Barchester Healthcare Homes Limited

Middletown Grange

Inspection report

Middletown
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Ratings

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

Overall summary

We inspected Middletown Grange on 9 and 10 April 2015. Middletown Grange provides nursing care for people over the age of 65. Some people at the home were living with dementia. The home offers a service for up to 56 people. At the time of our visit 53 people were using the service. This was an unannounced inspection.

We last inspected in June 2013 and found the service was meeting all of the required standards.

There was not a registered manager at the service. 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.

There was not always enough staff on duty to meet the needs of people. People were not protected from risks as staff did not always have time to to reassure people who were anxious, or support people's wellbeing..

Summary of findings

Where people, who lacked capacity to consent, were deprived of their liberty, conditions had been set by the authorising body to ensure people had the care and support they needed to meet their needs. These conditions were not always being met, as there was not always enough staff to meet these needs, which could have a negative impact on people's welfare.

Staff had identified people who could exhibit behaviours which challenged. There were not always care plans in place to support care staff to meet the needs of these people and protect them from harm. People's care plans did not always reflect their needs. Where people's needs had changed assessments had not been amended to ensure staff had the guidance they needed.

Care and nursing staff did not always have access to effective supervision and appraisal processes. Staff were not always effectively supported to develop professionally. However, staff told us they received support from the management, and spoke positively about the support they received from their colleagues.

The provider and manager had systems in place to manage the quality of the service, however these were not always effective. People's and their relative's views were sought, however these did not always inform changes to the service. Staff did not always feel the concerns they had raised to the manager or provider were acted upon. The provider and manager did not always inform CQC of notifiable incidents.

People were cared for by caring, kind and compassionate staff. Care staff knew the people they cared for, what they liked and what was important to them. People were given choice around day to day decisions such as choice of food and drink.

Nursing and care staff had good awareness of safeguarding and whistle blowing procedures. People told us they felt safe and relatives spoke positively about the way their loved ones were cared for.

Staff understood and acted in accordance with the legal requirements when supporting people who lacked capacity to give consent to care and treatment.

Where people had specific healthcare needs, nursing and care staff had the skills they needed to meet those needs. People's dietary needs were catered for, to ensure people had their nutritional and healthcare needs met.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires improvement

The service was not always safe. There were not always enough staff to meet the needs of people.

Where people were at risk of pressure damage they were not always protected from these risks.

People told us they were safe and staff had knowledge of safeguarding procedures. People received their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not always effective. People were not always receiving appropriate support when being deprived of their liberty where it was deemed to be in their best interests or for their own safety, as there were not always enough staff to meet these needs.

Where people exhibited behaviours which challenged, there was no guidance for care staff to follow to meet these people's needs.

Staff did not have access to an effective supervision and appraisal process to support their professional development.

People had access to suitable food and drink and were supported with access to other healthcare services.

Is the service caring?

Good

The service was caring. People spoke positively about the care they received from care staff.

People were treated with dignity and kindness from staff and were supported to make choices.

Staff respected people and ensured their dignity was respected during personal care.

Is the service responsive?

Requires improvement

The service was not always responsive. People's care records were not always current and accurate.

People living with dementia did not always have access to activities and support to maintain their wellbeing.

People knew how to complain, and felt their concerns were acted upon.

Is the service well-led?

Requires improvement

The service was not always well-led. The service did not always use audits, people's views and staff's views to make improvements to the service.

Summary of findings

The service did not always inform CQC on notifiable incidents.

People and their relatives told us the manager was approachable.

Middletown Grange

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 10 April 2015. The inspection team consisted of four inspectors.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding and contracts teams. We also sought the views of one healthcare professional.

We spoke with 14 of the 53 people who were living at Middletown Grange. We also spoke with six people's relatives. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

In addition we spoke with three nurses, seven care workers, one domestic worker, the deputy manager and general manager. We looked around the home and observed the way staff interacted with people.

