Bupa Care Homes (BNH) Limited

Melford Court Nursing Home

Inspection report

Hall Street
Long Melford
Sudbury
Suffolk
CO10 9JA
Tel: 01787880545
Website: www.bupa.co.uk

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Melford Court Nursing Home provides accommodation and nursing and personal care for up to 52 people who require 24 hour support and care. Some people are living with dementia.

There were 33 people living in the service when we inspected on 9 June 2015. This was an unannounced inspection.

The overall rating for this provider is 'Inadequate'. This means that it has been 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.

Summary of findings

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.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 a manager in the service who told us that they were planning to submit their registered manager application with us.

Improvements were needed in how the service protects people in relation to medicines management and administration.

There were procedures in place which guided staff in how to safeguard the people who used the service from the potential risk of abuse. Staff understood the various types of abuse, however, they were aware of how to report these internally but not how to report them to relevant agencies.

There were not enough staff numbers in the service to meet people's needs safely and effectively. Appropriate recruitment checks on staff were carried out. Staff were trained to meet people's needs. However, improvements were needed in the support provided to staff to ensure that they were provided with the opportunity to discuss the way that they worked and to receive feedback on their work practice.

There were procedures and processes in place to guide staff about the safety of the people who used the service. These included checks on the environment and risk assessments which identified how the risks to people were minimised. However, improvements were needed in the way that the service assessed and monitored people's safety in the environment. The premises were not well maintained and safe. Improvements were needed to ensure equipment in the service was clean and hygienic.

Improvements were needed in how people's ability to make decisions were assessed and recorded. The manager had taken action to seek support in the recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS). However, no referrals had been made, despite a decision being made to restrict a person's decisions regarding their medicines. Improvements were needed to ensure that people were not unlawfully deprived of their liberty.

Records of people's fluid and food intake were incomplete and not assessed to make sure that they had enough to eat and drink. Improvements were needed to ensure that people received positive mealtime experiences.

People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

People's care was assessed and reviewed and changes to their needs and preferences were identified and acted upon. However this wasn't consistently reflected in their records.

Staff had good relationships with people who used the service and spoke about them in a caring and compassionate manner. However, because improvements were needed in the staffing levels in the service people were not always provided with meaningful and caring interactions which they needed to reduce the risks of social isolation.

Staff understood their roles and responsibilities in providing safe and good quality care to the people who used the service. The service's quality assurance system had not independently identified shortfalls in the care provided to people. People's comments and concerns were not used to improve the service. Improvements were required to ensure the quality of the service continued to improve.

Summary of findings

We found multiple breaches of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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?

Inadequate

The service was not safe.

Staff were knowledgeable about how to recognise abuse or potential abuse. They were aware of how to report these concerns in-house, but not to the appropriate authorities.

There were not sufficient staff numbers of staff to meet people's needs safely.

Systems in place for medicine management were not robust. People were not provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Inadequate

The service was not effective.

Staff were trained to meet the needs of the people who used the service. Improvements were needed in how staff were supported.

Improvements were needed in how the service ensured people's legal rights were protected.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Records used to assess if people had enough to eat and drink were incomplete and not robust. Improvements were needed in people's mealtime experience.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were treated with respect by staff. However, due to the poor staffing levels in the service people were not always provided with meaningful and caring interactions which they needed to reduce the risks of social isolation.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Inadequate

The service was not responsive.

People's wellbeing and social inclusion was not planned and delivered to ensure their social needs were being met.

People's care was not planned and delivered in a way which was intended to ensure they received personalised care.

People's concerns and complaints were investigated and responded to. However, they were not used to improve the quality of the service.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The quality assurance systems and leadership were not robust enough to independently pick up shortfalls and act on them. People's comments and concerns were not used to improve the service.

Melford Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 June 2015 and was unannounced. The inspection was undertaken by two inspectors.

