Ultimate Care Limited

Barton Brook Care Home

Inspection report

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03 October 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Barton Brook is a care home in Salford which is registered with CQC to provide care for a maximum of 120 people, across 4 separate 'Houses'. These include Monton (EMI Nursing), Moss (Residential Dementia), Brindley (Nursing) and Irwell (Nursing). There were 110 people using the service at the time of the inspection.

People's experience of using this service and what we found
Not all risks were well managed at the home including those relating to falls, skin integrity and the environment. Staff did not always respond appropriately when physical and verbal altercations occurred between people living at the home. We have made a recommendation about staff receiving further safeguarding training. Actions following incidents weren't always followed through. We received poor feedback about staffing levels within the home and observed staff weren't always available to respond to people's needs. There were a number of environmental concerns observed on some of the units which could place people at risk of harm.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. There were a number of restrictions in place for people including 121 care, the use of covert medication and sensor mat/chair alarms. We also observed people's movements around one of the units being prevented. MCA assessments were not? completed to ensure this was in people's best interests.

People's bedrooms were not always personalised and some felt unhomely. The external grounds of the home were not well maintained, with lots of stray litter scattered around and overgrown grass. There were a number of instances where people's dignity was compromised where staff did not always respond accordingly.

People's care plans contained contradictory details and this posed the risk of staff not having the correct information regarding the care people needed. Activities and stimulation for people was limited. Nobody was receiving end of life care at the time of the inspection, although we received feedback from the local authority that attendance at their training sessions could improve. People's communication needs were not always met.

There had been a lack of leadership at the home in the past 12 months, with 5 different home managers in post. Leadership on each of the individual units was also a concern. Meetings for resident/relatives and staff had not been taking place consistently, although had now been scheduled to take place. Staff supervisions and appraisals did not always take place consistently. There had been a failure to ensure compliance with regulations and the ratings for each of the key questions had declined.

Rating at last inspection

The last rating for the service was requires improvement (Published July 2022).

Why we inspected
We carried out an unannounced focused inspection of this service on in May 2022 and a breach of regulation 17 regarding good governance was identified. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance systems within the home.

We undertook this inspection to follow up on specific concerns which we had received about the service including staffing, safeguarding, falls management and leadership. A decision was made for us to inspect and examine those risks.

We undertook this inspection to check they had followed their action plan and to confirm they now met legal requirements. We inspected and found additional concerns which could impact people's safety, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of effective, caring and responsive (in addition to safe and well-led).

The overall rating has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Barton Brook Care Home on our website at www.cqc.org.uk.

Enforcement and recommendations
We identified breaches regarding dignity and respect, consent, safe care and treatment, safeguarding, good governance and staffing. We have also made recommendations regarding safeguarding training, activities and complaints.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

Barton Brook Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 2 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.

Service and service type
Barton Brook is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection, the home did not have a registered manager.

Notice of inspection
This inspection was unannounced. We visited the home on 26 and 27 September and 3 October 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 4 relatives about their experience of the care provided. We also spoke with 12 members of staff including the acting home manager, deputy manager, regional manager, chairman and 9 care staff.

We reviewed a range of records. This included 19 care plans, 3 staff recruitment files, staff training records and records associated with the provider's quality monitoring systems.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection this key question was rated requires improvement, although this has now changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks within the service were not well managed. Where people were at high risk of falls, measures to help keep people safe were not always followed by staff. For example, mobility equipment was not always used, floor/chair sensors not being in place and people not wearing any footwear. Care plans were specific that these measures should be followed. Where people may refuse to wear footwear, this was not detailed in their care plan.
- A number of people's mobility care plans stated they required full support and supervision from staff to mobilize safely. Where incidents, such had falls had occurred, some of which resulted in people going to hospital, mitigating actions stated supervision and monitoring was required to keep people safe. We saw this was not always done and we saw people walking unsupported. When we provided this feedback to the service, it appeared information in people's care plans was inaccurate and had been written incorrectly by staff. This presented the risk of staff not having the right information about people to keep people safe.
- Where people were at risk of skin breakdown, staff did not ensure people were kept safe. Re-positioning charts were not completed consistently to demonstrate people received adequate pressure relief and we observed one person's airflow mattress was deflated and had a hole in it. This was despite us reporting these concerns during the second day of our inspection for this to be actioned. This person had redness on their skin around the same period where re-positioning had not been completed. A referral to the tissue viability service was then made as a result.
- There were a number of environmental risks observed which could place people at risk of harm, particularly on the dementia units of the home. This included the kitchen area not being secure, where people often walked in and out of throughout the day. There was hot water dispenser which presented the risks of burns/scalds, as well as a tube used to dispense washing up liquid, both of which people could access easily. Aerosols and shower gels were also accessible and we observed a number of people entering other people's bedrooms during the inspection, when staff weren't present. This meant there was a risk of people consuming these items unsafely.
- People had a range of risk assessments in place regarding their care, although we found some either weren't in place, or weren't followed by staff. For example, where one person had threatened another with a knife. Where people were at risk of absconding, staff were to provide re-assurance and distractions, although this wasn't followed.
- Regular checks of the building were carried out including gas safety, electrical installation, fire safety and PAT (Portable appliance testing).

