of people. Monthly statements were provided to people or their representative and the registered manager and service administrator audited and checked the accounts on a monthly basis. The provider managed the closure of accounts for people no longer using the service. People's relatives were asked to provide proof of their authority to manage money on people's behalf.

Inadequate

Is the service effective?

Our findings

At our previous inspection on 30 June and 4 July 2016 we rated the provider as 'requires improvement' under the key question of 'Is the service effective?' We found at this inspection that the extent to which people were receiving effective care from the service had deteriorated.

Our inspection of 30 June and 4 July 2016 found that not all staff had received the appropriate training and supervision to care for people effectively and not all staff had received an appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had failed to make all the improvements required.

Supervision and appraisal are processes which enable staff to reflect on and learn from practice, providing professional development; motivation and support in their role to support them to care for people effectively. Following our last inspection the registered manager told us staff had received a supervision session, they added "We are not up to date (with supervision) but we are rolling them out." We reviewed the records of eight staff. We found that these staff had not received supervision at the frequency described in the provider's policy. Although the provider had said staff supervision sessions would be booked in advance this was not evidenced by the records we reviewed. Six of these staff had been employed for over one year, of these, four had not received an annual appraisal.

The Care Certificate induction standards are nationally recognised standards of care, which staff new to care are expected to adhere to in their daily working life to support them to deliver safe and effective care. The registered manager told us that care staff were not completing these standards yet and said "But we will be introducing them". We were concerned that a staff member new to care had worked in the home for over three months. They had not completed the standards and the only training they had completed was in posture awareness and moving and handling. Their induction checklist had not been completed and they had not had a supervision session. This meant that staff could be supporting people without the appropriate level of skill, knowledge or behaviours that people should expect from staff who provide care.

We asked the provider to tell us which staff had completed training in; safeguarding adults, supporting people living with dementia and behaviours that may challenge others, the Mental Capacity Act (2005) (MCA) and health and safety. The provider was unable to give us this information because the system used to record staff training did not provide an accessible overview to enable the registered manager to identify and plan for training needs. Following our inspection the provider had introduced a system to identify gaps in staff training and to address these.

We looked at the training records for seven care staff. Of these, four staff had completed safeguarding awareness training, none had completed MCA training, two had completed health and safety training and two had completed dementia care training, but not the module entitled 'dealing with distressed behaviour in dementia care'. These topics were considered essential training by the provider and we found that people's needs were not always met in these areas. A staff member told us they did not feel they were adequately trained in supporting people with dementia when their behaviour challenged.

The failure to provide staff with appropriate support, training, professional development, supervision and appraisal as necessary to enable staff to carry out the duties they are employed to perform is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection of 30 June and 4 July 2016 found the premises were not properly maintained and free from malodours. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made the improvements in their action plan to address the issues identified such as the removal of malodourous carpeting and some maintenance repairs. However, we found other concerns with the cleanliness of the premises and an on-going concern about areas that were malodourous.

Records did not evidence that cleaning was always carried out to meet the provider's cleaning schedules. We noted that a shortage of cleaning staff had meant that for 12 out of 20 days during the period 26 October to 20 November 2017 there were insufficient cleaning staff to complete all the tasks on the schedules and they had done a 'basic clean only'. A housekeeping staff member told us this meant they did "As much as possible, although one staff for four hours was not enough" and the care staff also helped at these times. Weekly and monthly cleaning schedules were incomplete. Records of commode pots and chair cleaning were also incomplete. We noted some areas of the home and some equipment were not clean. For example there were toilets stained with faeces in the morning and the afternoon. A hallway carpet smelt of urine and the registered manager told us this was being replaced. There was a pool of urine in one person's room and we were told this had appeared after the room had been cleaned; however the floor of this room was tacky and had not been well cleaned. We also noted a lounge area which had just been cleaned still had crumbs on the carpet. A staff member told us there were not enough domestic staff and the home wasn't always clean. Our observations, the incomplete cleaning records, and number of 'basic clean only' tasks completed meant we could not be assured that the home was always clean or that the cleanliness of the home was effectively monitored.

