Mimosa Healthcare (13) Limited (In administration)

Pondsmead Care Home

Inspection report

Shepton Road, Oakhill, BA3 5HT
Tel: 0345 2937658
Website: www.example.com

Date of inspection visit: 20 and 21 May 2015
Date of publication: 18/09/2015

Ratings

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

Overall summary

This inspection took place on 20 and 21 May 2015 and was unannounced. We had received information of concern which we looked at as part of this inspection. Our last inspection was in August 2013.

Pondsmead Care Home provides personal and nursing care for up to 76 older people. At the time of our inspection there were 60 people living in the home. The home is situated in the village of Oakhill on the main route between Bath and Shepton Mallett. Currently rooms are situated over three floors.

There has been a registered manager in post since December 2014. 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.'

Following an incident which could be seen as abuse the registered manager failed to take the appropriate action to report the incident to Somerset safeguarding team or ourselves as required. . However action was taken to alleviate the risk of a further incident involving the two people concerned.

Summary of findings

The provider had not taken steps to make sure risks to people were minimised. When recruiting some members of staff the necessary checks had not been carried out to establish and ensure the fitness of the potential employees.

People we spoke with had varied views about the availability of staff to respond to their requests for assistance. Some people said they had to wait for long periods and staff were always busy and "rushed". Other people said staff responded well to their requests particularly at night. Changes had been introduced in the staffing arrangements however there was no system in place to demonstrate how staffing levels were decided.

There were generally good arrangements for the administration and management of medicines. However there had been medicines administering errors and whilst some action had been taken we were not assured the necessary measures had been taken to ensure the competency of nursing staff in relation to medicines.

There was a failure to ensure people's legal rights were upheld through the use of arrangements available in the Mental Capacity Act 2005. There were not robust arrangements to ensure decisions made about people safe care and protection were taken either with their consent or under best interest process.

People were not being cared for by staff who were appropriately supervised or supported. Staff had not received one to one formal supervision for a period of six months. Nursing staff were not being provided with clinical supervision.

There had been no opportunities for staff to undertake training to ensure they were updated in their skills and competence and had the confidence to fulfil their role and responsibilities effectively.

The registered manager had failed to take action in relation to monitoring and reviewing the competency of a member of staff. Whilst people had the opportunity to discuss their care needs there were no formal arrangements for reviewing their care arrangements.

People and staff did not feel they had a positive relationship with the registered manager. A number of people told us they did not know who the registered manager was and how he was not seen around the home.

People told us they felt safe in the home and "Trusted" staff. There were many positive comments from people about the caring nature and kindness of staff. Staff were very clear about their responsibility to report any concerns about the health and welfare of people living in the home. They understood how they had the right to go to outside organisations if they wished to report any such concerns.

Risk assessments were in place which identified potential risks to people's health and welfare in such areas as fall, skin integrity and nutrition.

People told us they appreciated the quality of the meals and food provided. Comments included: "I always enjoy my meals they are very good and there is always a choice", "I always get the food I like, the staff know my likes and dislikes.", "You can't fault the food it's very nice". There were arrangements for people's nutritional needs to be assessed and specialist advice and additional support provided to ensure these needs were met.

Peoples specific care needs were being met and improving their health and welfare. One person said "The staff have been wonderful……..now I feel so much better."

People told us they found staff "Caring and kind". People's right to privacy and respect for choices were upheld. One person told us "The staff always respect my privacy, they know my privacy is important to me" We observed staff supporting people and providing assistance in a caring and sensitive way. The home provided a welcoming environment to visitors and people told us their visitors were always made to feel welcome.

Care was arranged to ensure people's personal needs were identified and met. People told us how their preferences and choices were respected. One person told us "Staff appreciate what my choices and likes are and try to fit round them, they are very good."

There was a range of meaningful activities which offered varied choices for people. People told us how much they enjoyed the activities. One person told us how "It is lovely to have a proper chat."