Using medicines safely

- There were arrangements in place for the safe management of medicines.
- Medicines were stored in a secure treatment room which we saw was locked at all times. We found some

topical creams stored in people's bedrooms however. This meant people were at risk of harm. We asked staff for these to be moved.
● When people needed medicines on an 'as and when required' basis (PRN), protocols were not always in place. This meant we were not assured people were receiving their medicines consistently. We have reported on this matter further in the well-led section of the report.
● Staff had received training in medicines administration and had their competency checked.
● Medication records were completed accurately by staff with no missing signatures.
● People living at the home said they received their medicines safely. One person said, "Yes, they always remember to give them to me. I always have them with a drink."

The failure to manage risk and store medication safely meant there was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding safe care and treatment.

Systems and processes to safeguard people from the risk of abuse;
●People were not always safeguarded from abuse. People had been subject to poor care, for example, where people were at risk of falls and skin break down.
●Prior to our inspection, a high number of safeguarding incidents had occurred at the home and this was one of the concerns which prompted our inspection.
●During the inspection, we also observed numerous verbal and physical altercations between people living at the home, which weren't always responded to well. Certain people had risk assessments in place about how staff should respond, although we saw these were not followed. For example, we observed one person being verbally abusive to numerous people throughout the inspection. The risk assessment stated staff should intervene and use distraction techniques when this occurred, although this was not done, despite staff being in close proximity. ABC charts (to record challenging behaviour) were in place, although were not completed by staff when these incidents occurred.
●Another person had been involved in several incidents of a sexual nature with another person living at the home. Their risk assessment stated they were subject to 30 minute observations, although we saw these were not documented by staff. The person also walked around the unit, often unsupervised and was seen with the other person referenced in the incident. These recommendations had been recommended following a safeguarding investigation from the local authority.

The failure to safeguard people appropriately meant there was a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding Safeguarding service users from abuse and improper treatment

● People living at the home and relatives said they felt the service was safe. One person said, "Yes and it's because they make sure I am looked after." A relative also said, "Yes ,(person) has really good relationship with the staff, and they look after (person) when they can."
● Staff understood about safeguarding and said they had received training, which was documented on the training matrix. Our observations showed at times staff did not always respond appropriately when safeguarding incidents took place.

We recommend further safeguarding training is completed by staff.

Staffing and recruitment
●There weren't always enough staff available to keep people safe and there was high reliance on agency staff to ensure rotas were filled. The feedback we received from people living at the home and relatives was that there weren't always enough staff to care for people safely. One person said to us, "No, but they work

hard to keep things ticking over." Another person added, "No. I feel sorry for the staff as they are so overworked." A relative told us, "No, there weren't enough staff to watch (person). We came to (person) and she had wet herself and was soaking wet."

● Staff also voiced their concerns to us about staffing levels at the home. One member of staff said, "Staffing levels on this unit are atrocious." Another member of staff added, "When I am doing medication at night, there are only two other care staff. It is very difficult to monitor people then."

● During the inspection, we observed people weren't always supported to mobilize, particularly those at high risk of falls. One member of staff said, "We can't monitor people at risk of falls properly because there aren't enough staff." We observed people mobilising, at times unsafely, when risk assessments and incident forms stated they needed assistance from staff.

● Altercations took place throughout the inspection, particularly on Moss and Monton House which cared for people living with dementia. On one occasion, we observed several people congregated in another person's bedroom, which appeared to be causing the person whose room it was great distress. Several physical altercations also took place when staff weren't always present to intervene.

● There were delays in people receiving support from staff. One person was seen hanging over the side of their bed in an uncomfortable position, close to lunchtime. When we enquired about this, the member of staff said nobody had been able to deliver their personal care yet, although this was at 11.30am.

● Several people living at the home were subject to one to one care throughout the day. One person had suffered a fall from bed and was found on their crash mat by their social worker. This had been due to in-sufficient staffing at the home.

The failure to ensure there were enough staff meant there was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding Staffing.