We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with five people who used the service and five people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who may not be able to verbally share their views of the service with us. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to five people's care. We spoke with the area manager, the manager and nine members of staff, including kitchen, care and nursing staff. We looked at records relating to the management of the service, three staff recruitment records, training, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Records showed that people were not provided with their medicines as prescribed for external application, including creams and lotions. This included prescribed creams which were used to minimise the risks of pressure ulcers developing. Medicines administration records for other medicines including tablets, held gaps which identified that people were not receiving their medicines as prescribed. There were inconsistencies in how medicines that was prescribed 'as required' were recorded as being administered, some entries were blank and others used two different codes. This did not give a clear audit trail of the administration of these medicines.

For people who were prescribed with pain relief medicines which were to be administered via a syringe driver. There was no guidance in the administration records about how this should be administered in measurements to ensure people were provided with the right amount of pain relief. This meant that if people were not provided with the correct doses of pain relief they may be at risk of experiencing pain, which could be prevented if appropriate guidance was in place.

People's care records included risk assessments which identified how the risks in their daily living, including using mobility equipment, pressure ulcers, accidents and falls, were minimised. Where incidents had happened there were no systems in place to reduce the risks of them happening again. For example, they had not been analysed for potential trends and patterns and actions identified to reduce the risks.

Where people had pressure ulcers or the risks of them developing and had been assessed as requiring assistance to reduce the risks. Repositioning charts showed that people had not been provided with the assistance that they needed to minimise the risks of pressure ulcers developing or deteriorating.

We saw a person's relative showing a staff member their relative's repositioning chart, which identified that the person should be assisted to turn to minimise the risks associated with pressure ulcers, this chart showed that the person had not been assisted within the time that they had been assessed as needing. They told us that their relative was not always supported with their continence care and sometimes their bed was wet despite wearing a continence pad, they said, "There is only so much a pad will hold." This told us that people were not being provided with safe care and the systems in place to reduce risks were not robust.

Improvements were needed to ensure equipment was maintained to a clean and hygienic standard. Several hoists seen were dirty and stained. Improvements were needed in maintaining the safety in the premises. For example the handle on a bathroom door was not fixed flush to the door, where people could pinch their fingers in. There were cracked windows and rotting window frames. The windows in the kitchen were propped open with pieces of wood. The manager advised that these issues would be addressed.

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

There were not enough staff numbers in the service to ensure that people received the care and treatment to meet their assessed needs. People and people's relatives told us that call bells were not answered in a timely manner. One person told us that they sometimes had to wait for, "Half an hour," before their call bell was answered. They said that they thought this was because they were usually independent and could manage. They told us about the assistance that they needed. On the morning of our inspection they had got up at 8am, however had not received their breakfast until 10am, and was not supported with their personal care until after this. They said, "I wish there were more staff, so they did not have to work so hard." Another person at risk of falls had a sensor mat on the floor to alert staff if they should step on it or fall. We stood on the sensor mat and pressed the personal call bell to see how long it would take for the staff to respond to the alarms. It was over eight minutes before a member of staff was available as staff were assisting other people with their personal care or supporting people who required assistance with eating.

People's relatives also told us that call bells took a long time to get answered. One person's relative said, "They are not quick in answering the bell." Another person's relative commented that the staff did not have time to provide care for their relative, including assisting them to eat, and said, "They just don't have the time." They also commented that they had seen that other people who received no visitors

Is the service safe?

did not have anyone going into their bedroom and said that they needed to be in the service because they felt that if their relative died they, "Could be lying here five hours before anyone would notice."

People's relatives told us that there were many occasions when their relatives were not supported to wash and dress in the mornings, sometimes as late as 12:30pm, which was not their choice. We saw a person's relative waiting in the hallway whilst their relative was being provided with personal care by the manager and another staff member. The person's relative told us that they had arrived at the service at 11:15am to take their relative out and they had not been assisted to wash and dress by this time. They had asked for assistance and this had been provided. We were concerned that the staffing levels were not sufficient because the manager had to assist the staff to support this person. Another person's relative arrived at the service at lunchtime and their relative had not been assisted to wash and dress.