We looked at 11 people's care records, and at a range of records about how the home was managed. We reviewed feedback from people who had used the service.

Requires improvement

Is the service safe?

Our findings

People told us they sometimes had to wait for support from care staff. One person told us, "I have to wait, staff don't always come quickly." Another person said, "sometimes staff can be a bit rushed, however they always care." One person told us staff came when they needed, they said, "I think there is enough staff downstairs. They seem to manage very well."

Care and nursing staff told us they did not always have enough staff to meet people's needs. Comments included: "We don't have enough staff, all staff worry, we miss out on breaks if we have to", "we can be late to turn people and we can't always record what we've done", "we can struggle, we work well together, however there is no back up, it regularly happens we're shorter than expected" and "we try and manage, we're a good team, however there aren't enough of us."

The manager told us, and rotas showed, there were four care workers and one nurse to meet people's needs at night. The manager told us they were discussing the possibility with the provider of there being a second nurse at night to meet people's needs. Staff rota's showed us on four night shifts in the week prior to our inspection, although there were four care workers on duty, two of them needed to work under the supervision of other care worker's. Care and nursing staff told us this had an impact on meeting people's needs at night. One staff member said, "it's difficult, they have to be supervised, and can't care for people by themselves. It means we're rushed." Another staff member said it often meant they could not respond to emergencies whilst providing personal care, as the new care workers could not be left with people.

We observed throughout the course of our inspection that care staff on the first floor were often rushed and did not have the time to spend with people. One person was walking around the first floor and was agitated. Care and nursing staff were aware this person was agitated however did not have time to reassure them. Care and nursing staff told us they did not have time to spend with people to reassure them. They also told us they could not always assist people if they were agitated, or stop them from becoming agitated. One staff member said, "We haven't got time to reassure people." Another staff member told us, "we can't always ensure a member of staff is in the lounge to spend time with people and stop them from becoming agitated."

Staff told us they were often task focused, assisting people to get up and ensuring people were turned and had access to food and drink. We observed that while care and nursing staff acknowledged people they did not have time to sit and talk with them. One staff member told us, "there is always lots to do, the tea trolley can take a while."

Care and nursing staff told us they had raised these concerns with the deputy manager and general manager. We discussed our concerns with the general manager. They told us they had a dependency tool (a system to work out how many staff were needed to meet the care needs of people living in the home) which had been completed by a business manager on behalf of the provider. After we had discussed these concerns, the manager informed us their dependency tool was not correct and had implemented an action plan to help them ensure there were enough staff on shift to meet the needs of people. The manager told us about changes they had made to recruit care and nursing staff and would discuss staffing with the provider.

People were not always protected from the risk of pressure area damage. Where people had been assessed by nursing staff at risk of pressure sores, care plans and risk assessments were in place. These plans detailed how often people needed to be assisted to reposition to relieve pressure. Records of people being repositioned were not always being consistently recorded by care and nursing staff. Staff told us they did not always have time to assist people to reposition or were often late to assist people. Staff also said they struggled to document when they had supported people with their care. Comments included: "We don't have enough staff, we don't always turn [reposition] people in time", "We struggle. Hourly checks on people don't always happen" and "we can be late to turn people and we can't always record what we've done."

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people had risk assessments which stated care and nursing staff needed to check on them every hour. Staff needed to do this as the people were unable to use their call bells and were at identified as being at risk of

Requires improvement

Is the service safe?

falling. There was no record that staff were checking on these people. We discussed this with care staff and nursing staff who informed us these checks were not happening. This meant plans which had been implemented to protect people from risk were not being followed.

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

People told us they felt safe living at the home. Comments included: "I'm perfectly safe", "I'm safe here" and "I'm as safe as I will be anywhere. I've got the bell. I've not had to call too much. They do come if you need it." A relative told us, "they're safe there. I have peace of mind they're looked after."