This was a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was making improvements to the premises and this included creating an attractive area for people to use that included a sweet shop and café area. However, areas of the premises were not suitable to meet the needs of people living in the home, especially those people living with dementia. The signage was not clear around the building. There was a blank door which led off from one unit to another but was unsigned. Signage can be important to help people to orientate around the home. Toilets and bathrooms were poorly signed, for example; one toilet door had a picture of a toilet on it others were blank with the word 'toilet' not standing out clearly. Corridors and lounges were still in need of decoration. There was limited contrast in colours and carpets were old and patterned and not a consistent colour which is more appropriate for people with dementia. Handrails were not particularly contrasting with the décor and this can help people to see the handrail more clearly. Day clocks were in units but we did not see that time clocks were available. There was no independent access to outside space, although we observed several people trying to get outside. Most areas lacked a point of interest other than seating placed around the room and facing a TV. Most spaces were not clutter free.

We recommend the provider considers current best practice guidance on providing a dementia friendly environment to meet the specialist needs of people living with dementia.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of

people who 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 capacity to make particular decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible. We were told by senior staff that a number of people lacked mental capacity. The care plans of these people did not have any mental capacity assessments in place to determine their level of capacity to make decisions. There were also no examples of best interest decision making on behalf of people who lacked capacity to agree to the delivery of their care.

Staff had a limited understanding of the Mental Capacity Act 2005. One staff member told us "I'm not sure about it, I haven't had the training" while another senior member of staff told us " It's knowing if someone has capacity but I'm not confident to assess it" This meant that people rights in relation to making decisions could be compromised.

The failure to ensure people only receive care and treatment with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was following the necessary requirements. DoLS authorisations had been obtained, or were in progress where needed.

Staff were observed giving people choice which included choices of what to drink and what to watch on T.V. One staff member asked a person "Would you like a drink", then "hot or cold" and further "tea or coffee"? The person was able to make this decision. We also observed staff asking for consent before they delivered care and respecting their decision. We saw two staff members offering assistance to a person. The person didn't want any help at this time and the staff member replied by saying, "That's ok, shall we come back after we've made you a cuppa?" The person was happy with this.

We saw that people were being weighed regularly and support from health professionals was sought if someone had lost weight. Supplementary drinks were given to people who needed them. However, a screening tool to identify adults who are malnourished and at risk of malnutrition or obese, was not in use.

Some people's food and fluid intake was being recorded to monitor and evaluate their needs. However, these records were ineffective. There was no daily intake or output targets recorded on fluid charts to enable staff to evaluate people's needs. There was nothing documented within daily records to show that staff had recognised below average food and fluid intake or whether they had escalated their concerns to a senior member of staff when a person had eaten or drank a small amount. There was no accountability for checking and acting on the food and fluid information that was recorded. Whilst people were supported with their food and fluid needs, the systems in place to ensure people's needs were assessed and met was not effective. The lack of nutritional assessment, care planning, monitoring and evaluation put people at risk of malnutrition and dehydration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People were offered nutritious and healthy food and were positive about it. One person told us "the food is excellent". Another person was particularly complimentary about the cakes saying "the cakes are to die for".

There was a rolling menu of foods and each main meal had an alternative if people requested. Where people did not want the menu choice, a meal could be prepared of what they wanted, if available. However, we found people living with dementia were not offered meal choices in a meaningful way. They were asked to select their menu choices the day before, so they could not remember what they had ordered. Although staff told us some photographs were available to help people choose their meals, they told us these were not used.

The chef was aware of the dietary needs of people and most staff were aware of individual likes and dislikes of people. However, information about people's preferences of food and drink and how they wished to be supported was not recorded in people's care plans. This meant that new staff and agency staff needed to rely on permanent members of staff to give them this information if people were unable to tell them.

We observed three dining experiences and these were variable. In one dining room a heated trolley was delivered. One person was up and down to the hot trolley or walking around. Other people had to sit and wait whilst the staff member tried to support the person safely and serve lunches. One person had to wait for 20 minutes before they got their lunch due to the staff member having to constantly support the person. The staff member told us "We usually have a runner but they have gone off". In another dining room the atmosphere was calm and people were served in a timely way. However, people had their meals interrupted because a senior staff member gave them their medication whilst they were eating. One person said "What do I want them (tablets) for now?"

Staff supported people to eat in a sensitive manner. Most people just needed occasional prompting to eat and we saw this was done in a supportive way. Some people needed full support to eat and this was provided on a one-to-one basis. Other people needed a pureed diet and we saw they received this consistently. People were offered more food once they had finished.

People were given drinks and snacks throughout the day by staff. One person told us "I can have tea or coffee whenever I like" However, we heard at handover that squash and fruit must be kept out of people's reach which meant people couldn't help themselves. We observed one occasion where a person requested blackcurrant squash but was given orange instead. When the staff member was questioned, they told us they couldn't give the person orange squash as it was on top of the cupboard and they couldn't reach it.