People's relatives told us that they had raised concerns about the staffing levels in the service and they had been told that there were sufficient staff numbers. This was confirmed in meeting minutes. One person's relative said that additional staff were being provided during busier times such as evening meal times and this was called a twilight shift which, "Might help."

We saw that the only interaction people received from staff, who chose to remain in their bedrooms, was during meal times or when they were served with drinks or provided with personal care.

Three health professionals told us that they were concerned with the high use of agency nursing staff which did not support continuity of care and the numbers of nursing staff provided to meet the needs of the people who used the service. One person's relative told us that they were concerned that agency nursing staff did not always have the knowledge that they needed about people's individual care needs. The manager told us that they were taking action to recruit permanent nursing staff and where agency nurses were used they tried to keep a consistent team.

Staff told us that they felt that there were not enough of them on each shift to meet people's needs safely. They told us that they had raised this in meetings but had been advised that there were enough staff numbers, this was confirmed by meeting minutes. They were committed to providing good quality care but were unable to because of the numbers of staff to meet people's complex needs. By lunchtime staff had not taken a break because they needed to support people. We also saw that staff worked past the hours when they were due to finish their shift to ensure that they had all the jobs that they needed to do done, including updating people's care records.

Staff told us that a colleague had called in sick and when this happened there were rarely extra staff put on shift to support them. There was not a robust system in place which assessed the staffing levels needed to meet people's needs and to manage short notice absence of staff. This was evident because what we had seen and been told during our inspection.

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

Following our inspection the provider told us that they had taken action to reduce the risks to people of not having enough staff to meet their needs. This included a review of systems and increase staffing.

Records showed that checks were made on new staff before they were allowed to work in the service. These checks included, if prospective staff members were of good character and suitable to work with the people who used the service.

Staff had received training in safeguarding adults from abuse. They understood the different types of abuse and the signs and indicators of these. They knew how to report concerns internally, but were not clear about how to report concerns of abuse to relevant organisations who have the responsibility of investigating safeguarding concerns. We told the manager and the area manager about what we had found and they assured us that this would be addressed.

Risks to people injuring themselves or others were limited because equipment, including hoists and equipment were checked so they were fit for purpose and safe to use. Regular fire safety checks and fire drills were undertaken to reduce the risks to people if there was fire. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire.

Inadequate

Is the service effective?

Our findings

We spoke with the manager about Deprivation of Liberty Safeguards (DoLS) legislation. They told us that they had not made any referrals to the local authority in accordance with new guidance to ensure that any restrictions on people, for their safety, were lawful. However, they said that they had contacted the local authority for advice and guidance. Therefore we were not assured that all people were protected when restrictions were required to make sure that they were safe.

Records identified people's capacity to make decisions. However, for those who did not have capacity to make decisions, there were no care plans in place to show how decisions were to be made in their best interests. The records did not show which decisions people needed assistance in making, which decisions they could make themselves and when their capacity to make decisions varied over time. There were discrepancies in one person's care records which stated in one part that they did not have capacity to make decisions and in another part that they had variable capacity. This person's records stated that they were to be administered with one of their medicines hidden in food as they were not compliant in taking this medicine. The records stated that this had been authorised by the person's doctor. However, no DoLS referral had been made to show that this decision had been taken in the person's best interests and was lawful. Therefore we could not be assured that the systems in place were robust enough to support people who lacked capacity to make decisions regarding their care and treatment.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about the quality of the food provided varied. They told us that they were provided with choices of food and drink. One person said, "The food could be better, there is not much variety." Another person said, "I love breakfast, you can have anything you like." We spoke to one person about their specific diet and they told us, "The food is so so," and how their preferences of food were not always provided in the way that they liked them.

