Beech House (Partington) Limited

Beech House Nursing Home (Partington)

Inspection report

Beech House Nursing Home
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Greater Manchester
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21 March 2017
22 March 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Beech House Nursing Home on 20, 21 and 22 March 2017. The first day of the inspection was unannounced, which meant we did not notify anyone at the service that we would be attending.

Beech House Nursing Home provides nursing and residential care for up to 28 older people. At the time of our inspection there were 25 people living in the home.

People are supported in two buildings. The house provides accommodation for people requiring nursing care. The bungalow next door provides residential care.

The house has a communal lounge area and large conservatory used as a dining room. The bungalow has a small dining area and separate small lounge area. The kitchen where meals are made is in the main house and there is a smaller kitchen for snacks and drinks in the bungalow. The laundry room is situated in the bungalow. The house has two floors; the upper floor is accessed by stairs and a lift.

At the comprehensive inspection of Beech House Nursing Home on 1and 3 December 2015 we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). We issued the provider with six requirements stating they must take action to address these breaches.

Following that inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. This inspection was undertaken to check that they had followed their plan, and to confirm that they now met all of the legal requirements.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The service had a new manager who had worked at Beech House Nursing Home for ten weeks prior to our inspection. They were in the process of being registered with the Care Quality Commission. 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.

At the last inspection we found there were not sufficient levels of staff of staff on duty. At this inspection we found staffing levels had not improved and we noted people did not receive their care in a timely manner.

We observed some positive interactions between people and staff when direct care was being provided. However, we saw staff rushing around and not always acknowledging people as they passed them or entered their rooms. Consideration was not always given to people's privacy and dignity as people's personal information was not always protected.
Robust recruitment processes had not been followed because one some staff member did not have references from their previous employment.

Care plans were based on the needs identified within the assessment, however we found care plans were not always person centred, and didn't provide enough information on people's past histories.

We found systems were in place to make sure people received their medicines safely. When we did raise an issue with medicines this was explored and resolved straight away.

Potential safety hazards were identified by the inspection team as we walked around the building. We brought these concerns to the management team's attention and found these had been resolved on the second day of our inspection.

All areas of the home looked clean. Procedures were in place to prevent and control the spread of infection. An infection control audit in February 2017 had identified areas for improvement and these were being implemented.

Policies were in place to ensure people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were protected. Although policies and procedures were in place it was clear that they were not always put into practice.

People had access to activities, however we received mixed feedback with regards to the activities provided. People were not always protected from social isolation. The range of activities available were not always appropriate or stimulating for people.

People had enough to eat and drink throughout the day. Where people needed support with eating, they were supported by a member of staff. However, we found people who needed their fluid intake recorded had not always been completed correctly by staff.

Audits on the home's quality were not accurate which meant systems to improve the quality of provision at the home were not always effective. We found the home in breach of the regulation in relation to good governance as there were not effective systems in place to monitor the quality of the service. Surveys were completed but the information was not collated and used to improve the provision of care at the home.

The home environment was not dementia-friendly, in that adjustments had not been made to help people living with the condition to navigate around the home. We recommended that the home investigates and implements good practice in modern dementia care to improve people's quality of life.

Healthcare services were available to people who required them. People had access to health care services when their health needs changed. Staff made referrals to health care professionals for further advice and guidance to manage their health conditions. Staff followed health professional's guidance and recommendations for people.

People told us they knew how to complain if they were unhappy and records showed the service responded appropriately to complaints they had received.

We found 11 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

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 not was safe.

There were an insufficient number of staff to provide people with safe care and protect them from harm.

Robust recruitment processes had not been followed because one some staff member did not have references from their previous employment.

Improvements had been made to ensure a more robust management of medicines. People received their medication as prescribed.

Is the service effective?

Inadequate

The service was not effective.

People's rights were not protected as the service failed to adhere to the principles of the Mental Capacity Act 2005. The majority of staff had not received training on the MCA or DoLS.

Staff didn't receive sufficient training to enable them to develop further skills and knowledge.