Staff were clear about which people needed thickening powder in their drinks to reduce the risk of them choking and thickening powder and guidance was available in each kitchen for this purpose.

People were supported to access other healthcare services. We saw people regularly saw doctors, specialist nurses and mental health professionals. A community outreach matron told us they went into the home several times a month; this was in relation to matters such as medication reviews, end of life care planning and specific injuries. They told us they had a good relationship with the staff in order to support good outcomes for people. A relative gave an example of when a staff member had gone the extra mile in taking a person to an appointment and they were appreciative of this.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection on 30 June and 4 July 2016 we rated the provider as 'good' under the key question of 'Is the service caring?' We found at this inspection improvement was required.

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the attitude and approach of the staff. Comments from people included "the care here is wonderful, it is not just the carers, it is the cleaners and the cooks – they are all great" and "the carers are so kind". Relatives also praised the care at the home. One relative told us "He is happier here than we could make him at home" and, "I am satisfied that the standard of care is good enough to prevent me from moving my mother to get her closer to my home. A community health professional said of the staff, "Are they caring? Yes, they know the residents well, this is one of their strengths, they genuinely care about the people they look after"

Interactions we observed between staff and people were mainly positive and showed most staff knew people well; for example they asked about their family members and on one occasion we observed a staff member talking to a person about their previous occupation. They engaged with people, made eye contact, bent down to their level and used touch appropriately to reassure. One person was singing in a communal area, a staff member told them they had a lovely singing voice and joined in for a short time, this made the person smile and laugh. There appeared to be genuine warmth between staff and people and gentle banter was observed, one staff member was having a joke with a person about cakes and the person clearly enjoyed this.

However, people's care plans did not always include background information and a life history of the person. When we spoke with staff, we found not everyone could tell us information about people. For example, a staff member did not know what a person's previous occupation was. Where temporary or new staff did not know people well, they relied on people's care plans to provide them with information about the individual. Care plans did not contain accurate up to date information to enable temporary or new staff to support people appropriately. This meant that people may not always be cared for in the way they preferred. The registered manager and five members of staff told us there were not enough staff on duty to provide care and support in a compassionate and personalised way. One staff member told us "It is very difficult to care for people when we are short staffed, especially in the evenings". Another staff member said "Some days there can be four or five (staff) and then when you are rushed you can't spend time with people that I would like to." The registered manager told us "We can get the basics done with six members of staff but we can't do anything extra".

We looked at how people's privacy and dignity were protected in the home. We saw that when people were having personal care, their bedroom door was closed. People looked well-presented and were dressed appropriately. Staff knocked on people's doors and usually waited for a response before entering, however we saw on one occasion a staff member walk in to someone's room as they were knocking the door, they did not wait for a response.

Some people's doors were open and they were lying in their beds. Where people did not have capacity this

should be considered a best interest decision. We noted that incontinence pads were on show in peoples bedrooms and when their doors were open other people in the home could see these. This did not protect people's dignity. A message on a notice board in a kitchen/dining room that was regularly used by people contained information about people's dietary needs. This compromised people's privacy. We observed most staff discreetly asking people if they needed to go to the toilet. However, on one occasion, we saw two staff members with gloves on loudly telling a person it was time for the toilet in front of other people.

The failure to protect people's privacy and dignity is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff were able to tell us how they promoted people's independence. One staff member told us "I try to encourage and not take over"; we observed an interaction between a person and a staff member, the staff member said "Would you like me to help you get the pen off your hands or do you want to do it?

Staff described how they met people's religious and cultural needs. They told us a church service was held in the home and people were supported with prayers and communion. We observed one person drinking a hot chocolate. The staff were able to tell us this was because they did not drink caffeine due to being of a particular religion. They went on to tell us about a bible in the person's room and the importance of it.

Family members told us they were made to feel welcome at the home. One family member told us "I can even go into the little kitchen and make tea or coffee and sometimes have lunch here" The service had set up a monthly family support group. This was appreciated by the family members we spoke with.

A newsletter had also been developed to keep people and their representatives up to date with changes and events in the home.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 30 June and 4 July 2016 we rated the provider as 'good' under the key question of 'Is the service responsive?' We found at this inspection improvement was required.