There were jugs of cold drinks in people's bedrooms and people, who remained in their bedrooms, had a drink in front of them. However, some were not able to access these drinks independently.

Where people had been assessed as being at risk of not eating or drinking enough, there were systems in place to monitor this, including referrals to health care professionals. However, food and fluid charts were incomplete and there was no indication of what people were assessed as needing to eat and drink each day. Fluid charts were not totalled and assessed. Therefore, these systems were not robust. This told us that people were at risk of not having their nutritional needs appropriately assessed and met.

We saw that people's experiences during lunchtime could be improved. Staff were task focused and provided limited social interaction and engagement to people. Staff concentrated on providing people with their meals in the dining room and ensuring that people who chose to eat in their bedrooms had their meals and assistance provided where required. Although people received their meals in a timely manner there was limited interaction in the dining room apart from questions such as, "Is the food alright?" and, "Can I get you anything else?"

During lunch we saw three people try to engage with staff at different times; making eye contact and smiling and two people asked a question about the menu. Staff did not pick up on the communications as they were too busy preparing meals. There was an inconsistent approach by staff in recognising and responding to people's needs. For example a kitchen member of staff when asked what was for lunch put the menu in front of the person and waited for their response. The person did not understand what was on the menu and said, "I can't see this, what is it, what can I have?" Again the menu was placed in front of them for them to choose. The person was seen to ask the people they were sitting with what they were having and made their choice that way. We saw another kitchen member of staff respond differently when asked the same question. They went through the menu with the person explaining what the choices were and helped them to choose. People were not supported to be independent and to make informed choices at meal times, the menu's and signage were not accessible to everyone and in a format such as pictures or photographs of the food that could support people to make their choices.

We saw instances where people were provided with food which was only eaten when staff encouraged them to eat. When staff walked away to assist somebody else or to

undertake a task, people became disengaged in the activity and stopped eating. We noted that one person without the encouragement by staff ate very little. Improvements were needed to people's meal time experiences.

This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff had the skills to meet their needs. Staff told us that they were provided with the training that they needed to meet people's requirements and preferences effectively. This was confirmed in records. There was a training plan in place to show how staff's training was updated to make sure that they were provided with the most up to date information about how to meet people's needs effectively.

Staff told us that they had not had regular supervision meetings to ensure that they were supervised and supported to improve their practice. This was confirmed in records. We spoke with the manager who told us that they were in the process of addressing this and showed us a supervision plan to confirm what we had been told. Supervision meetings provided staff with a forum to discuss the ways that they worked and to receive feedback on their work practice to identify how to improve the service provided to people.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided. One person told us how they were supported by nursing staff with their condition, which they felt was, "Healing nicely." They also told us about when they had a cold, "They [staff] offered to get the doctor in, they said it was just to give me peace of mind," which they felt was positive.

Records showed that people were supported to have access to healthcare services and receive ongoing healthcare support. Records showed that where there were concerns with people's wellbeing was identified action was undertaken to seek support and guidance from healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were caring and treated them with respect. One person said that the staff were, "Overworked, but they are very pleasant and will do anything for us." Another person talking about the care staff told us, "They mean well and try ever so hard but not enough of them to go around." One person's relative said that the staff were, "Wonderful, but there are not enough, they are stretched."

We saw that the staff interacted with people in a caring and respectful manner. For example staff made eye contact and listened to what people were saying, and responded accordingly. However, where people required to engage further with staff this was not provided. For example, a person was sitting alone in the lounge on the first floor, when a staff member passed by they said, "Hello dear," to which staff responded politely to. They then explained that they were busy and were unable to stay and chat even though the person said, "Please stay."

Staff talked about people in an affectionate and compassionate manner. They understood people's individual needs and how they were met. They recognised the shortfalls in the care that they could provide to people due to the lack of time for social and caring interaction. Staff were committed to providing good quality care to people but were unable to do this to the standard that they would like to. Records and our observations showed that staff interactions with people were task based and did not provide people with social interactions which enhanced their wellbeing.

