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# Hillside Care Home

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

The inspection took place on 28 August 2018 and was unannounced. The last inspection was in December 2015 where we rated the service 'Good' and found no breaches of the legal requirements. This inspection found seven breaches of the legal requirements in relation to risk management, reporting of incidents, care planning, governance, consent, fees and statutory notifications. You can see what action we asked the provider to take at the end of this report.

Hillside Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hillside care home provides support to up to two people in one adapted building. People living at the service had learning disabilities, autism and mental health conditions. At the time of our inspection, there were two people living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager, but they resigned from their post after the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk plans lacked detail and we found instances where measures to manage known risks were not robust enough. There was a lack of monitoring of accidents and incidents and these were not always being reported to the appropriate agencies to safeguard people. The provider had also failed to notify CQC of an incident that they were statutorily required to.

There was a lack of clarity about people's fees and what they paid for. We also found instances where the mental capacity act had not been followed in relation to people's finances. Activities that were planned for people often did not take place and care plans sometimes lacked detail about people's needs. People's healthcare appointments were not always tracked and changes to people's health had not always resulted in referrals to healthcare professionals.

Audits were not robust enough to identify the issues we found during this inspection. People's records were not always readily available and the provider did not have oversight of incidents at the service. The complaints policy lacked accuracy and was not always accessible to people. We made a recommendation

about the information provided to people about complaints.

Staff felt supported by management and we found that there were sufficient numbers of staff to support people in the daytime. Checks were carried out on new staff but we found instances where information gathered through recruitment checks was incomplete. We made a recommendation about recruitment checks.

Where people were not able to consent to their care and accommodation, we saw that the correct legal process had been followed. Information had been gathered and an assessment was carried out before they came to live at the service. Staff involved people in tasks and encouraged them to be independent. People's privacy and dignity was promoted as staff provided care respectfully. People were supported to make meals based on their food preferences and dietary needs.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Plans to manage risks were not always robust and there was a lack of oversight of accidents and incidents.

The provider had not shared important information about safeguarding incidents with the local authority.

Checks were carried out on new staff but we found gaps in a work history. We made a recommendation about recruitment checks.

There were enough staff to meet people's needs at daytime, although we did find an unmanaged risk at night time that was addressed after the inspection.

People's medicines were managed and administered safely.

The home was clean and there were systems in place to reduce the risk of the spread of infection

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Information about people's healthcare needs was lacking and appointments were not tracked and booked promptly.

The correct legal process had not been followed where people were supported to make purchases.

People received food in line with their preferences.

People's needs were assessed before they came to live at the home. The home environment was suited to people's needs.

Staff had received training for their roles but we found that supervision meetings were not always taking place. We made a recommendation about supervision meetings.

## Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always involved in their care and we found one person's religious needs were not met.

Staff and people interacted warmly and got on well.

People were provided support that encouraged them to be independent.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of creativity when it came to activities and people did not attend activities as planned.

Care plans sometimes lacked detail about people's preferences and routines. Reviews were not identifying and responding to changes in need.

There was a complaints policy in place but this was not accurate. We made a recommendation about complaints.

End of life care had been planned sensitively, in line with people's needs.

## Is the service well-led?

Inadequate

The service was not well-led.

Audits were not robust and had not addressed concerns found during this inspection. Records were also incomplete.

There was a lack of clarity over people's fees and what they should pay for.

The provider had failed to notify CQC when required and there was a lack of transparency in sharing information with health and social care professionals. We made a recommendation about links with the local community and stakeholders.

People and staff had regular meetings that were used to discuss care. Staff felt supported by management.

# Hillside Care Home

**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 was planned to check 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.

This was a planned comprehensive inspection. However, at the planning stage CQC were made aware of a safeguarding concern raised by the local authority. The concerns related to information sharing, person centred care, access to healthcare professionals and finances. As part of this inspection, we looked into these concerns.

This inspection took place on 28 August 2018 and was unannounced.

As this was a small service, the inspection was carried out by one inspector.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with two people. We spoke with the registered manager and two care staff. We looked at care plans for two people including risk assessments daily notes. We checked medicines records for two people. We looked at mental capacity assessments and applications to deprive people of their liberty.

We looked at a variety of checks and audits as well as records of surveys and minutes of meetings of staff, people and relatives. We looked at two staff files and checked records of staff training and supervision. We carried out observations throughout the day to observe staff practice and interactions with people.

Requires Improvement

# Is the service safe?

## Our findings

A relative told us they felt the service was safe. They told us, "From what we have seen, it is safe."