Information gathered at pre-admission assessments and placement reviews was not used to develop individual care plans. Care plans lacked information in relation to people's physical, emotional, social and health needs. For example, the care plan of a person living with dementia did not include information about the type of dementia they had and how they could be supported with this. Another person who had diabetes did not have a care plan related to their health condition. Care plans lacked life histories and detailed information about peoples' preferences. This is significant in a service for people living with dementia as the information can aid staff in communicating and assisting in reminiscence-based activities with people.

Care plans were out of date and did not sufficiently guide staff on people's current care and support needs. For example we saw that one person had been assessed as having no needs around nutrition. On a monthly review it was recorded they needed encouragement at mealtimes and were continually dribbling. There was no care plan in place to guide staff on how to support the person with this. We also saw that it had been recorded in October 2017 that their mobility was poor at times but the care plan around mobility had not been updated since November 2016 and there was no guidance on how this person needed to be assisted with their mobility. People were at risk of receiving inappropriate care and treatment because their needs and preferences were not based on an up to date assessment.

There was no evidence that people or their representatives were involved in care planning. Where there was a space for people or their representatives to sign to confirm that they had been involved, they were blank. The views of people about their care had not been captured or recorded in their care plans. Monthly reviews often consisted of a sentence. For example 'reduced mobility', 'no change' 'must be aware of whereabouts at all times' it was clear people had not been involved in this.

There was a risk of people not receiving person-centred care, because the information was not available to guide staff on how to provide appropriate care that met people's needs and reflected their preferences.

People were appreciative of the activities provided in the home which were provided by a part-time activities coordinator who worked 19 hours per week over three days. Other staff members we spoke with told us they did not carry out activities with people. Comments included "I don't have much to do with activities" and "The activity coordinator does the activities."

We observed more activities were needed to provide stimulating and meaningful activity for people and to meet their emotional and social needs. On the first day of inspection, we saw three people making Christmas decorations and enjoying a chat with the activity coordinator. The remainder of the people in the home were not engaged in an activity. We saw people sitting in lounges for long periods of time without any social engagement. In one lounge, the television was on all day and people were not watching it. Other

people were walking around the home and had little interaction with anyone else. On the second day of inspection, there were no activities happening in the home and again, people were either sitting for long periods of time or walking around the home. A staff member commented "There's nothing for people to do, that's why they're unsettled, it's really sad".

We looked at people's activity records; we noted that two people had nothing recorded for the three months' worth of records that we saw. The registered manager told us it was because they were difficult to engage with. We saw in resident meeting minutes that people had been given the opportunity to suggest activities. One person had suggested gardening and had been able to grow vegetables. Other people expressed a desire to go to Southsea, or the park, watch more football, flower arranging and activities relating to the Royal family but we did not see evidence that these had taken place. There was a lack of planning and availability of meaningful activities which people could take part in. Staff told us that some people enjoyed household tasks such as washing up, laying tables and food preparation. We did not see any evidence of this taking place.

People who required individual person-centred activities on a one to one basis with staff did not receive them. The registered manager told us this was due to a lack of staff. This meant peoples' wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs.

The failure to assess, plan and provide care and treatment to meet people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no information in people's care plans about their end of life wishes. This meant that staff would have been unable to identify how people wished to be cared for at the end of their life. They would also not be aware of their wishes following death. We discussed end of life care with the registered manager. They told us new care plans were being developed and this information would be included. The registered manager and three members of staff were undertaking the Six Steps programme. This is a nationally accredited course which aims to develop staff knowledge and enhances end of life care for people. The registered manager described the support they received from GPs and nurses in relation to end of life care and a health professional confirmed this. A staff member told us "the managers are very supportive at this time, they are good at this".
The activities that were available were planned and those listed included; quizzes, art and craft sessions, sing songs, cooking, bingo and a pop up animal farm. People were positive about these activities. A relative told us "I am surprised that my father would have been interested in any of these events, but he now looks forward to the next one with enthusiasm, I am happy for him"

The service manager told us there were plans in place for volunteers to carry out some activities in the home. They said they had forged links with the local university and other members of the community. This was to be called 'Be there for care' The service had made plans to improve social engagement for people. They were in the process of building a café and a sweet shop in the home. They also told us they were purchasing an interactive table where light animations are used. This is particularly useful for people with mid to late stage dementia.

The provider had a complaints procedure. This was clearly displayed on a notice board in the front entrance. People and representatives said they knew how to complain. We looked at the complaint log. We saw that two complaints had been logged and both had been investigated and resolved satisfactorily.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection on 30 June and 4 July 2016 we rated the provider as 'requires improvement' under the key question of 'Is the service well-led?' at this inspection we found further improvement was required.