People told us that they felt staff listened to what they said and their views were taken into account when their care was planned and reviewed. This included where they chose to eat their meals and what they wanted to wear that day. People and their relatives, where appropriate, had been involved in planning their care and support. This included their likes and dislikes, preferences about how they wanted to be supported and cared for.

People told us that they felt that their choices, independence, privacy and dignity was promoted and respected. This was confirmed in our observations. Staff knocked on bedroom doors before they entered and doors were closed when people were being supported with their personal care needs. When people required assistance with their personal care staff spoke with people in a hushed tone, so not to be overheard by anyone else which respected their privacy and dignity. However, we had received concerns from people's relatives about how people were not supported with their continence care in a timely manner, which did not respect their dignity. People were provided with drinks from plastic cups which were stained, which also did not respect their dignity. The manager told us that new cups were on order.

Inadequate

Is the service responsive?

Our findings

People told us that they received personalised care which was responsive to their needs. However, concerns were received from people and people's relatives about the amount of time that staff took to respond to call bells, that people were not assisted to get up in the morning due to staffing arrangements and relatives spoken with felt that they needed to spend time in the service to ensure that their relative's needs were met.

The service provided was not responsive to ensure that people's needs were met in a timely manner. During our inspection we saw that staff were busy undertaking tasks associated with people's care. However, these were not always being met, including call bell response times, the provision of meaningful interaction and the assistance that people required with their personal care needs, such as during the morning. Records also identified that people were not always provided with the care and support that they needed, for example with repositioning.

There was an activities coordinator in the service. However, we only saw them provide an exercise activity with four people in the lounge of the first floor. During the afternoon three people undertook a reminiscence activity, a visitor played the piano and one person was taken out in the community. For people who stayed in their bedrooms there was no social interaction other than when they were having visitors or when staff were supporting them with task based care, such as eating and drinking and personal care. We checked on one person, who remained in bed, several times throughout the day of our visit and saw that they only received staff support when they were being supported to eat. In addition to the lack of social interaction to reduce people becoming lonely or isolated, people's relatives told us that there was an issue in accessing the service during weekends. One person's relative told us that it sometimes takes up to twenty minutes for the door to be answered and another relative had left when the door was not opened, meaning that the person living in the service did not have a visit. People's relatives told us that they had raised this in meetings and had been told that they could go round the service and alert the catering staff of their arrival. This told us that there were barriers in place during the weekends which prevented positive interaction to improve their wellbeing for people who used the service.

The area manager told us that they were aware of this and were looking at ways to improve. However, this had been identified by relatives in a meeting in November 2014 and was still not addressed.

The manager told us that people's care plans were in the process of being reviewed and put onto a new format. The ground floor had been completed, and plans were to complete the first floor. They said that the provider's timescale for doing this was by the end of June 2015, but they were not clear how long this would take. The care plans we reviewed held some inconsistencies and lack of information. For example, including people's capacity to make decisions and one person's records stated that they had a mental health condition but there was no care plan in place to show how to work with this person to reduce their anxiety. Another person's care plan contained no information about their individual care needs and the risk assessments in place, despite them being in the service for over 24 hours receiving care. A member of staff explained that they were working on the care plan and using the person's previous care plan from a respite visit two weeks prior to inform staff. We were not assured that people's care records reflected their current situation and care needs without the appropriate assessments having been carried out.

We could not be assured that people's changing needs were identified and met. This was because daily records were sometimes incomplete by not having an entry each day or for each shift, and entries were task based and did not identify changes in people's wellbeing and preferences. Without this information we could not be assured that staff were able to efficiently identify changes in people's physical and emotional wellbeing and take action to make sure that any changing needs were met.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that they knew who to speak with if they needed to make a complaint.