Staff we spoke with had knowledge of types of abuse, signs of possible abuse, which included neglect and their responsibility to report any concerns promptly. Staff members told us they would document concerns and report them to the nurse in charge, the manager or the provider. One staff member said, "I would report concerns to the nurses or the deputy manager." One staff member added that, if they were unhappy with the manager's or provider's response, "I know who to contact if I needed to. There are contact numbers available for safeguarding." Staff told us they had received safeguarding training and were aware of the local authority safeguarding team and its role.

All medicines were securely stored in line with current and relevant regulations and guidance. People's medicine records accurately reflected the medicine in stock for each person. Medicine stocks were checked monthly by nursing staff. These checks showed staff monitored stock to ensure medicines were not taken inappropriately and people received their medicines as prescribed.

We observed two nurses assist people with their prescribed medicines. They always ensured people had time and support to take their medicines. They gave people time to refuse medicines and provided encouragement if needed. One nurse said, "We spend time with them to make sure they have their medicines." One person said, "I get my medicine, they know what I need."

Requires improvement

Is the service effective?

Our findings

Deprivation of Liberty Safeguards (DoLS) authorisations were applied for appropriately. Deprivation of liberty safeguards is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety. Where people were deprived of their liberty, conditions had been set by the authorising body to ensure people had the care and support they needed to meet their needs. For two people there was no evidence these conditions were being met. For example, one person's DoLS authorisation stated they should spend time with other people in the lounge, where staff were present, to ensure their social needs were met, whilst managing their anxieties. Throughout our inspection we observed this person stayed in their room, and often went without support from care or nursing staff for long periods of time such as two hours. The person's DoLS conditions requested the person be supported regularly by staff. We discussed this with care and nursing staff who told us they did not have the time to meet these needs.

Another person's DoLS authorisation stated, “enable sufficient access to sufficient levels of stimulation”, “If refuses should make efforts to provide regular one to one (support)” and “should facilitate access to community from time to time.” None of these conditions were documented in the person's care plans. There was no evidence to show how care staff supported this person to meet these goals. Care and nursing staff told us there was not enough staff to meet these needs.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff informed us of one person who was often resistive of personal care. We saw from the on-going care records for this person they were often physically or verbally aggressive to staff. This information had not been used to inform the person's care plan. Care staff had no guidance on how to assist this person if they became challenging. We discussed this person's needs with care staff, who informed us they would assist the person with another care worker, explaining the support they were providing. They also told us the person was often aggressive during personal care and they had discussed this with nurses.

We observed one person who became agitated during the course of our inspection. While care staff had recorded this person could become anxious there was no risk assessment or care assessment on how care and nursing staff should support this person. Care and nursing told us they would support people who were anxious. One care worker said, "We always explain what we're doing. Try and give them time and reassure them."

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and nursing staff told us they did not always receive effective supervision (one to one meetings with their line managers). Comments included: "I haven't had one for a while" and "I've had one recently, however not many of them." We looked at supervision records for eight staff members. One nurse had not received a formal supervision since 2013. Another nurse had recently had an appraisal, however had not had supervision since January 2014. One care worker told us they frequently received supervision and had an annual appraisal. They told us they used this to discuss training and career development opportunities. We saw a record of this person's appraisal. The appraisal clearly documented their goals around training and health and social care qualifications. While these goals had been documented, there was no action plan to support this care worker.

We discussed these concerns with the manager, who informed us they had identified not all staff had received supervision as regularly as required by the provider. The manager had implemented a supervision record to ensure staff were receiving support around their professional development.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care and nursing staff told us they felt supported in their roles, however the majority of staff felt low levels of staffing sometimes affected this. Comments included: "I feel supported, I feel we have a good staff team", "We work as a team to meet people's needs, I feel supported by the team."

Requires improvement

Is the service effective?

People and their visitors spoke positively about the support they received from care staff. Comments included: "The staff are good, they know what to do", "they've always been informative" and "I think they're well trained."