Risks to people were not always managed safely. Care plans contained assessments of known risks and staff documented plans to keep people safe. However, these plans were not always robust. For example, one person had known risks at night time. Records showed they were at risk of putting paper in the sink and toilet which meant they required 'close supervision', to reduce the risk of flooding. Waking night staff had been put in place to manage this risk but had been removed by the provider two months before our visit. Despite this measure to manage the risk having been removed, we did not see evidence that the risk had reduced or any alternative measures, such as equipment or technology, had been considered. An entry on the person's behaviour chart in April 2018 showed staff had found paper blocking the person's toilet in the morning. The registered manager told us that there had been other similar incidents but we did not see record of these, which showed a lack of record-keeping relating to this risk. There was one sleep-in staff member on duty at night and the registered manager told us that if the person got up the sound of their footsteps would wake the staff member up, when sleeping downstairs. This was not a robust way of ensuring a prompt response to this known risk at night time. After the inspection, the provider told us that they would re-introduce waking night cover at the home.

Another person's records reflected that they could become agitated, which could result in behaviour that might place them or others at risk. Their care plan recorded that staff were to 'look out for early signs of agitation', but did not describe what these were. The behaviour care plan documented that staff should, 'try to raise [person]'s awareness to help him deal with feelings more positively' but there was no guidance for staff on how to do this. We did note that this person did not have recent recorded instances of these behaviours and they were supported by regular staff which minimised the impact of this. However, the guidance available to staff was not sufficient to ensure staff could respond appropriately should an incident occur.

The person also had epilepsy and there was a protocol for staff on how to respond if they suffered a seizure. However, the protocol did not provide guidance for staff about when to call emergency services and when to administer emergency medicines. The person was prescribed emergency medicines to be administered in the event of a seizure, but this had not been reviewed for over two years. The form of medicine prescribed is not used regularly due to it being an invasive method of administration. There are now alternative forms of medicine available which are less invasive. The person had not had a documented seizure for over two years.

Accidents and incidents were not always accurately recorded and monitored. Each person had charts in their records which documented behavioural incidents, including what caused the behaviour and what actions were taken in response. However, the registered manager was not able to find their central record of accidents and incidents. One person's daily records showed that they had sustained an injury following an unwitnessed fall at night in December 2017. There was no incident record relating to this available on the day and the provider had to provide these records after the inspection. We also saw there was no overall

analysis of incidents, this meant there was a lack of systems in place to enable learning from incidents.

The shortfalls in planning to manage risks and the lack of documentation relating to accidents and incidents were a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always protected from abuse because systems to inform relevant agencies of incidents were not followed. Prior to the inspection, we gathered feedback from the local authority. The local authority had recently opened a safeguarding investigation because they had not been informed of incidents. One person had sustained an injury and been admitted to hospital, but the local authority had not been informed. Where the person had unexplained bruising that could be a sign of abuse, the provider had not informed the local authority of this. Another person had recorded behavioural incidents that could indicate increased risk or a change in their needs, and this had not been reported to their funding authority. The local authority relies upon information from providers to inform them about risk for people under their care. Staff did understand their roles in safeguarding and knew who to contact if they suspected abuse. However, our findings show that the provider was not sharing information with the local authority. We also found information relating to people's finances was not stored in an orderly manner, which heightened the risk of financial abuse occurring. One person had been supported to make large purchases and the receipts were not all on file. After the inspection, the provider was able to find these and submit evidence of them to CQC.

The failure to report incidents in a transparent way was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider carried out checks to ensure they recruited staff safely. Staff files contained evidence of references, health declarations, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carries out criminal record checks and holds a list of potential staff who would not be suitable to work in social care. We did note one file did not contain a full work history. This meant that the provider did not hold a record of everywhere this staff member had worked previously. We informed the registered manager of this and they submitted evidence after the inspection to show that this check had been fulfilled.

We recommend that the provider reviews their recruitment processes to ensure a full work history is gathered before staff come to work at the home.

During the daytime, there were sufficient numbers of staff to meet people's needs. People had staff present at all times and were able to go out with the level of support necessary. Staff were observed as able to spend time with people supporting them to do tasks. Staff told us they were able to complete all the tasks they needed to do each day without being rushed or hurried.

People's medicines were managed and administered safely. Medicines were stored securely within a locked cabinet. Staff regularly checked the temperatures of storage areas to ensure medicines were stored in line with the manufacturers guidance. Medicine administration records (MARs) contained photographs of people, so staff could easily confirm their identity before administering medicines to them. MARs were up to date but we did identify two recent gaps which the registered manager was able to address the same day. MARs were checked on a weekly basis and records showed staff had usually filled MARs in accurately, with a record of when people had received their medicines and if they had not been administered, staff documented the reason why.