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. Complaints were documented and addressed. However, there were no systems in place to use

Inadequate

Is the service responsive?

these concerns to prevent similar issues happening and improve the service. For example, complaints had been received about the staffing levels in the service but actions had not been taken to address this.

In one person's care plan there was written information about concerns from a person's relative. We asked the manager and they told us that they would look into it.

Following our inspection the manager told us that they had written this information following information received. However, this was not recorded as a concern and there was no detailed information about how this was addressed. Improvements were needed in the ways that concerns and complaints were used to improve the service.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in the service. However, there was a manager who assured us that they would be making a registered manager application with us.

The provider's quality assurance systems were not robust enough to independently identify shortfalls and to drive continuous improvement. The manager told us that some shortfalls identified in our inspection had been identified. However, there was no written evidence of this or how improvements were to be made. There were no action plans in place for which timescales were worked on and revisited to check how improvements were effective or needed changing to improve the quality of the service provided to people.

Records and discussions with the manager showed that incidents, such as falls, complaints and concerns were not analysed to identify possible trends, used to improve the service or reduce the risks of incidents re-occurring. This lack of oversight and effective management exposed people to ongoing avoidable harm and risk.

People and their representatives were asked for their views of the service and kept updated with changes in the service. However, we found that where concerns had been identified, these comments were not used to improve the service. People's relatives told us that they had raised concerns but did not feel that they were acted upon. This was confirmed in records. For example, complaints received in July 2014, September 2014, March 2015 and relative and resident meeting minutes showed concerns had been raised about staffing levels. Despite this, improvements had not been made to address the overall concerns of staffing throughout the day, apart from the inclusion of a 'twilight' shift. Complaints received in September 2014, November 2014 and relative and resident meeting minutes in November 2014 and February 2015 showed concerns had been received about the difficulty accessing the service. Despite this, improvements had not been made.

Records of provider reviews and quality manager home visits showed that the majority of shortfalls in the service had not been identified by the provider's quality assurance systems, including how people's care was affected by there not being enough staff, hoists which required cleaning, which presented a risk to cross infection and windows in the kitchen being held open by pieces of wood, which was unsafe for the staff working in there. Where shortfalls had been identified in a provider review in April 2015, including inconsistencies in care records and topical medicines records being incomplete, there was no action plan in place to show how these were going to be addressed to improve the service.

The provider's quality assurance systems and governance were not robust and were ineffective to ensure that people were provided with good quality and safe care and to drive improvements in the service. Following our inspection the provider told us about actions that they had taken to reduce the risks to people using the service. This included providing more staff and further support to the manager to oversee improvements made. We were so concerned about what we had found during our inspection we invited the provider to meet with us to provide assurances of improvement.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were complimentary about the approach of the manager and said that they felt supported by them. They told us that there was now an open culture in the service and that they could approach the manager at any time if they had concerns and were confident that these would be addressed. People told us that the manager regularly spoke with them and checked that they were happy with the service they were receiving.

Staff and the manager were committed in providing a good quality service to the people who used the service. They understood the ethos of the service and their roles and responsibilities to provide good care.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk because they were not provided with safe care and treatment. Regulation 12 (1) (2) (a) (b) (g).

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 People's capacity to make decisions was not adequately identified and actions taken to ensure that decisions are made in their best interests. Systems in place to ensure that restrictions on people for their safety were lawful and how people's capacity to make decisions were identified were not robust. Regulation 11 (1) (2) (3).

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 People are at risk because there are insufficient staff numbers to meet people's needs. Regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People are at risk of not being supported to eat and drink enough because their nutritional and hydration needs were not adequately assessed and met. Regulation 14 (1) (2) (a) (b) (4) (a).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not provided with person-centred care which met their needs. Regulation 9 (1) (a) (b) (c) (3) (b) (h).
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes are not robust, established and operated effectively to ensure risks to people are mitigated and to provide a good quality service to people. Regulation 17 (1) (2) (a) (b) (e).