People felt confident in telling staff if they had any worries or concerns and they would be listened to. One person

Summary of findings

told us they were aware they could make a formal complaint if they wanted to and felt able to do so. However some people did not feel confident the registered manager acted on concerns raised.

We found 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.

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.

The provider had failed to take the necessary action following a potential safeguarding incident.

People were potentially at risk because recruitment procedures were not fully followed to establish the fitness of employees.

There were not proper and safe arrangements for the management of medicines.

There were varied views from people and staff as to the availability of staff and staffing arrangements.

Staff demonstrated a good understanding of the nature of abuse and their responsibilities to report any concerns.

Risk assessments were in place to protect people's health and welfare and action had been taken to alleviate risks to people's health and welfare.

Is the service effective?

Inadequate

The service was not always effective.

The registered manager did not have the necessary knowledge of the Mental Capacity Act 2005 (MCA) and had failed to identify a person who potentially should be subject of formal restrictions.

There were no formal or robust arrangements for ensuring action was taken in the best interest of people where they were unable to give consent to specific decisions.

There was a failure to ensure staff received the necessary formal supervision and training to ensure they had the necessary skills and competence to meet the needs of people effectively.

People's health and nutritional needs were being met effectively.

Is the service caring?

Requires improvement

The service was not always caring improvements were needed in involving people in their care arrangements.

There were no formal arrangements for people to be given the opportunity to be involved in reviewing their care arrangements.

People were very positive about the caring and supportive nature of staff.

People's dignity, respect and rights to privacy were upheld.

Summary of findings

Is the service responsive?
The service was responsive.

People had the opportunity to undertake meaningful activities which suited their interests.

People felt confident about voicing their concerns and worries and if necessary making a formal complaint.

Good

Is the service well-led?
The service was not well led.

The registered manager had failed to meet their responsibility and ensure actions were taken to monitor a staff members competency to practice.

There was a lack of an inclusive environment where people and staff felt engaged with the registered manager.

The registered manager had not promoted a culture whereby staff felt valued and involved in the delivering of a quality service.

Quality assurance systems were not always effective in identifying areas which required improvement.

Inadequate

Pondsmead Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 21 May 2015 and was unannounced. It was carried out by two adult social care inspector and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at information we held about the home. This included information regarding significant events that the home had informed us about.

During this inspection we spoke with 11 people who lived at the home, four relatives and a healthcare professional. We also spoke with fifteen members of staff and the registered manager. Throughout the day we observed care practices in communal areas and saw lunch being served in the dining room.

We looked at a number of records relating to individual care and the running of the home. These included seven care plans, risk assessments, quality assurance records and medicines records.

Requires improvement

Is the service safe?

Our findings

We were told by staff and confirmed by the registered manager of an aggressive incident involving two people. However no referral had been made to Somerset Safeguarding or ourselves about this incident which could be considered one of abuse. This meant there was no independent investigation of the incident to ensure appropriate action had been taken to protect people's safety. We noted action had been taken as a result of the incident and we have commented on these actions under Is the service effective.

Recruitment records showed there were no previous employer references for some recently recruited staff. However other checks such as enhanced criminal record checks, personal references or recommendations had been undertaken. This meant the provider could not be assured employed staff were "fit and proper" and able to provide appropriate and safe care.

The lack of appropriate recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had varied views about the staffing arrangements with some saying there were sufficient staff and "We don't have to wait long". However others said they felt there was not enough staff. One person said "They're very busy. It's better at night we don't have to wait as long". Another person said "There is not enough staff. They are lovely, you couldn't get better, but there are not enough of them."

Staff told us that whilst there had been changes in staffing they felt there was not always enough staff. They told us there were increasing number of people who required the assistance of two staff. We were told by staff there had previously been two activities organisers but this had been reduced to one. The registered manager confirmed this and said it was because there were not enough people in the home to warrant two activities organisers. They told us this would be reviewed as admissions increased.

On the days of our inspection we observed staff in the mornings were responding promptly to call bells. However in the afternoon there were a number of occasions when staff were not available. On one occasion we noted a call bell was not responded to for five minutes and on a second occasion a person was calling for assistance for six minutes before staff responded.