Staff told us they had a range of training to meet people's needs and keep them safe including safeguarding adults, moving and handling and fire safety. Staff spoke positively about the training they had received. Comments included: "We have the training we need", "there is always quite a lot of training, and I've been able to request the training I feel I need" and "We have received palliative care training which has been helpful."

Nurses had attended a local clinical group's "tissue viability forum" as this was an area of interest and development. We saw records had been kept which showed nurses were recording information using this scheme. This helped to ensure people were protected from the risk of skin breaks or pressure ulcers, as staff were involved in identifying concerns around incidents and accidents.

Staff understood their responsibilities under The Mental Capacity Act 2005 (MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time). One person had a best interest assessment over their care and treatment, including their accommodation. Care staff, the person's GP, family and social worker were involved in this decision. The person's views were also sought and it was in their best interest to stay at Middletown Grange.

A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, psychiatrists, district nurses, community mental health nurses, speech and language therapists, and other professionals from the Care Home Support Team. One healthcare professional told us staff sought their advice when necessary. They also said when advice was provided, this was followed. They told us, "They follow advice and are always quick to ask for it. When we have given guidance it's documented and the nurses make sure it's communicated."

People were referred appropriately to the dietician and speech and language therapists if staff had concerns about their wellbeing. One person had lost weight in recent months and was being supported by staff and other healthcare professionals to ensure their wellbeing was maintained. The person was being provided with information to make an informed decision on their treatment.

Other people were supported by staff with thickened fluids because they were at risk of choking. Where staff had identified people were at risk of malnutrition, food supplements were available and the chef produced calorie rich meal options. Staff understood how to meet each person's dietary needs and report any concerns when they had identified them.

Good

Is the service caring?

Our findings

People and their visitors told us they were treated with kindness and compassion by care staff. Comments included: "I really like it here, no one is horrible and everyone is kind and nice to me", "Staff are very caring. They think for you", "The staff look after you very well here" and "the staff always appear kind and caring." One relative told us: "Care is lovely here. They look after [family member] well."

We observed a number of positive caring interactions between care staff and people. For example, one care worker assisted a person with their choices over their breakfast. The care worker warmly welcomed the person to breakfast and asked if they needed assistance to pick a seat. They briefly talked, and the person was given a choice over their breakfast. The person was happy and told us, "There is always a bit of choice, tea, cereals and cooked breakfast." They also told us, "The carers are really lovely."

People's choices around their health care needs were respected. One person who was receiving end of life care was choosing not to drink or eat. Care staff were aware of and respected this person's choice, however ensured they regularly offered the person support to eat and drink. One care worker told us, "We record how we help them, however we will not force them."

Care and nursing staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs, all staff spoke confidently about them. One care worker told us about one person who liked to walk, "We try and support them to go outside. The activity co-ordinator has really helped with that." One relative told us, "The staff know their needs really well, when I need any information I know I can ask staff." Another relative said, "I can't fault the staff, they are really gemmed up on people and their needs."

People's rooms were personalised to their choice. People had pictures and items which were important to them in their room. Two people who were living with dementia knew where their rooms were because of pictures on their doors and items in their room. One person said, "I know where my room is, and I can go there when I choose." Another person we spoke with told us how important their room was to them. They were able to lock their room and told us, "staff always knock or ask before they come in." One care worker said, "it's their room, that's very important to them, if we need to go in, then we always ask if it's okay."

People were treated with dignity and respect. We observed one person, who was living with dementia, walk into another person's room and rest on their bed. A care worker intervened and asked the person if they would like to go to their own bed. They supported the person and when they arrived at their room, ensured the person's door was shut before assisting them to rest. We observed whenever staff assisted people with personal care, this was done behind closed doors. One person told us, "We get kindness, thoughtfulness."

Care staff told us how they ensured people were treated with dignity and respect. Comments included: "We make sure people receive support in privacy, respect the individual", "I explain what I'm doing, make sure they are happy" and "I treat people as I want to be treated. Respect them, talk to them and make sure their privacy is respected."

