Mr & Mrs J B Wescott

Neilston Residential Care Home

Inspection report

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Ratings

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

Overall summary

Neilston Residential Care Home is registered to provide accommodation and personal care for up to 22 older people living with dementia. Nursing care is provided by the local community nursing team.

This inspection took place on 21 April 2015 and was unannounced. There were 17 people living in the home. The service was last inspected on 22 February 2014 when it met the regulations we looked at.

There was a registered manager who was also the registered provider. 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. A new manager had been appointed to the service and had been in post for 12

Summary of findings

weeks. They demonstrated a good understanding of the legal requirements of the role but were not yet applying to take on the registered manager's responsibilities at the home.

People who lived in the home were not safe. The local authority safeguarding team shared concerns with us about the safety of people before our visit. The provider had not informed the local authority or the CQC when allegations of abuse had been made.

Risks were not always identified and managed. People were not protected from the risk of harm in the event of a fire. The fire officer visited the service on 5 December 2014. They identified concerns and told the provider they needed to make improvements. The registered manager had not completed all of the required actions. We notified the fire authority of our concerns. The premises and equipment were not maintained to ensure people were kept safe. The registered manager was unable to provide evidence that some safety checks had taken place. People were at risk because the directions for when to give prescribed dietary supplements were not clear.

People did not always benefit from support from staff who had the knowledge and skills to carry out their role. Some staff had not completed fire safety and infection control training. Staff handovers were short and there was little interaction between the staff. Staff were not always clear about their responsibilities. They were unsure whether they were accountable to the registered manager or manager. People were not always treated with dignity and respect. Some staff did not talk with people when they provided support. People were not always at the centre of the care they received because staff sometimes focused on the task, rather than them, as individuals. For example, after lunch each person was taken to the toilet without being asked if they wanted to go. Some staff were kind and caring, showing patience and skill. Staff knew people well and were able to tell us how they met people's needs and preferences.

Most people seemed cheerful. When asked about the food and the staff, the responses were generally positive. One person said to a staff member "I like you very much". Some staff showed patience and skill when encouraging people and distracting them to relieve distress. One person was seen to be distressed on a number of occasions. When the person showed distress in front of the registered manager they did not stop and take the time to reassure them.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People's freedom to leave the premises or move around freely within the home were restricted without the protection of a legal authorisation to do so.

People's needs had not always been assessed to ensure they received appropriate care and support in relation to behaviour and nutrition. Care plans had not been regularly reviewed to ensure they met people's changing needs. Some information dated back several years and people's current care needs were not easily identifiable.

Most of the people who lived in the home had some degree of dementia. The environment was not suitably adapted for people living with dementia. People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

The registered manager was visible in the service but records showed they were not aware of their legal responsibilities, such as the requirement to let the CQC know about events that took place in the home. The culture was not always open or transparent. Information was not always communicated clearly between the registered manager, manager, and staff. Some staff expressed confidence in the management but others were reluctant to voice opinions or views about leadership of the service. The registered manager had not handled a recent safeguarding issue in an open, transparent and objective way. Where an incident of alleged bullying took place, action had not been taken to tackle it.

The systems that had been used to monitor the quality of the service had not found a number of concerns identified during our inspection.

The new manager had identified a number of areas for improvement and had started working on these. Safeguarding training had been updated. A more challenging staff one-to-one supervision system was in place with actions and development plans. The manager had undertaken frequent observations of care to check staffs' understanding of their role. Care plans were being reviewed to reflect current needs and preferences. The

Summary of findings

manager told us they had recently started to sit with each person and talk to them about their care. Relatives were also involved in care planning. This information was then included in the care plan review. A new complaints policy and procedure was in place. The manager was looking at ways to make sure people understood this, and received support to help them make a complaint. Residents' meetings had been introduced and people were encouraged to give feedback on the day of our inspection. Formal staff meetings had been introduced to give staff the opportunity to contribute to the running of the home.

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

We are considering our regulatory powers to decide what action needs to be taken.

The overall rating for this provider is 'Inadequate'. This means the home will be placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from abuse. When incidents took place the registered provider did not always contact the local authority safeguarding team.

People were not protected from the risk of harm in the event of a fire. After a visit from the fire officer, the management of the service had not taken action to improve the safety of the service.

Risks to people were not always identified or managed appropriately.

Is the service effective?

Inadequate

The service was not effective.

People were being deprived of their liberty without the protection of a legal authorisation to do so.

People were at risk of malnutrition as there was poor monitoring and management of eating.