The registered manager told us they had recently introduced changes in the staffing arrangements of the service. They were now having three care staff on each floor during the day with two nurses on duty. Previously there had been one nurse and two care workers on one floor on each shift. At night there was five care staff and one nurse. The registered manager told us they regularly reviewed the staffing and had made the changes because of increased admissions. They had also been able to recruit nurses. There were monthly dependency scores which had not been completed for some people we looked at. However there was no system to evidence how the decision about staffing levels were made and staffing arrangements were appropriate.

We had received information of concern regarding a medicines incident. The registered manager had taken action to address this incident with regard to the agency member of staff. There had been a further two incidents regarding the administration of medicines and disciplinary action had been taken against the member of staff. However in speaking with the registered manager we could not establish how the action they had taken had addressed the practice of this individual and addressed their future competence in this area. Nursing staff we spoke with told us they had not undertaken specific training in the management and administration of medicines. One nurse had no previous training or experience of having responsibility with regard to medicines. We noted for new members of nursing staff there was no evidence of competency or training being undertaken. There was not a system to ensure nursing staff had the necessary training and competence to undertake the administering of medicines. This meant people were at risk because nurse competency in relation to the management and administering of medicines had not been ensured.

Medication administration records showed that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We looked at the stock and found there were the appropriate levels of stock. However we found stock for two people who had deceased which had not been returned to the pharmacist within seven days following their death. This is the recommended practice unless a coroners inquest is to take place. We noted in a medicines audit undertaken in March 2015,

Requires improvement

Is the service safe?

when this medicine would have been in stock, it stated there was no medicines being kept longer than this period. The home's medicines policy does not provide guidance on disposing of medicines on the death of a person.

We looked at administration records and other records of medicines that required additional security and recording. These medicines were appropriately stored and additional records for these medicines and daily stock control was in place. We checked records against stocks held and found them to be correct. Administration records of other medicines were completed correctly with the appropriate codes and no gaps.

The failure to have proper and safe arrangements for the management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. One person said "I get on really well with all the staff and know they will do anything for me. I know I can tell them anything that is worrying me." Another person told us "I can trust the staff here I have nothing to worry about how they treat me."

Staff demonstrated an understanding of what is considered abuse and their responsibility to report any concerns about possible abuse. Staff were very clear about reporting any concerns to "the nurse or manager". Staff told us they had completed safeguarding training however they told us they had not completed any recent or updated safeguarding training.

Staff were aware of how they could report any concerns about the care and management of the home to an outside organisation. They were able to tell us how this could be done under whistle blowing "we would be protected."

There were emergency plans in place. These gave information about the support and assistance people required in the event of an emergency such as a fire. There had been a number of incidents which had resulted in concerns about people's welfare and safety. In one instance an incident had resulted in the reviewing of the call bell arrangements. Following a further incident arrangements had been put in place to improve the security of fire exit doors. This meant the risk of people leaving the building and placing themselves at risk had been reduced.

There were detailed risk assessments in place as part of people's care planning arrangements. These included supporting people with skin integrity, nutritional assessments and risk of dehydration. Risk assessments had been reviewed as part of care planning reviews and following any incidents.

Inadequate

Is the service effective?

Our findings

We discussed with the registered manager their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They told us they had made a DoLs application for one individual which was awaiting authorisation. However we identified a further person where an application should have been made to the local authority regarding potential DoLs. The registered manager did not have a full understanding of the circumstances and criteria for when a DoLs application should be made.

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.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

We asked care staff about their understanding of the MCA and DoLS. They said they had received training in this area but they were not able to tell us the principles of the act or what DoLs related to in terms of protecting people. This meant people potentially did not have their rights fully protected under MCA legislation. However they demonstrated how they ensured people were able to make choices about their daily lives and routines.