Following our previous inspection, the provider sent us written information about how they would improve the service. This action plan was ineffective. The provider had failed to take sufficient action in response to the shortfalls identified and at this inspection we found there had been little improvement in the level of service provided and some areas had deteriorated. We identified nine breaches of regulations, three of which were continuing breaches from our last comprehensive inspection.

At our last inspection we had identified a breach under Regulation 17 Good Governance as systems and processes did not enable the provider to continually evaluate and improve services by seeking and acting on feedback from people about the service provided. The provider had also failed to establish systems or processes to assess monitor and improve the quality and safety of the service.

At this inspection visit we found a continuing breach of Regulation 17. The quality assurance systems used by the registered provider were ineffective in assessing where the service required improvement in terms of implementing and sustaining improvement effectively within a reasonable timescale. There were widespread and systemic failings identified during the inspection. Audits did not identify the concerns we found. Actions identified through audit were not monitored to ensure they were complete. We have reported in other domains the shortfalls we found in safety, staffing, care planning, medicines management and dignified, person-centred care.

There was a lack of effective and proactive analysis of accidents and incidents in the home. For example, the registered manager had not completed monitoring and analysis of the falls people had to identify improvement actions and prevent a reoccurrence. There were no records to support what action was taken following incidents to minimise further incidents or to keep people safe. Risks to people from building works had not been assessed; risks associated with the premises and fire safety had not been appropriately monitored and managed. This meant the system in place to assess, monitor and mitigate risks to the health and safety of people and others was not effective and people could be at risk of unsafe care and treatment.

Despite being told in the provider's action plan that the provider's representative would complete quality audit visits on a regular basis, we found this had not happened. There had only been one structured quality assurance visit in the last year and the progress of the service in meeting the previous breaches of regulation had not been assessed. The visit focused on a small number of areas and did not identify the concerns that we found during our visit.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and

omissions in the care records and to analyse concerns. We saw records which were undated, unsigned, incomplete and incorrect. All seven care plans we saw had an element of this with some being significantly worse. We asked to see audits relating to care plans and only one had been undertaken in the last year. This identified some actions were needed but there was no evidence that these had been checked as carried out.

When we discussed this with the Registered Manager they told us "This is an area that's poor, I'm well aware of this, I'm aiming to improve" The Registered Manager went on to tell us the provider had devised new care plan audits that all Portsmouth City Council homes would use.

The provider engaged people, their representatives and staff in the running of the service and invited feedback through the use of questionnaire surveys. Feedback was predominantly positive, however individual issues were not explored or resolved for people: for example, we saw comments such as; "I would like another bed", I would like more staff to talk to me" and "the staff wouldn't let me out when I asked".

Meetings for people and their representatives were also used to gain feedback about the service. When we looked at the minutes we saw that suggestions had been made but not always followed up. People in one unit had asked for blankets in April as they felt cold, in July we saw they asked for these again as they were still chilly. On the day of inspection we did not see that blankets were in use for people. This meant that people could not always be confident that they would be listened to or any issues investigated and rectified.

In the foyer, we saw a board entitled 'You said, we did'. This was used to publish comments from people, together with action staff had taken in response. For example; Photographs of staff with their names on the wall were asked for. The action stated this would be done once the redecoration had taken place.

Records of staff meetings showed staff were able to raise concerns during staff meetings and did so regularly. Examples included concerns about how long it took to get people up in the mornings when short staffed and therefore people ate a large breakfast and not much of their lunch. Staff suggested swapping the main meal to the evening but this hadn't been actioned. Another concern was raised about senior managers leaving the care staff when they were short staffed and they felt unsupported. There was no record of any action being taken in response to these concerns. Action plans were not developed and the minutes of subsequent meetings did not indicate that the issues had been resolved.

Although systems were in place to seek feedback from people, their representatives and staff to evaluate and improve the service, this feedback was not always acted on.

A failure to have effective systems and processes in place to drive continuous improvements, to assess, monitor and mitigate risks relating to the health and safety of people, and the failure to maintain an accurate, complete record in respect of each service user was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to safeguarding incidents including allegations of abuse. For example, we saw several incidents recorded in people's daily notes that they had struck another person. These incidents had not been recorded in the service's accident and incident management system, reported to the local safeguarding authority or to the Commission.