The environment was not suitably adapted for people living with dementia to ensure the best possible outcomes.

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy was not always maintained. People were not always treated with dignity and respect. Some staff did not talk with people when they provided support.

Other staff were kind and caring, showing patience and skill. Staff knew people well and were able to tell us how they met people's needs and preferences.

Is the service responsive?

Requires improvement

The service was not responsive.

People's care needs had not been regularly reassessed to reflect their current needs. This put people at risk of inappropriate care.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

The manager had put a new complaints policy and procedure in place. They were looking at ways to make sure people understood this, and received support to help them make a complaint. People were encouraged to give feedback during a residents' meeting on the day of our inspection.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The registered manager was not aware of their legal responsibilities.

Leadership within the service was inconsistent. Information was not always communicated clearly between the registered manager, manager and staff which did not result in the best outcomes for people. Staff roles and responsibilities were not clear.

The culture was not always open and transparent. The registered manager had not handled a recent safeguarding issue in an open, transparent and objective way.

The systems that had been used to monitor the quality of the service had not found a number of concerns identified during our inspection. The new manager had introduced more robust quality assurance processes.

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

This inspection visit took place on 21 April 2015 and was unannounced. The team included two adult social care inspectors and a specialist advisor.

Before the inspection, the provider completed a Provider Information Return (PIR). This was a form that asked the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of our visit, 17 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with five people. We spoke with the registered manager, manager, and five staff. We asked for feedback from health professionals but didn't receive any.

We spent time observing care and used the Short Observational Framework for inspection (SOFI). This gives us a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care plans, medication records, staff files, audits, policies and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not safe and were placed at risk of harm because safeguarding concerns were not always reported or managed appropriately. The local authority safeguarding team shared concerns with us about the safety of people before our visit. The provider's safeguarding policy said "information about a safeguarding concern is appropriately shared in line with multi-agency procedures". However, we received information that there had been three safeguarding incidents where allegations of abuse had been raised with the registered manager. We spoke with the registered manager about these allegations. They told us they had not realised they were safeguarding incidents. The registered manager said they were not sure if they needed to investigate two of the incidents. A meeting was held within the home in relation to the third incident. The registered manager had not reported these incidents to the local authority safeguarding or the CQC. The manager reported the fourth incident to the local authority safeguarding team. The registered manager had attended safeguarding training the day before our inspection. They told us they now knew how to report safeguarding incidents.

This was a breach of Regulation 13 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment were not maintained to ensure people were kept safe. The registered manager was not able to provide evidence of the fixed electrical installation check or the gas safety check. A gate at the bottom of the stairs had broken pieces of wood. If people touched this it may have caused splinters or cuts. The weighing scales had not been checked or calibrated to ensure they were accurately showing people's weight. Stair lifts and hoists had been checked to ensure they were safe to use.

People were not protected from the risk of harm in the event of a fire. The fire officer visited the service on 5 December 2014. They identified concerns and told the registered provider they needed to ensure adequate provision was made for the evacuation of people in an emergency. During our inspection, there was no emergency plan in the event of the fire alarm sounding. There were no personal emergency evacuation plans available. Escape routes were not marked with signs. The fire extinguisher by the front door was tangled in a power cable and had boxes in front of it. The boxes were cleared away. However an hour later, three large delivery boxes had been stacked in front of the extinguisher. We notified the fire authority of our concerns.

This was a breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always well managed. For example, staff carried trays of hot drinks from the kitchen to the lounge. If staff were to trip there was a risk of people being scalded. The registered manager had not identified this risk. The registered manager told us they had a trolley but had stopped using it. They said they would make sure this was used in future. There were not enough tables in the lounge for people to put their drinks on. People were seen to doze off with a drink in their hand which could have spilt over them. The registered manager said they would put more tables in the lounge.

This was a breach of 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were busy on the day of our inspection, they attended to people's needs. People received care and support in a timely manner. The registered manager and manager were on duty. There was one senior care staff, three care staff, one care/domestic staff, a cook, and a staff member who came in for several hours to do activities. The registered manager told us there were usually three to four care staff during the day. There was one waking care staff overnight and one sleeping care staff who was on call from 12am to 5am. Staff who worked in the home covered absences. The staff rota was not clear. There were lots of changes on the rota. The staff written on the rota did not reflect the actual staff on duty on the day of the inspection. Some of the staff on the rota were on leave but this was not clearly labelled. Other staff who were on duty were not on the rota. Due to the inaccurate recording, we could not be sure people benefited from enough staff at all times.