People were protected against the risk of the spread of infection. The home environment was clean with no

mal-odours. During the inspection, we observed staff cleaning the home and people supported them with some domestic tasks. Staff had checklists each day which included cleaning tasks. When completed, staff signed these off. The provider carried out a regular infection control audit to check and monitor the cleanliness of the home.

Requires Improvement

# Is the service effective?

## Our findings

People were not always supported to access healthcare professionals. Records were kept of people's visits to healthcare professionals but we found instances where records were incomplete and appointments had not been booked. For example, one person had no record of having attended a dentist appointment for two years. This had been picked up when they attended a health check with the GP in May 2018 and subsequently a dentist appointment had been booked for October 2018. The registered manager told us they could not remember when this person last attended the dentist and records of healthcare visits showed no entries for a dentist visit for two years. The lack of dental check-up had not been identified by the provider and the appointment had only been booked following this being flagged up by the GP during a health check-up.

After the inspection, the local authority informed us of an incident where this person choked in March 2018, but we did not see any record of this during our visit. The provider confirmed that no referral was made to a speech and language therapist (SALT) in response to this. This person had also been admitted to hospital in April 2018 and there was no record of the hospital discharge summary, despite them being in hospital for two days. The person had attended accident and emergency in December for treatment for an injury and there was no information from the hospital about changes in support needs in care records. The registered manager told us this information may have been archived, despite it being recent. After the inspection, the registered manager provided this information to us. However, this showed a lack of robust record keeping relating to people's healthcare appointments as important information was not readily available.

The failure to ensure people attended their health check-ups and maintain accurate healthcare records was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were not always protected because records were not kept about decisions that affected them. People's care records contained mental capacity assessments and best interest decisions from the local authority. These documented that they were unable to make the decision to come to live at the home and consent to care. Therefore, best interest decisions were documented and DoLS applications had been authorised. Whilst these were in place and showed the correct legal process had been followed when the local authority visited people to carry out assessments, the provider's paperwork was not fully compliant with the MCA. We saw mental capacity assessments in people's records but these did not state which

decisions these related to. These assessments were general screening tools and did not assess people's mental capacity in a decision-specific manner.

The correct legal process was not always followed where people could not make specific decisions. We found that where people were supported to make large purchases or go on outings where they paid for staff meals, there was no record of a mental capacity assessment or best interest decision. This meant that the legal process had not been followed where people were unable to make financial decisions.

The failure to follow the correct legal process where people were not able to make a decision was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's dietary needs were met. People's care plans contained information about their food preferences and dietary needs. For example, one person's care plan documented a need to maintain a healthy weight as they had a history of weight gain. Their care plan documented that they needed support to eat balanced healthy meals and to go for walks and exercise. Records showed the person was regularly supported to go shopping and prepare home cooked meals with staff. The person was weighed monthly and records showed a gradual decrease in their weight due to these measures being in place.

People's needs were assessed before they came to live at the home. Care plans contained evidence of admission assessments that captured information about people's needs and backgrounds. For example, where one person had come to live at the home we saw evidence of an assessment by the provider that captured information about the person's behaviour that had been added to their care plan. The provider had also gathered information from the person's previous placement as well as the local authority and healthcare professionals. This information had been added to the person's care plan. We did note some lack of detail in care plans which we have reported on further in Responsive.

The home environment was suitable for the people living at the service. The registered manager told us they wanted the environment to be homely and we observed that this was the case. Communal areas were decorated with bright colours and pictures. People's rooms had pictures and items of their choosing within them. We observed people moving around the home environment freely during our visit.

Staff had received training for their roles. Records showed staff had training in areas such as health and safety, infection control and safeguarding. Staff told us that this training was useful to them in their roles. One staff member said, "They have given me training and we refresh it." Records were kept of staff training but we could not find record of recent supervision meetings for two staff. Staff did tell us they worked with the registered manager and provider regularly due to the small size of the home. Despite this, we could not see record of supervision for two staff who had started work at the service in early 2018. There was also no record of appraisals for these staff and one staff member who had been employed for over a year. There was no system to track and monitor supervision and appraisals.

We recommend that the provider reviews their systems to ensure staff have regular meetings with their line managers and opportunities to discuss performance.