● Staff were recruited safely, with all the necessary procedures followed including interviews, seeking references and carrying out DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Relatives were encouraged to visit people at the home and people were supported to visit relatives and the local community.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection this key question was rated good, although this has now changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorized under the MCA. We checked whether the service was working within the principles of the MCA.

● Correct procedures were not followed if people lacked the capacity to make their own decisions. There were a number of restrictions in place for people who lacked capacity including 121 care, covert medication and the use of chair/sensor mats. We also observed people's movements around one of the units being prevented, where they were often told to remain seated by staff. MCA assessments were not always completed to ensure these decisions were in people's best interests.

The failure to seek appropriate consent meant there was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding need for consent.

●A matrix was used to monitor DoLs applications and we saw these were submitted to the local authority as required.

Adapting service, design, decoration to meet people's needs
● Some people's bedrooms were personalised to suit them with their own belongings, although this was inconsistent throughout the home. Some people's rooms were bare and unhomely.
● The home had garden areas around the building, although these were not well maintained and were overgrown, with lots of stray litter scattered about. We saw maintenance staff began mowing the lawns during the inspection.
● Dementia units at the home (Monton and Moss) contained memory boxes and photographs outside people's bedrooms and objects on the wall for people to touch and explore. Photographs of the local Salford area were on the walls for people to relate to and remember.

Staff support: induction, training, skills and experience

● Staff told us they were supported in their roles and were provided with the relevant training to enable them to care for people effectively. A training matrix detailed the training staff had undertaken.

● All staff completed an induction and this covered areas such as policies and procedures, relevant training and meeting people they would be supporting and caring for.

Supporting people to eat and drink enough to maintain a balanced diet

● Feedback about the food was mixed. One person said, "I think it is a quite good standard and there is enough of it. We get a choice of two options." Another person said however, "I don't like the food that much. I have my own tins of soup. I don't like mashed potatoes and meat."

● We observed mealtimes at the home, on several units. Despite staff being busy, people received the support they needed to eat and drink and were able to eat independently if possible.

●Dining rooms had a daily pictorial chart showing what the meals were for that day. People were shown small samples of the meals on offer in order to help choose the one they preferred.

● The tables were covered in bright wipe down cloth and had a vase of flowers on them. The food was served from a heated trolley and was served with a hot or cold drink.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

● People's needs were assessed before moving into Barton Brook to ensure it was the best place for them to live and to ensure the service could meet their needs.

● People received support from other health care professionals where needed such as speech and language therapy (SaLT) and dieticians.

● Where people needed modified diets, such as thickened fluids, or foods that were easier to swallow, we saw these were provided. If people had lost weight, supplement drinks were given to people where necessary.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection this key question was rated good, although has now changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● People were not always treated with dignity and respect and we saw several instances where this was compromised.
●We saw some people had long dirty fingernails and some females had facial hair. These people's care plans did not state whether this was a preference, or if they were resistive to staff helping them in this area.
● Some people were often seated in undignified positions in the lounge area. For example, with their legs exposed and still wearing nightwear late in the day. Other people were seen to have hair that was uncombed, despite being seated at the dining table by staff. One person was wearing pants that were too large for them and were seen to be falling down.
● On numerous occasions we observed people going to the toilet, whilst leaving the door open. Although staff were present, they did not intervene to ensure people's dignity was maintained.

The failure to treat people with dignity and respect was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding Dignity and Respect.

● People were supported to maintain as much independence as possible. For example, by eating their own meals and doing elements of personal care where they could.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
● People living at the home and relatives told us they were happy with the care provided. One relative said, "They are excellent. It's the way they look after the people. The staff have always been good with (person)." Another relative added, "They go above and beyond. They would do anything for the people here."
● Observations showed staff had good relationships with people and we saw lots of laughing, joking and re-assurance throughout the inspection.
● Staff were described as kind and caring. One person said, "Yes, they are kind they do nice things for you." A relative said, "Some of the staff are wonderful."
● People and relatives were able to provide feedback about the service through regular conversations and reviews.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection this key question was rated good, although this has now changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●An electronic care planning system was used, where information about people's care needs was recorded. We found these contained lots of contradictory information regarding people's care which posed the risk of staff not having access to accurate information about people. We were told this was because staff had inputted incorrect information into the system.

● 'About me' and 'Life Story' documents for people had not been completed. This meant staff didn't have access to information about things people enjoyed and liked to spend their time. We were shown a template during the inspection where this information was to be captured. We have reported on this further in the well-led section of this report.

● There was a lack of activities for people during the inspection and we observed people were predominantly seated in lounge areas, unstimulated throughout the day. Staff did attempt to include people in a ball game on one occasion, although people did not appear interested. One relative said, "They used to have a wide range of activities to keep people occupied, although that stopped a long while ago. At the moment (person) is bored."