Records for food and fluid intake were not accurately completed. The new manager was unable to evidence what people had consumed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

The mealtime experience was not positive or well managed.

End of life care plans were not person centred as they lacked information about people's preferences and wishes during that time.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always experience person centred care. The registered provider had not taken sufficient action to improve activities for people.

Information about how to make a complaint was available for people and their relatives.

Is the service well-led?

Inadequate

The service was not well-led.

Audits in place did not identify the shortfalls we found and timely action had not been taken in response where the service had identified shortfalls.

Staff felt supported by the new manager and relatives gave us positive feedback in relation to her.

The new manager had applied to the CQC for registration, however the new manager resigned shortly after this inspection.

Beech House Nursing Home (Partington)

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 20, 21 and 22 March 2017 and the first day was unannounced which meant no one at the service knew beforehand that we would be attending. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience working in nursing settings.

Before the inspection we reviewed the information we held about the service. This included asking the Local Authority and Healthwatch Trafford for information. The Local Authority did not raise any concerns.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Part of the local Healthwatch programme is to carry out Enter and view visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. Healthwatch had undertaken an Enter and View visit to Beech House Nursing Home in December 2016. The outcome of the visit was positive and the authorised representatives leading the visit felt that the standard of care at Beech House Nursing Home was good.

We also reviewed information from the local NHS Trust's infection control lead; an infection control inspection had been carried out in February 2017. The infection control lead had drawn up an action plan for the service after issues had been identified.

During our inspection we spoke with 10 people living at the home, eight of their relatives and two visiting health professionals to obtain their views of the support provided. We spoke with 12 members of staff, which included the registered manager, area manager, the administrator, two qualified nurses, activities coordinator, senior care staff, three care staff, catering and domestic staff.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building including bedrooms, bathrooms, the kitchen, the laundry room, clinic rooms and in communal areas. We also spent time looking at records, which included four people's care records, three staff recruitment files, training records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person when asked if they felt safe said, "Yes I do feel safe at this home", another person was asked the same question said, "I feel safe in here, I have my own room." A third person told us, "I believe this home is safe."

During the last inspection we observed people being assisted to transfer by care workers using hoists on a number of occasions. On two occasions during the last inspection, a member of the inspection team observed care workers assisting a person to move using inappropriate moving and handling techniques.

At this inspection we observed a number of manoeuvres that were carried out safely, however on the second day of our inspection we observed one staff member supporting a person with their wheelchair in an unsafe way. We noted the staff member only placed one of the foot plates down on the wheelchair while they began to push the chair forward, we immediately intervened and informed the staff member that only one of the foot plates was down on the wheelchair, this unsafe moving and handling could have potentially trapped the person's foot under the wheelchair and caused an injury. We discussed this with the new manager who said she would speak with all care workers at the home and provide further moving and handling training especially around the use of wheelchairs.

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

At our last inspection on 1 and 3 December 2015, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to a lack of sufficient staff on duty. At the time of our inspection the home was providing nursing accommodation for 19 people and the adjacent bungalow was providing residential accommodation for 6 people. When we arrived at 8.30am on the first day of our inspection there was one care worker in the bungalow and a nurse and four care workers in the home. We looked at the rota and saw that during the day there were one care worker in the bungalow and a nurse and four care workers in the home. In addition there was a cook in the home and a housekeeper who prepared cold drinks, managed the laundry and did the cleaning in both buildings.

We observed that the staff were busy supporting people to get up in the morning. The nurse was administering medication and so was in and out of the lounge area and also taking medicines to people's rooms. This meant breakfast was not served until after 10am. Some people had got up before 7am and had been provided with one cup of tea before their breakfast was served. On the second day of our inspection we noted a similar pattern to the first day. This meant that people sometimes had to wait for support as the staff were busy supporting other people. Staff were also very task orientated as they did not have the time to sit and talk with people. During the afternoon we observed two people asking for assistance to be taken to the toilet. One person became distressed and was not happy they had to wait. One of the staff members who was passing reassured this person and commented that they would be supporting this person next to the toilet. However, we noted this person waited 15 minutes for this to happen.