Requires Improvement

# Is the service caring?

## Our findings

People were not always involved in their care. Care plans contained information about what was important to people, but there was a lack of evidence of people's involvement care planning. For example, one person had been at the home for a long time and information on what they enjoyed the bed each morning."doing and their preferences was lacking. This person was regularly supported to visit friends and we saw that this person's important relationships were documented. However, we noted this person was listed as being of Christian faith and their activity schedule recorded they attended church every Sunday. We did see that information about the person's culture, language and sexuality had been gathered, but there was a lack of care planning around how to support this person to practice their faith. Daily notes showed that they were not attending church as planned. Records also showed that the person had suffered a bereavement and their behaviour had changed at that time. Despite this, the person's records did not contain any evidence of support for them to access therapy or support for their loss.

People had activity timetables in place, but there was no evidence of how people had been involved in producing them. Both people's activities schedules were very similar and lacked unique input that reflected any interests or hobbies that they had. Both timetables recorded that they regularly went shopping or attended another of the provider's homes, with no evidence of how this related to their preferences or background. Both people had different backgrounds and ages, yet the activity scheduled were similar. This showed a lack of involvement of people in planning activities.

The failure to involve people in their care and respond to preferences was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed pleasant caring interactions between people and staff. During our visit, people sat with staff and looked happy in their company. Staff used appropriate touch and verbal prompts to interact with people. For example, in the morning staff asked after one person's wellbeing as they looked tired. The person wanted some fresh air so staff took the person's hand and they went into the garden. Later, the registered manager played a board game with one person and the interactions between them were warm and the person was heard laughing and enjoying the game. Staff told us they were dedicated to their roles and got job satisfaction from supporting people. One staff member said, "I enjoy it and just went them to feel at home, this is their house so I make it feel like their home."

Support was in place to encourage people to be independent. During the inspection, we observed people being encouraged to help with tasks and daily notes recorded people did this regularly. For example, we observed one person supporting staff to sort recycling ready for collection. Staff told us they regularly involved people in tasks and understood the importance of doing so. One staff member said, "Whenever I am working with them I encourage them as much as possible. [Person] needs some help to make

Staff provided care in a way that was respectful of people's privacy and dignity. Where people were supported with personal care, this was done discreetly behind closed doors. Staff knocked on people's doors and waited for permission before entering. People had clean clothes on and looked well kept and

comfortable.

Requires Improvement

# Is the service responsive?

## Our findings

People did not always receive person-centred care. Activities lacked creativity and there was no evidence of how these were planned in line with people's interests and hobbies. There was a lack of life stories and detailed information about people's preferences and interests were not documented. Timetables also showed that activities were regularly not attended. For example, both people's schedules included a weekly trip to another of the provider's homes to use the sensory room. They also both attended another day club at the same time each week, but daily notes showed they had not attended this club regularly and went to another of the provider's homes multiple times a week instead. Despite the lack of attendance of the day club, this activity remained on timetables and had not been changed through reviews. This showed a lack of person-centred planning around people's activities.

Where people had specific needs, the care planning around them sometimes lacked detail. For example, one person had a care plan for personal hygiene and dressing. It contained basic information about the support they needed but did not state what kinds of clothes the person liked to wear or what times they liked to receive care. We also found details on how to identify triggers that may cause negative behaviours and guidance for staff on how to respond to them was not detailed. Care plans were focused on tasks people needed support with each day and whilst they did contain information about preferences, they did not contain goals or outcomes that people wanted to achieve.

Care plans contained evidence of reviews but we did not see examples of care plans being changed following reviews. This was despite records showing that activities were not being attended and incidents had taken place, which could require a change to behaviour care plans. Care plans simply documented a review date and signature to state no changes were required, despite changes being evident.

The lack of person-centred care planning and shortfalls in activities were a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The complaints policy was not completely accurate. The complaints policy was within the 'Service User Guide' given to people but the information provided to people and relatives was not accurate. The policy stated people could 'bring your complaint to the Commission inspector of the home who will look into your complaint'. This is inaccurate because CQC do not look into complaints. The policy did contain contact details for the Local Government Ombudsman (LGO), who can look at complaints. The complaints policy did not make their role clear to people and relatives. We noted that there had been no complaints since our last inspection.

We recommend that the provider reviews their complaints policy to ensure that it is accurate and accessible to people and their relatives.

End of life care had been planned for appropriately. People's care plans contained an end of life booklet, which was accessible with pictures and short questions regarding people's preferences for end of life care. The information within these was limited, due to the lack of detail observed throughout care plans.

However, these did show that conversations had taken place with people about what would happen at that time of their lives. It included information such as when they wished to be admitted to hospital, who they would want to be present and advanced wishes for funeral arrangements.