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

Following two incidents action was taken to restrict access for people in the home to two people's rooms through the use of stair gates. Both of these individuals were not independently mobile and required hoisting and assistance from care staff to mobilise. In one instance the individual had agreed with the suggestion they had a stair gate. This was because they would not feel so confined in their room in that they could have the door open at any time. Their consent to this arrangement had been documented. For the other person there was no record of consent being obtained for this arrangement. No capacity assessment had been undertaken regarding this decision nor was there a best interest decision taken. This meant the decision had been taken without the appropriate arrangements in place to ensure people rights were being upheld.

The failure to ensure consent is obtained is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there had been no one to one supervision since the previous registered manager had left in December 2014. They told us they wanted supervision because it was an opportunity to "air our views, see how we doing and talk about training." One said "I don't really have a clue what we are meant to be doing now or whether I am still doing it right." The registered manager said he had not undertaken any formal supervision since he had started. We asked for the supervision policy and this stated "all staff are offered supervision six times a year."

We discussed with the registered manager the arrangements for clinical supervision of nursing staff. They told us this would be provided by them however we were also informed he was no longer a registered nurse and therefore not practising clinically. This meant he was not in a position to provide clinical supervision but had made no arrangements for this to be provided.

The failure to ensure staff are appropriately supported is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were very positive about the care staff and how they provided care. However one person said "Some are not as well qualified or as well trained." Most of the staff we spoke with told us they had not completed any training in the last six months. Two told us they had not undertaken any up to date training such as safeguarding or moving and handling. Some staff told us they did not feel confident in their current abilities to support people's care as they felt their care skills were not up to date. Some had completed moving and handling training in the last month. The registered manager told us there had been no training available to staff in the last six months. They were in the process of looking for training providers.

Staff said how there was an increasing number of people living in the home who had dementia. They had been told by the registered manager this was an area of care the home was going to develop. The registered manager told

Inadequate

Is the service effective?

us they hoped the home would become a more specialist home for people living with dementia. However no arrangements had been put in place for staff to undertake dementia training and some told us they had not received any dementia training. Some staff expressed concern about caring for people with behaviour which could challenge and felt there had been insufficient support and training to enable them to manage people with complex behaviours with confidence and competence. One said how they did not feel confident working with people who had dementia. Another said "I don't know if I am doing the right thing." The manager confirmed to us there were no arrangements in place for staff to undertake dementia training. This was an area he wanted to improve.

The lack of appropriate training and supervision of staff is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food. One person said "The meals are lovely there is always a choice and they seem to know what I like and don't like". Another person said "I always enjoy the meals here it is important we get good food which we do." One person who was vegetarian told us "They appreciate I am vegetarian and they try to give me a good choice of meals." We observed the main meal of the day and noted food was well presented and portion sizes were ample. Staff offered discreet encouragement and assistance to people who had difficulty eating.

People's nutritional needs were assessed and where necessary referrals made to a nutritionist where there were concerns about people's weight or nutritional needs being met. Some people had been prescribed food supplements or fortified diets to ensure their nutritional needs were being met.

Where people were assessed as being at risk of skin breakdown we saw pressure relieving equipment was in place in the form of pressure relieving mattresses and cushions. One person had been admitted with a pressure wound and there were photographs in their care plan showing how it had improved. There was a specific care plan which set out how the wound was to be treated and the person repositioned regularly to relieve pressure on their skin.

Another person had a care plan in place because of skin breakdown they told us "The staff have been wonderful I had a very sore area and now it has healed. I had to lie on my bed at times during the day and I had a special cushion, now I feel so much better." This demonstrated how staff were assessing people's care needs and the care planning and delivering of care was appropriate to effectively meet those needs.

People told us they could access health services such as GPs, chiropodists and opticians. One person said "I can see my doctor when I want I only have to ask." Records showed people had seen health specialists on a regular basis. Referrals had also been made to specialists such as tissue viability nurse to support staff in caring for people who were at risk of skin breakdown.

Requires improvement

Is the service caring?