We recommend the service research people's hobbies, interests and life histories to enable meaningful activities to take place for people living at the home.

Meeting people's communication needs Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People had communication care plans in place, which provided an overview of their sensory requirements. Some of these stated people were required to wear glasses, although we saw staff did not always prompt these to be worn. Some people's glasses could not always be located when we enquired about where they were. Care plans did not state people would refuse for these to be worn.

● One person living at the home did not speak English as their first language and we observed staff struggling to communicate with them during the inspection. When care instructions were given by staff, this person often did not understand what was being said. Staff said this was difficult and tried using google translate to communicate.

●Some relatives also reported language barriers between staff and people living at the home, particularly

with agency staff.

Improving care quality in response to complaints or concerns

● There was a complaints policy and procedure in place and a complaints file was maintained, with details about any responses made. Some people and relatives said they didn't always know who to make a complaint to because there had been so many different managers at the home in the past 12 months.

● Some relatives also said it was difficult to get in touch with the correct person to speak with over the phone, if they needed to make a complaint or raise a concern.

We recommend the complaints procedure is updated to enable people and their representatives to speak to the correct person should they need to raise a concern.

End of life care and support

● At the time of our visit there was no one receiving end of life care. Policies and procedures were in place if people's needs were to change. We received feedback from the local authority that attendance at their training sessions could improve however.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated requires improvement, although has now changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection improvements were required to record keeping and the provider was in breach of regulation 17. Not enough improvement had been made at this inspection and the provider was still in breach of this aspect of regulation 17.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- Widespread concerns were identified during the inspection regarding people's care. This related to mobility, skin integrity, the environment, safeguarding, staffing, treating people with respect and use the mental capacity act. Appropriate governance arrangements were not in place to ensure compliance with these regulations.
- Ratings for each of the key questions inspected had all declined since our last inspection in May 2022, two of which were now 'Inadequate'.
- Following our last inspection of the home in May 2022, the provider sent us an action plan detailing how they would ensure compliance with regulations. Certain aspects of this action plan had not been met.
- As referred to in the Safe domain of this report, PRN (when required) protocols were not in place for several people. Re-positioning charts contained gaps and were not always completed. Our responsive section of this report makes reference to contradictory information in people's care plans and no details about people's life histories and interests. This meant accurate and contemporaneous records were not being maintained regarding people's care and support
- Residents, relative and staff meetings had not been taking place in order to seek feedback and improve service delivery. These were scheduled to take place shortly after our inspection.
- Staff supervisions and appraisals were not held consistently. We were told staff should receive supervision every 3 months (quarterly), plus an annual appraisal. A matrix was used the monitor this although demonstrated these were not held. A member of staff said, "I have worked here for nearly a year and haven't had a supervision." A plan for these to commence was put in place during the inspection.

The failure to ensure monitor the quality of service effectively meant there was a continued breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding good governance.

Managers and staff being clear about their roles and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● At the time of the inspection, the home did not have a registered manager. However, a new manager had recently started at the home. Day to day support at the home also came from a deputy manager, with oversight from the area manager, operating on behalf of the provider (We Care Group).
● Since our last inspection in May 2022, there had been 5 different managers at the home, who had not proceeded in the position for a variety of different reasons. Historically, the home had unit managers and clinical leads in post, although this was no longer the case. Our observations were that there was a lack of leadership on the units, meaning people's care needs were not met at times.
● The provider knew to submit statutory notifications to CQC as required, although due to high turnover of managers recently, some of these had been delayed.
● It is a legal requirement for the ratings from the last inspection to be displayed on any websites operated by the provider and at the office location. We saw the ratings were displayed at the home from the last inspection and on the provider website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● Although staff told us they enjoyed working at the home, we were told staffing levels and a general lack of leadership impacted the culture within the home. One member of staff said, "The last 12 months have been difficult. Lots of permanent staff are leaving and morale is low."
● The service worked in partnership with other agencies as required, including local authorities and social work teams. Prior to our inspection we sought feedback about the home from various health care professionals, who provided us with an update about their involvement with the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Appropriate systems were not always in place to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Appropriate systems were not always in place to ensure people could provide consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate systems were not always in place to ensure people could provide consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Appropriate systems were not always in place to ensure sufficient staff were available to care for people safely.

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
Treatment of disease, disorder or injury	Appropriate systems were not always in place to ensure safe care and treatment.

The enforcement action we took:

We issued a warning noticed regarding this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Appropriate systems were not always in place to ensure good governance within the service.

The enforcement action we took:

We issued a warning noticed regarding this regulation.