Requires improvement

Is the service responsive?

Our findings

People's care plans did not always reflect people's changing care needs. One person's mobility needs had changed significantly since their care plan had been written. The person needed full assistance of care and nursing staff to mobilise. We observed care staff assist this person with their mobility and with their dietary needs. The person's care plans still stated they were able to mobilise independently despite being reviewed recently. Care and nursing staff knew how this person should be supported with their mobility and told us their needs had changed.

Another person had been identified by nursing staff at being at risk of having a fall. A risk assessment had been implemented, which was signed by staff as being reviewed monthly. This risk assessment should have been updated when the person had fallen. We saw on-going care records for the person showed they had fallen twice, and neither fall had informed the risk assessment and the support the person required.

One person had bed rails in place as they were assessed as being a risk of falling out of bed and family had consented to this action. We looked at this person's care files and no bed rail risk assessments had been completed by nursing staff. Care and nursing staff we spoke with understood the reason for rails in place and had systems to ensure the person was not at risk.

Another person's nutritional needs had changed. Nursing staff had asked for changes to their diet to ensure they were protected from the risk of malnutrition. On the days of our inspection the person was offered a soft diet in line with their needs. The person's nutritional care plan did not reflect their needs, which could put them at risk of inappropriate care and treatment.

We discussed all of these concerns with the manager who told us there was an action plan in place to ensure people's care records were udpated. A nurse had been chosen to review and update care files however due to staffing levels this work had not been started.

While action was clearly planned, these issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us an activity co-ordinator worked at the home and provided activities for people on both floors of the home. People and care staff spoke positively about this person and the impact they had had. On the second day of our inspection we observed people engaged in arts and crafts activities, people were smiling and happy throughout.

People spoke positively about the activities and access to gardens. One person told us, "I can go outside by myself, we've got lovely gardens." Another person said, they liked to have their lunch outside, staff supported this person's choice. On the ground floor, we observed care staff taking time to talk to people about current events. One person said, "I've been treated in a lot of places and this is second to none. I'm very happy, very settled here."

People living with dementia did not always receive the support they needed to maintain their wellbeing. Care and nursing staff told us there was not always enough staff and time to meet their needs. One care worker said, "we don't have time to support them to use the home's gardens." Another care worker said, "we don't have the time to sit and engage with people. I'd love to be able to have the time to talk to people."

One person we spoke with told us they liked to go outside to walk. They said, "I walk in the home, as I like to get some exercise." Three people's care files showed they should be supported to access the home's gardens and the local community, however care and nursing staff told us this did not always happen.

We observed people living with dementia throughout our visit. On occasions people were left without stimulation. During one observation in the afternoon we observed three people who for a period of 45 minutes received no interaction from care or nursing staff. One person appeared agitated and walked around the lounge with purpose, however no staff were available to assist or talk with this person.

We discussed these concerns with the manager, who informed us they were looking at where the activity co-ordinator was placed to ensure staff could support people's wellbeing..

Care staff responded when they identified concerns with people's health and wellbeing. One nurse told us care staff had told them a person's teeth appeared to be moving. The nurse asked the person if they were in discomfort and

Requires improvement

Is the service responsive?

assisted the person to remove the teeth. The person was thankful for this support. The nursing staff arranged for the person to have a soft diet to enable them to maintain their nutritional needs and referred the person for dental support.

People and their relatives told us they knew how to make a complaint to the service if they needed. The home had a complaints policy which was on display in the entrance of the home, alongside leaflets on safeguarding and advocacy. The manager had a complaints log which showed no formal complaints had been received since the last inspection. We spoke with one relative who told us they had raised a concern and the manager had dealt with this immediately.

A person told us that, if they were unhappy with an aspect of care "I'd tell them. I can speak up to the person concerned." The person indicated a member of staff and described them as "always approachable". They added "It's no use grumbling to your family."