Inadequate

# Is the service well-led?

## Our findings

Systems for auditing people's care were not robust enough to identify and address concerns. We saw that audits were carried out that covered the home environment, health and safety, medicines, infection control and documentation. However, these were not always robust enough to identify the issues we found during our visit. For example, audits of records had not identified that important medical information was missing from one person's records. They also did not pick up that the person had not seen a dentist for over two years. Care plans showed evidence of having been reviewed but where we found information lacked detail or was incomplete, audits had not identified or addressed this.

There was no audit of accidents and incidents and there was no process for management to sign these off. At the time of the inspection, the registered manager was unable to find the record of accidents and incidents. Where behavioural incidents had been documented in people's daily notes, the provider was not aware of them. This showed that there was a lack of oversight and governance of accidents and incidents. This had contributed to the lack of information provided to the local authority, as staff were documenting incidents without them being monitored and signed off by the provider.

The lack of robust auditing and shortfalls in record keeping were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider did not always fulfil the responsibilities of their registration. Providers are required to notify CQC of important events such as allegations of abuse, injuries and deaths. We found two instances where CQC had not been notified of when such events had taken place. For example, one person fell and sustained a skin injury that required closing. This would constitute a 'serious injury' and providers have a statutory duty to notify CQC of these. We also found that CQC had not been notified where a person had developed unexplained bruising that could be consistent with abuse.

The failure to notify CQC of important events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a lack of clarity about people's fees. A relative told us, "We had a bit of a surprise as we weren't aware we'd have to pay for [person]'s holiday." People and relatives were not always given sufficient information about what people would be expected to pay for at the home. We noted that receipts showed that one person had been regularly buying meals for staff when being supported to go on outings. The registered manager told us that this was the provider's policy but we did not see any evidence of how people or their representatives had agreed to this. Receipts also showed people regularly paying a set amount for petrol, even when they had not used a vehicle that week. The registered manager said this was also part of the provider's policy but there was also no documentation to show how this had been communicated to people or relatives. The 'Service Users' Guide' that was provided to people and relatives stated that people 'are allowed to purchase their carer a drink or meal when out in the restaurant and café'. However, it also said that if people are not happy with this they were to inform their keyworker. We did not see any record of this having been discussed with people or relatives to confirm they were happy with this

arrangement, despite people regularly paying for staff meals.

It was unclear what people were responsible for paying for. We saw that people were purchasing furniture and mattresses for their rooms. In one case, the local authority were funding the person's care and they told us they expected purchases of furniture to be included in the fees they paid. The 'Service User Guide' stated people should pay for, 'wilful damage to property', which was not considerate of people who could cause damage as a result of behaviours related to anxiety or agitation. A safeguarding had been raised by the local authority and they had requested that people were reimbursed where they had made these types of payments. The provider had committed to doing this.

The failure to ensure people and their representatives had all the information that they required about fees was a breach of Regulation 19 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not share information in an open and transparent way. We found a lack of information being shared with relevant agencies and CQC. Whilst we saw evidence of contact and communication with health and social care professionals, we found that this was not always regular. As reported on in Safe and Effective, there was a lack of safeguarding information shared with social services and people did not always attend their healthcare appointments. This heightened the risks of potential health conditions or abuse not being followed up by the relevant professionals. Whilst we saw that people regularly went out with staff into the community and sometimes attended a day centre, we did not see evidence of the provider reaching out to the local community in order to build the service and improve people's care experience.

We recommend that the provider identifies ways to engage positively with the local community and relevant stakeholders.

People had regular meetings. We saw evidence of meetings where people were asked about their day to day care and activities. For example, a recent meeting had been used to discuss increased exercise with one person and they expressed a desire to go out on more walks which had been actioned and added to their activity schedule.

Staff felt supported by management. We saw that staff had regular meetings that were used to discuss people's needs and any current issues or messages. The provider attended these meetings and a staff member told us they felt motivated by the provider, which gave them confidence in their role.

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<br><br>the provider had failed to notify CQC of two incidents that they would be required to. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider failed to ensure people's healthcare needs were accurately recorded and appointments attended.<br><br>People were not always involved in care planning and care plans lacked person-centred information. Activities lacked creativity and were not always attended as planned. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The correct legal process had not been followed where people lacked the mental capacity to make financial decisions. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There was a lack of information relating to risk and the provider did not carry out analysis of accidents or incidents. |

| 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<br><br>The provider had failed to inform the local authority of incidents in order to ensure people were safeguarded from abuse. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's audits were not robust enough to identify the concerns identified at this inspection. Records were incomplete and were not readily available. |