People's medicines were stored securely. Staff completed medication administration record (MAR) sheets after they had given the person their medicines. MAR sheets had been fully completed. This showed people had received their medicines as prescribed to promote good health.

Inadequate

Is the service safe?

Safe recruitment processes were in place. Appropriate checks had been undertaken to ensure staff were suitable to work with people who lived in the home.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care because not all staff had received the training they needed. They did not have the information they needed to ensure they could meet people's needs, including their nutritional needs People were being deprived of their liberty without authorisation and the environment was not suitably adapted for people with dementia.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The front door was locked and people were not able to leave the home. There were also coded locks on doors that prevented people from moving up and down the stairs. The registered manager was not aware of changes to DoLS due to the supreme court judgment, or the need to make an application to the local DoLS team. People were being deprived of their liberty without the protection of a legal authorisation to do so.

This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two DoLS applications had been made. One application was awaiting an outcome. The other application had been authorised and there was evidence the person's best interest had been properly considered.

People were not always offered choices. They were given hot drinks but were not always given a choice of the type of drink. The menu for lunchtime did not provide a choice of cooked meals for people. The cook said some people may have a sandwich instead of a cooked meal. On the day of our inspection, one person had a sandwich. People also had sandwiches for tea. It was not clear how staff ensured people received a balanced diet.

People's nutritional needs were not always appropriately monitored to ensure they had enough to eat. For example, one person's nutritional assessment tool had last been reviewed in July 2014 when they weighed 59.3kg. The person's care plan identified a need for regular weight monitoring. The last recorded weight was in December 2014 and showed the person had lost over 2kg since July 2014. Staff did not know what this person now weighed. There was no evidence that action had been taken in response to the weight loss.

This person required support to eat their lunch. Care staff brought them a plate of soft food. Soon after another member of care staff came to give the person their medicines which took several minutes. Some minutes later the original care staff returned and started assisting the person with their meal. The food was getting cold by this time and little was eaten. Staff did not offer the person anything else to eat.

Where people were prescribed dietary supplements the directions for when to give them were not clear. For example, one person's medication administration record (MAR) sheet said to use as directed. There was an instruction to staff on the wall that said to give the supplement in the mornings only. The MAR sheet showed the supplement had been given in the morning and the afternoon on some days. Staff told us they gave the supplement when they person hadn't eaten much. There was no evidence of when to give the person the supplement to ensure it was in line with the prescription.

This was a breach of Regulation 14(1)(4)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training systems that had been in place had not ensured that all staff had completed up-to-date training to ensure they had the knowledge to effectively meet people's needs. The manager had identified that most staff needed to complete training. The majority of the training had been completed at the time of our inspection, and there was a plan in place for the completion of all training.

Staff had completed a safeguarding training update the day before the inspection. The manager had recently attended an event about the new Care Certificate.

Staff did not communicate effectively to ensure they could carry out their roles and responsibilities. The staff handover between shifts only lasted a couple of minutes. The staff member giving the handover quickly went through a list of people, where they were in the home, and whether they had been to the toilet. There were no questions or any other interaction between the staff. Important information about people's health and needs may not be passed on and actioned.

The environment was not suitably adapted for people living with dementia. For example, some areas and bedrooms had strong patterns on the walls. This could be difficult for people living with dementia to understand.

Inadequate

Is the service effective?

There were very few things for people to pick up and handle throughout the home. This type of stimulation can improve mood, encourage people to talk with others and take part in daily activities. People did not have easy access to the garden as there was a chair and table in front of the door leading to outside.

Staff had an understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. If people were not able to make decisions for themselves staff spoke with relatives and appropriate professionals to make sure people received care that met their needs and was deemed to be in their best interests.

People were supported to access health care services. People had seen professionals including GP, optician, dentist, and specialists.

Staff received regular supervision which included observations of their care practice. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues. The manager had recently put a more challenging supervision system in place to check care staffs understanding. Records included actions and development plans. The manager had undertaken frequent observations of care. Staff confirmed supervisions were now more frequent and more thorough.

We recommend the provider takes into account the NICE guidance for supporting people with dementia which states "environments are enabling and aid orientation".

Requires improvement

Is the service caring?

Our findings

The quality of interactions between staff and people were variable.

People were not always called by their name. Staff used the term "dear". This was not people's preferred term of address and did not show respect for the person.

People were not always treated with dignity and respect. For example, a member of care staff stood in front of a person whilst supporting them to eat. This did not promote an enjoyable experience and may have been intimidating for the person. They did not say a lot to the person. Over an hour after the person had finished eating, staff had not removed the protective cover from their clothes.