The service used a dependency tool to determine the number of staff required based on the needs of the people living at the home. The dependency tool scored each person monthly according to the level of support they needed with the activities of daily living and calculated the number of staff hours needed to provide the required level of support for all the people. We noted this dependency tool had last been updated on 31November 2016, the delay in this being updated was partly due to the change in managers. The area manager updated the dependency tool during our visit and found the home needed to increase the staffing levels by 5.5 hours per day. As a result of this dependency tool and our concerns in relation to the staffing levels, the area manager increased the staffing levels by introducing a 9am to 3pm shift on the second day. However, this person worked their shift at the bungalow, therefore the staffing levels were still not adequate in the main house where people required nursing care.

At the last inspection we received varied opinions in relation to whether there was enough staff on duty. At this inspection we continued to receive mixed comments, these included, "If there was an extra girl helping it would be better," "They can be very short at times, but they are doing their best", and "It's awful when you have to wait (for the toilet). You can't go to the toilet before the breakfast is cleared away, the staff make residents wait. I'm sick of asking them to go to the toilet."

Comments from people's relatives were also concerned about the staffing levels, they included, "I believe the staffing levels are adequate, but I don't visit that often", "The week is reasonable, but the weekends are short (staffed)", "I got here; she [resident] was upset, waiting to be taken to the toilet. I feel a nuisance when I have to ask. She has often been asking before I get here" and "The staffing levels are not good really, the staff do work hard but they are constantly running around because they are short on the ground."

We asked staff if they thought that staffing levels were appropriate. Comments received were negative and staff felt the staffing levels need to be increased. Comments included, "I worked at the bungalow, only one staff member to support six people, and when I need assistance I sometimes have to wait for staff to come over from the main house", "We cannot sustain this workload, we need more staff", "I think the management are aware we need an extra staff member at least, it can be chaotic at times" and "We need more staff, every shift."

By speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the home, it was clear that whilst people's basic care needs were largely being met, there were not enough staff to support all of the people as they needed. In addition, staff did not have time to provide engagement and stimulus to the people living at the home.

The lack of sufficient staff was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we were informed by the previous registered manager that the home had difficulties finding and retaining permanent nursing staff at Beech House Nursing Home. At the time of the last inspection there were no permanent nurse's working day shifts, and the home relied on agency nurses. At this inspection we found the home had recruited two full times nurses and were in the process of recruiting a third nurse. This meant the home had made improvements in this area and ensured there was now continuity between the nurses on shift.

Records showed that the registration of the nurses was checked annually with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse.

At the last inspection we recommend that the home reviews and improves medicines management practice

and audit at the home in line with current national guidelines and standards. For example, not all people had medicine protocols for 'as required' pain medication.

At this inspection we found a number of improvements had been made, however the storage of warfarin medication was not robust.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for some of the medicines with others supplied in boxes or bottles. We observed two medicine rounds in the house where nursing care was provided. People were given their medicines in a caring way and those who required more time or encouragement and support received it. The nurse made sure the medicine trolley was locked when they went to give medicines to each person, ensuring items were kept securely. This demonstrated people were receiving their medicines safely and in a person-centred way.

Each person's medication administration record (MAR) contained a photograph of the people and there were details of any allergies and a copy of their medicine prescription. MAR's for each person's tablets and liquid medicines were up to date with no gaps in recording. However, during our audit of warfarin medication we found anomalies in relation to the quantity recorded on the MAR and what was left in the box. Although, we found no discrepancies with the administration of the warfarin, we were not assured with the process in place for checking the balance of the warfarin medication. We noted the new manager completed a medicines audit on 2 March 2017, and also picked up on the same discrepancy we found. However, the manager's audit did not provide an action how this matter would be resolved. The manager commented that they discussed this discrepancy with one the nurses for them to follow this up, however we found this discrepancy had not been resolved.