Our findings

Some people told us they felt able to discuss their care needs with staff. One person said "I can always tell staff if I need more help" and another said "Staff are very good they asked me what help I needed, what I can and can't do." However people said they were not involved in formally reviewing their care arrangements though a relative told us they had been involved. Care plans had been reviewed regularly but there was no evidence of any formal care plan review with the individual. One relative told us staff spent time with them finding out the preferences of their relative who was unable to communicate with the staff team.

People told us they found staff "Kind and friendly", "Very caring" and "Look after me well". One person said "I am looked after very well all the staff are very good" Another person said "They respect my choices. It is not a problem if I want to stay in my room."

We observed care staff caring for people and were kind and gentle in their approach and appeared to be well known to the person they were assisting. Staff treated people with respect and protected their dignity when they assisted them. For example we saw one person being supported by two staff using a hoist. Staff were very conscious of protecting the person's dignity and telling them what was happening and was going to happen. We observed staff interacting with people in a warm and appropriate manner. Staff made good eye contact and, where necessary, bent down to be clearly visible to the person.

Staff knocked on people's doors and importantly waited for them to answer before entering the room. One person told us "The staff always respect my privacy they know my privacy is important to me."

Visitors were always made welcome which enabled people to maintain contact with friends and family. Relatives told us they were able to visit at any time. A relative told us "I visit regularly and tend to have a routine, but I do feel I could come whenever I want to."

One person told us "We have plenty of visitors, they come when they want." Another person said "I have lots of visitors, they come and go and all feel welcome." We observed a staff member welcoming a visitor and offering them tea and coffee.

Good

Is the service responsive?

Our findings

Staff told us there were no strict routines in the home and they encouraged people to chose what they wanted to do during the day. One member of staff said "We always ask people what they want everyone is different some have routines others don't." This was confirmed by people we spoke with. One person said "It is up to me how I spend my day and where I want to be and staff know this". Another person told us "I can choose when I get up I don't really have a routine and staff understand that." Other people told us how they were able to make choices about when they got up and went to bed and whether or not to join in with activities.

As part of people's care plans there were memory dairies. These provided information about the person's life history, important relationships, occupation and interests. We observed staff talking with people about their lives and families. There was a sense staff had a good knowledge of people as individuals. One person told us "Staff know I used to like art and always tell me if there is something going on I might enjoy."

The provider employed an activities co-ordinator who provided a range of activities on a daily basis. These included quizzes, cookery club, arts and crafts, flexicise, poetry afternoon and film afternoon. The activities co-ordinator told us they also spent time with people on a one to one "Because not everyone likes to join group activities." One person told us "I so look forward to the days when I have time with the activities person on my own it is lovely to have a proper chat."

One person told us how they really liked the activities. They said "I go down and see the activities co-ordinator and make cakes. I join in the hymns and prayers, play bingo and cards." Another person said "I enjoy going to the church service." Another person told us they went to the local church and walked down to the local pub and shop. One person was keen on gardening and had spent a lot of time in the garden. One staff member said how lovely they had made it planting lots of flowers. A relative told us how their relative knew what activities were available and did cookery.

Staff told us they would have liked to spend more time with people "Just having a chat" and "Sometimes we try and take part in the activities". We observed some staff sitting with people having a chat.

People told us if they had any worries or concerns they would speak with a member of staff. One person told us "I know they would listen to me and do something about it." Another person said they knew they could make a complaint and "If I was worried about something I would feel able to make a complaint."

Inadequate

Is the service well-led?

Our findings

We had been told about a staff member whose professional body had taken action in relation to their ability to practice. The registered manager confirmed a staff member was under conditions of practice from their professional body. This was due to allegations about their competency and the allegations were in the process of being investigated. We looked at public documents related to this person as to the conditions of practice they were under and need for supervision. The registered manager advised us they were not aware of these conditions of practice despite being in force for over six months. The registered manager had failed to ensure these conditions had been followed by the individual. The registered manager had not undertaken their responsibilities as to supervising and monitoring the practice of this staff member. However we noted how this staff member was not on duty without another staff member of equal grade and responsibility being available.