Staff did not always talk to people whilst supporting them. For example, at lunchtime, staff gave one person their medicines. The staff member did not say anything to the person.

This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other interactions showed care staff were kind and caring. Staff knew people well and were able to tell us how they met people's needs and preferences. Staff were aware of people's histories and interests.

The manager had carried out observations within the home. We saw evidence they had reminded a staff member to ensure they protected a person's dignity by cleaning their face after supporting them to eat.

People's privacy was not maintained at all times. People's personal information was recorded on their individual bedroom doors and on a board in the lounge.

Most people seemed cheerful. When asked about the food and the staff, the responses were generally positive. One person said to a staff member "I like you very much". Some staff showed patience and skill when encouraging people and distracting them to relieve distress. One person was seen to be distressed on a number of occasions. When the person showed distress in front of the registered manager they did not stop and take the time to reassure them.

We spent 30 minutes carrying out a Short Observational Framework for Inspection (SOFI) observing people in the lounge. Some interactions were good and showed staff respected people at the home. For example, when staff stopped and spoke with people this lifted the person's mood. However, some people did not have as many interactions as others. Most people were passive, asleep or dozing. People were given a drink but not offered a choice. One person dropped their cake on the floor. Care staff offered to go and get them another cake. The person happily accepted the offer. This showed the staff member respected the person and treated them in a caring way.

Arrangements were being made to make sure people were involved in making decisions and planning their own care, where they were able to. The manager told us they had recently started to sit with each person and talk to them about their care. They told us relatives were also involved in care planning. This information was then included in the care plan review.

Requires improvement

Is the service responsive?

Our findings

People's needs had not always been assessed to ensure they received appropriate care and support. For example, one person's care plan contained a behaviour chart which said "Verbally aggressive, shouting , signs of anxiety" . The record was not dated. There was no information about the triggers that could result in these behaviours, which would help staff to support this person in a proactive way, or how staff should support this person if they were in a distressed state.

Care plans had been developed but these were not always regularly reviewed to ensure changing needs were met. Some information dated back several years. People's current care needs were not easily identifiable. For example, in September 2012, one person had been assessed as being at risk, due to a medical condition, if their weight dropped below 59kg. In March 2015, their recorded weight was 50kg. There was no information how this impacted on their medical condition or how staff should support this person. There was no evidence health professionals had been contacted for advice. This person had been put at risk of inappropriate care.

This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The manager was aware improvements to the care plans were needed. They had started to review each care plan to ensure it reflected people's current needs and preferences. A short term care plan was recently written after one person had a tooth extracted. The plan told staff what to do if the person was in pain or they observed any swelling.

People were not always at the centre of the care they received because staff sometimes focused on the task, rather than them, as individuals. For example, after lunch each person was taken to the toilet without being asked if they wanted to go.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. The television was on all day in the lounge but people were not watching it. A staff member came in to provide exercise activity and 10 people joined in with this. People were encouraged to join in and were smiling and clapping. Another staff member was manicuring a person's nails. However, other people were not engaged in activities that were meaningful to them.

We recommend the provider takes into account the College of Occupational Therapists guidance in relation to engaging people with dementia.

Systems for handling past complaints were not clear. We received a complaint from a relative in 2014. There was no evidence that the complaint had been investigated. The registered manager said they were aware of the complaint but the previous registered manager had dealt with it and they couldn't locate the information. The manager had identified that the complaints system was not effective and accessible. They had put a new complaints policy and procedure in place, and were looking at ways to make sure people understood this, and received support to help them make a complaint . People were encouraged to give feedback during a residents' meeting on the day of our inspection. The manager invited people to comment on recent activities and the food in the home. They asked people what they would like to do and made suggestions for outings. The manager asked people if they had any complaints. There were none raised and one person commented "Very happy as we are".

Inadequate

Is the service well-led?

Our findings

The registered manager was also the provider of the service. They were visible in the service but records showed they were not aware of their legal responsibilities, such as the requirement to submit notifications to the CQC. For example, the service previously had two registered managers. The second registered manager left their employment in December 2014. The provider had not notified us of this and ensured the manager had de-registered.

This was a breach of Regulation 15 (1)(b) of the Care Quality Commission (Registration) Regulations 2009.

The registered manager did not know they were required to notify us about the allegations of abuse that had been made.

This was a breach of Regulation 18(1)(e) of the Care Quality Commission (Registration) Regulations 2009.