Boxes of tablets and bottles of liquid medicines in the drug trolley were dated upon opening. Staff recorded when people had refused medicines. There was a system in place so that people could have homely medicines when they needed them; homely medicines include over the counter medicines such as paracetamol, laxatives and cough syrup.

There was a system in place for the destruction of medicines and we saw that records were kept. We noted the clinic room was predominantly used by the nurses, the area manager, new manager and administrator whenever they needed to use the printer or access the electronic care planning system. We discussed storing the returned medicines securely in a locked cabinet, to ensure these medicines were not interfered with. The new manager commented that the home were in the process of reviewing the storage in the clinic room. We will review this at our next inspection.

We checked the storage and management of controlled drugs; controlled drugs are prescription medicines controlled under Misuse of Drugs legislation and include medication such as morphine. We checked the stock of three controlled drugs and found that it tallied with what was documented in the controlled drugs book. Two staff members had checked in new supplies and recorded the administration of any controlled drugs.

We noted that some people were prescribed medicines to be taken 'as required'; this meant they were prescribed to be taken when the person needed them. When people receive support to take their medicines staff need guidance to explain the circumstances when the medicine should be given, so a medicine protocol is developed for each 'as required' medicine a person takes. A protocol is therefore a list of written instructions that states what the medicine is for, the correct dose and how often it can be taken. Medicine protocols were now in place at Beech House Nursing Home.

We saw that people's medicated creams were stored in their bedrooms and applied by the care assistants. Application records and body maps to explain why, how often and where creams and lotions should be applied were kept in people's rooms and signed by the care staff. Creams and lotions that were in use had the date they were opened written on them; this is important as some medicines expire a certain time after they are opened.

During our tour of the home we noted three potential safety hazards. On the first day we noted a hoist had been stored on the first floor outside a vacant bedroom on the corridor, this posed as a potential trip hazard. On the second day we also noted a hoist had been stored under the stairwell, again this posed as a potential trip hazard due to the hoist equipment sticking out. Furthermore, we noted two plastic boxes were being stored under the stairwell, this contained paper and cardboard. This storage in a stairwell contributes to combustible material load. In a fire, people would use the stairs and not elevator. Therefore, stairwells must not have combustible material stored due to the risk of a fire starting from the stairwell and resulting in the collapse of the stairwell.

We brought these concerns to the management team's attention; they ensured the boxes were stored in a more appropriate location, but commented that storage at the home was difficult due to a lack of space.

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

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included mobility, nutrition, maintaining independence, continence, sleep / rest, communication, medication and emotional / psychological care. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

We found the home was clean and tidy. This included communal areas, in people's rooms, in bathrooms and toilets and the equipment people used. However, we noted one bedroom did have a malodour due to the continence issue of the person who lived there. We discussed this with the new manager who confirmed they were working with the person to ensure they used the toilet during the night. The domestic worker we spoke with could explain the daily and weekly cleaning schedule and described how rooms were deep-cleaned when people left the home. This meant that the home was clean which helped keep the people safe from infections.

We saw that the local authority NHS Trust's infection control team had completed a recent audit in February 2017 and the service had been rated 65% compliant overall. At our inspection the home was planning to install a sluice into the bungalow, we found this work had been completed. We also saw some of the actions that had been identified in the audit had already been completed, and the new manager was in the discussion with the provider to provision the installation of a deep sink unit with hot and cold water, in a dedicated room for the decontamination and disinfection of domestic cleaning equipment. This meant that there were still work outstanding for the home to reduce the risk of infections spreading, but the management team were confident these areas would be actioned in a timely manner.