There had been further incidents of alleged poor practice by this staff member. Disciplinary action had been taken however the registered manager had not ensured the staff member's professional body had been informed of this disciplinary action and outcome. This had been part of the employees conditions of practice set by the professional body. This staff member was supervising staff in specific duties which were under investigation for alleged poor practice by the staff member and had been the subject of disciplinary action. This meant the registered manager had failed to meet their responsibilities in ensuring the staff member was acting in a safe and competent manner and fitness to practice was monitored and reviewed.

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

We asked people about their contact with the registered manager. They told us he was not often seen and some did not know who the manager was. One person did not know his name and said "Yes he has been in a few times." Another person said "I know him by sight but he doesn't come in to see me." A third person said "He does walk around but it doesn't happen a lot." A fourth person said "We don't see the manager very much."

Two people told us staff had spoken to them in a negative way about the registered manager. One person had subsequently spoken to the registered manager about a number of issues. This meant staff were acting inappropriately in voicing these views and potentially cause anxiety and loss of trust from people living in the home towards the registered manager.

People told us they used to have residents meetings but had not done since the new manager had been in post. The lack of residents meetings, and limited contact between people and the registered manager, meant there were limited opportunities for people to share heir views or make suggestions about the running of the home. There had been no opportunities for people or others to voice their views about the service through questionnaires.

A relative told us how the registered manager had not made himself known to them when he started in the home. They had gone to see him about their relatives care. Another relative told us how they had not spoken to the manager "We often visit the home but he has never come to introduce himself."

Staff told us they saw little of the registered manager as they "Rarely visited all the areas of the home". Staff comments about the registered manager included: "He doesn't support the staff enough", "We never see him on the floor", "I have no respect for him", "Has little to do with residents, "Doesn't want to engage with residents", "Has no rapport with residents". Staff described the moral as poor and did not have any sense of what the registered manger wanted to achieve in the home. Some commented he was only interested in "Filling beds". They described a staff meeting when the registered manager had described the behaviour of staff in a negative and derogatory way.

We discussed these views with the registered manager. He did not recognise the descriptions of him but acknowledged his style was different to the previous manager which could he believed account for the staff feelings. He confirmed the comment he had made about staff at a staff meeting.

One person said they had spoken with the manager about the lack of sufficient staff and how the care staff had too much to do. They said though he had listened she felt nothing had changed. They had also spoken with the registered manager about how there had been two activities co-ordinators. He had told her "When we have more residents and money they can come back". The

Inadequate

Is the service well-led?

former activities co-ordinator had remained working at the home in another capacity. They confirmed they would be offered their post back once the home's occupancy had increased.

The registered manager spoke of the importance of increasing occupancy and therefore increasing revenue so they could improve the quality of care for example in relation to staffing arrangements and re instating of activities co-ordinator. His view was that of needing to improve the quality of care in the home to a level where it was seen as excellent.

There were some systems in place to monitor the quality of the service provided. There were monthly audits in place including infection control and medicines. Questionnaires asking people and representatives about their view of the quality of the service had been issued in 2014 but none had been issued this year. The registered manager told us he was planning to issue questionnaires. There were accidents and incidents audits in place which showed any actions taken following the incident. These included re-assessment and referrals to other agencies for support and advice such as falls prevention. Support of staff, staff training and competency to practice had not been reviewed or monitored as part of the quality assurance system.

The failure to have effective systems and processes to monitor the quality of the service is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

.

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 11 HSCA (RA) Regulations 2014 Need for consent **The registered manager failed to ensure care and treatment was provided with the consent of people using the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered manager failed to ensure there were proper and safe arrangements for the management of medicines.**

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 **The registered manager failed to ensure people rights were upheld and action taken where necessary to protect people's health and welfare.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered manager failed to ensure there were effective systems and processes to assess, monitor the quality and safety of the service and mitigate risks to people.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered manager failed to ensure person employed by the provider received appropriate support and training to make sure competence is maintained.
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered manager failed to ensure appropriate and effective recruitment procedures were in place to ensure potentially employees were fit and proper persons.