Requires improvement

Is the service well-led?

Our findings

Allegations of abuse had been raised and investigated on behalf of people. The provider had discussed these issues with the appropriate authorities and social care professionals. The safeguarding authority had been notified of these incidents. However, the Care Quality Commission (CQC) had not been notified of all allegations of abuse. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

A regional manager employed by the provider conducted bimonthly quality audits of the home. We saw records of visits from March and January 2015. The audit in March identified not all safeguarding concerns were being notified to the CQC. It also identified not all staff had received supervision and that care plans were not always reflective of people's needs. Actions had been identified following this visit and informed a service action plan. These actions had not always been completed, for example actions around care plans and notifications.

People and their relatives were asked for their views, and were able to discuss any concerns or improvements, however these were not always acted upon. Resident and relative meeting minutes from January 2015 documented that relatives felt there was limited communication from the home. An action was set that a weekly "what's on" email to be sent to relatives. At the time of our inspection this action had not been completed.

Some care and nursing staff told us they did not always feel the manager or representative of the provider acted on their concerns. Before and during the course of the inspection nursing and care staff raised concerns about staffing within the home. While staff had told us they had raised these concerns since February 2015, they did not feel the provider had acted upon them. One staff member said, "we raised the concerns, however nothing changed."

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a manager, who had been in position at the home since December 2014, when the previous registered manager had left the service. It is a condition of this service's registration that a registered manager is in post. The manager was in the process of registering with CQC to become the registered manager.

Some staff spoke positively about the manager and how they responded to their requests around equipment and training. One care worker said, "I raised a concern around equipment, I told the manager and it was acted on immediately.

Staff all understood the need to whistle blow if they felt concerns were not effectively dealt with. One staff member said, "I will raise concerns further if I am concerned." Another staff member told us, "I would inform the commission or safeguarding if I felt people were at risk."

People and their relatives spoke positively about the manager and felt they were approachable. Comments included: "the manager is approachable, they've been helpful" and "I've been able to talk to them if needed."

Where issues were raised by staff these were discussed in team meetings and actions were taken to address them. Nurses meeting minutes showed a referral book had been introduced to record referrals to other professionals. One nurse showed us this book and told us they thought it was useful as it enabled the referral to be recorded immediately. This prevented any referrals not being recorded.

Healthcare professionals spoke positively about the nursing staff and the decisions they made within the home. Nursing staff took proactive roles in ensuring people's healthcare needs were met, which included making referrals. Nursing staff we spoke to told us they were supported to make decisions by the manager and provider.

The home had a deputy manager who acted as the clinical lead for the service. They carried out audits around medicine management. We saw that where concerns had been identified the deputy manager set clear actions which were then completed. Nurses worked together to ensure people's prescribed medicines were managed and kept effectively.

Care staff meetings showed care staff were given positive feedback following regional manager visits. Information regarding changes to the home and feedback on visits was regularly passed to staff.

Requires improvement

Is the service well-led?

Incidents and accidents were recorded by nursing and care staff when they occurred. The registered manager looked at these records to identify any possible trends when accidents had occurred. The manager was proactive in identifying these trends and had ensured information was shared with local healthcare professionals. The manager used this information to ensure people were protected from the risk of repeated incidents.

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 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Persons employed by the service provider did not always receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. Regulation 18 (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users. The registered person did not always assess the risks to the health and safety of service users of receiving their care or treatment. The registered person did not always do all that was reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The Care Quality Commission (CQC) had not been notified of all allegations of abuse. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: The service did not maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2)(c)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(e).

The enforcement action we took:
We have issued a warning notice informing the provider they must make improvements by 30 June 2015.

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 The service did not have sufficient numbers of suitability qualified, competent, skilled and experienced persons deployed in order to met the requirements and people's needs. Regulation 18 (1).

The enforcement action we took:
We have issued a warning notice informing the provider they must make improvements by 30 July 2015.