A new manager had been appointed to the service and had been in post for 12 weeks. They demonstrated a good understanding of the legal requirements of the role but were not yet applying to take on the registered manager responsibilities at the home.

Staff did not always have a clear understanding of their roles and responsibilities. For example, senior care staff did not have a clear written description of their additional responsibilities. Supervision records for senior care staff, from 2014, did not record or discuss their additional responsibilities. The manager told us that they wanted to develop clearer role responsibilities for senior care staff. Recent supervision records showed that senior staff were being encouraged to develop in their roles. For example, they were contacting health professionals rather than waiting for the manager which may delay people's treatment.

Staff were not always clear about whether their day to day accountability was to the manager or registered manager. There was not a shared vision of how the service could support and involve staff in developing the service. For example, some staff told us they never had staff meetings. The registered manager said they favoured informal meetings at the end of shifts whilst the new manager planned a full staff meeting with an agenda which the team could contribute to.

Information was not always communicated clearly between the registered manager, manager and staff. For example, the provision of activities on the day of our inspection was confusing. At 10.30am the registered manager came into the lounge and said there would be exercises in a minute. Twenty minutes later a staff member came into the lounge and started setting up the room for exercises. Ten minutes after this the manager came into the room to hold a residents' meeting so the exercises were stopped. The exercises started again after the meeting at 11.15am.

The culture was not always open or transparent. Some staff expressed confidence in the management but others were reluctant to voice opinions or views about leadership of the service. The registered manager had not handled a recent safeguarding in an open, transparent and objective way. Staff who raised concerns had not been supported and the registered manager was not aware of their responsibilities under the Public Interest Disclosure Act 1998. This act protects workers who raise concerns at work from dismissal or victimisation as a consequence of doing so.

Action had not been taken to tackle bullying and harrassment. One staff supervision record referred to an incident of alleged bullying and a staff member feeling picked on. No action was taken in response to this and nothing had been put in place to support the member of staff.

Records relating to people's care and treatment were not well organised or reviewed appropriately. A number of records were not accurate or kept up-to-date. This included care plans, weight records, and staff rotas. The office was disorganised and the manager was unable to locate information we asked for. This included complaints and safety check certificates.

The registered manager had not completed all of the actions in relation to the Fire Safety Order dated 8 December 2014.

The systems that had been used to monitor the quality of the service had not found a number of concerns identified during our inspection. For example, people were not safe and were not protected from the risks of harm. Allegations of abuse had not been reported. There was no evidence that safety checks had been carried out. Risks were not always identified; action was not taken to minimise risks. Care plans were not reviewed regularly to reflect people's

Inadequate

Is the service well-led?

current needs. Nutritional needs were not well monitored. Records were not always clear and accurate. Staff had not completed training to ensure they knew how to meet people's needs effectively.

The home provides support to people living with dementia. The arrangements in relation to activities and the environment did not reflect current guidance.

This was a breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had introduced more robust quality assurance processes. They had reviewed the service and identified areas for improvement. For example, there were documented observations of care delivery and clear action points from this. Staff were appropriately challenged, to ensure they supported young workers to take legally required rest breaks and monitor their total hours worked.

An external consultancy had been commissioned to review health and safety at the home. A meeting between the manager and registered manager was scheduled to discuss the audit findings. Some actions had been completed such as checking of the room temperatures in the home. Other actions such, as ensuring clear personal evacuation plans were accessible, had not yet been undertaken.

The manager was keen to develop and improve the service. They told us how they accessed resources to ensure they kept up to date with research and current best practice. For example, they accessed information from Skills for Care and Social Care Institute for Excellence. The registered manager told us they had attended forums and meetings with other providers. They received the monthly updates from the CQC and had subscribed to a monthly care magazine.

This service has met the CQC Regulations at the previous three inspections carried out in the past two years.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment because systems were not operated effectively to prevent and investigate abuse. Regulation 13 (1)(2)(3) People were deprived of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not receive their dietary supplements as prescribed because there was no system in place to make sure people received them at the specified times. Regulation 14(4)(b) People's nutritional needs were not monitored to ensure they received choice, adequate food, and support. Regulation 14(1)(4)(a)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. Regulation 10(1)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not assessed risks to people's health and safety to make sure staff were able to keep people safe. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The registered person did not give notice in writing to the Commission when the registered manager ceased to manage the regulated activity. Regulation 15 (1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission when allegations of abuse were made. Regulation 18(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems did not enable the registered person to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)