This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, we have been sent notifications in relation to behaviour that challenges and the local authority had also been notified.

The provider had not always demonstrated good leadership in respect of the support provided to the Registered Manager. Despite the Registered Manager having monthly supervisions and regular informal support, we found that during the inspection the Registered Manager was unaware of all of the responsibilities associated with their role. There had been vacancies amongst the senior staff team and the home was going through an extensive refurbishment programme. This meant the Registered Manager had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. Although the Registered Manager told us they felt well supported, we nonetheless concluded that the provider had failed to provide sufficient time and support to enable the Registered Manager to undertake their role effectively and to a good standard.

Communication in the home was not always effective. The Registered Manager was often unaware of incidents that had occurred. In the staff meeting minutes it was noted that staff were not always told straight away about people's changing needs and requirements, this could put people at risk. There was a communication book in place but this was not used for sharing important information about people. A staff member told us "There is a distinct lack of communication here" The Registered Manager told us a new communication book was in the process of being developed.

Staff received a verbal handover in meetings between shifts and they also received daily handover sheets. These meetings and handover sheets aimed to provide the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of people they were supporting. We saw that the daily handover sheets only contained information about people's diagnosis of dementia and DoLs status. We discussed this with the registered manager and they told us staff added on information about people's changing needs. They went on to say they were in the process of updating these to incorporate more details about people.
This is important to ensure all staff, including those who do not know people well, have important information about people's needs to guide them to provide appropriate support.

People and their representatives told us they thought the home was well run. One relative confirmed this by saying "The management here are very responsive and proactive". Staff did not always share the same view. One staff member said "Actually, I think the care staff run the place" Staff members told us the Registered Manager was supportive. Comments included "(Name) is a good, fair manager, you can talk to her" and "(Name) helps us on the floor". However, staff felt that not all the management team were helpful. When we asked a staff member what could be improved in the home, they replied "The management, we need new blood, one senior staff member never helps us, I reported it to the Registered Manager but nothing has changed".

All the staff expressed commitment to the people living at Hilsea Lodge. They used comments such as "The best thing about this home are the resident's" "They're lovely". Staff were also complimentary of each other. They said "We're a good team" "It's like a big family here" and "We support each other" However, staff told us they were not often supported by the management team with issues such as behaviour that challenges or being short staffed. They said "We just get on with it" and "My colleagues help; no, the managers don't".

The previous CQC rating was prominently displayed in the entrance hall to the home. However, the most recent rating was not on the provider's website. We addressed this on the first day of our visit and by the second day, this had been rectified.

The Registered Manager was open and transparent throughout the inspection. They were keen to drive improvement in the home. They told us "We will take this inspection as a positive, use it as an action plan and improve. I know we can do this". The service manager also told us they would be implementing changes to improve the service which included new care plans, new audits and a dependency tool to establish how many staff were needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify the commission without delay of relevant incidents. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred Care. The failure to assess, plan and provide care and treatment to meet people's needs and preferences Regulation 9 (1)(3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect. The failure to protect people's privacy and dignity at all times.Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 11 HSCA RA Regulations 2014 Need

personal care	for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent. The failure to ensure people only receive care and treatment with the consent of the relevant person. Regulation 11 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises and equipment because of inadequate cleaning Regulation 15 (1) (b).

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The failure to ensure risks relating to the safety and welfare of people using the services are assessed and managed. The failure to identify, assess and do all that is reasonably practicable to mitigate and manage risks to people from premises and equipment. The failure to fully protect people from the risks associated with the unsafe management of medicines Regulation 12 (1)(2)(a)(b)(d)(e)(g)

The enforcement action we took:

We issued the provider with a Warning Notice requiring them to be compliant by 30/03/2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 20104 Safeguarding service users from abuse and improper treatment A failure to establish and operate effective systems and processes to prevent abuse of people. Regulation 13 (2)

The enforcement action we took:

We issued the provider with a Warning Notice requiring them to be compliant by 30/03/2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A failure to have effective systems and processes in place to drive continuous improvements, to assess, monitor and mitigate risks relating to the health and safety of people, and the failure to maintain an accurate, complete record in respect of each service user. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We issued the provider with a Warning Notice requiring them to be compliant by 30/03/2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014 The failure to provide staff with appropriate support, training , professional development, supervision and appraisal as necessary to enable staff to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)

The enforcement action we took:

We issued the provider with a Warning Notice requiring them to be compliant by 30/03/2018.