We found policy and procedures were in place for infection control. Training records seen showed that a 20 members of staff were provided with training in infection control, however the further 11 members of staff

needed to undertake this training. We saw monthly infection control audits were undertaken which showed any issues were identified and acted upon. We reviewed the systems in place to help ensure people were protected by the prevention and control of infection.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse to the registered manager. Care workers could explain the forms of abuse that the people using the service could be vulnerable to. All care workers we spoke with said that they would report any concerns to the registered manager. We viewed the homes training matrix and found there was still a high number of staff who had not yet completed this training, with 22 out of the 31 staff requiring this essential training. The new manager confirmed this training would be reviewed to ensure all staff have are trained in this area. Referral details for safeguarding concerns were clearly displayed in the house foyer. This meant that staff understood their responsibilities in terms of safeguarding and people were kept safe.

During the inspection one staff member provided us with concerning information about the practice of one of their work colleagues. We informed the management team of this disclosure, who immediately begun an investigation. On the last day of our inspection the area manager informed the inspection team they were also in the process of carrying out an investigation into the conduct of three staff members, we will review the outcome of this investigation once concluded.

As part of the inspection we checked the accidents and incidents that had been logged at the home since the last inspection. Details of accidents or incidents were recorded and kept in people's care files and notifications had been sent to the Local Authority and to the Care Quality Commission as appropriate. This meant that accidents and incidents were recorded and reported by the home.

At the last inspection we raised concerns about the lack of personal emergency evacuation plans (PEEPs) for all people. At this inspection we checked the systems in place to protect people in the event of an emergency. We found that PEEPs were in place for all people who used the service and a copy was kept in the staff office. These plans detailed if a person was independently mobile or what support they would require to evacuate the building during the day and at night. This meant information was available for the emergency services in the event of the building needing to be evacuated.

We looked at the records for gas and electrical safety and manual handling equipment checks. All the necessary inspections and checks were up to date. A detailed emergency plan was in place in the event of a systems failure or other emergency situation and there was a continuity plan for the house and for the bungalow. The home had records of internal checks on aspects such as water temperatures, the lift, emergency lighting and hoists. We found that effective systems were in place to protect people from harm or injury in the event of a fire. The fire alarm, smoke alarms and emergency lighting had been inspected in March 2017 and there was a schedule of regular fire drills, during which the maintenance person spoke with staff about fire safety and the safe evacuation of people.

There was a sled for use when evacuating people from the first floor of the house and the registered manager said staff had been trained to use it.

Inadequate

Is the service effective?

Our findings

We looked at records in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

Some of the people living at the home who lacked mental capacity had complex health care needs which meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that capacity assessments for DoLS had been done and applications for DoLS had been made by the service to the Local Authority for the people who needed them. During the inspection we spoke to a health professional who was assessing a person's mental capacity, they commented, "I feel the home are making appropriate DoLS referrals, I don't have any concerns."

At the last inspection we identified people as lacking mental capacity and we found that capacity assessments for all other aspects of care had not been done. Some people's care files contained a basic mental capacity assessment completed as part of the admission process but this had never been updated since they moved into the home and was not comprehensive. At this inspection we found the service had made some improvements in this area and were now ensuring the mental capacity assessment covered all areas. However, we noted from one person's care plan they were living with dementia and the person's Lasting Power of Attorney (LPA) for health and wellbeing were signing consent forms on this person's behalf. We noted no mental capacity assessment had been undertaken since this person moved to the home back in May 2014, and therefore the home could not determine at this stage if the person lacked capacity. We discussed this person with the new manager and they were unsure why this person had never had a mental capacity assessment undertaken, and commented that the one of the nurses will carry out a mental capacity assessment as soon as possible, and ensure a DoLS application is made at the same time if this person is deemed to lack capacity for care and treatment.

Under the MCA a relative cannot give consent on behalf of a person who lacks capacity to consent themselves. The only exception is if the relative or representative has been granted a LPA for health and wellbeing. In the absence of that, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. Depending on the situation, it does not have to be too formal. We discussed this issue with the management team during the inspection and they confirmed they would be reviewing all consent forms in people's care plans as they accept they misunderstood the requirements of the MCA.

During the last inspection, the previous registered manager told us that some MCA/DoLS training had been

carried out but that none of the current care staff working at the home had received the training, furthermore we found staff knowledge on the MCA and DoLS was not sufficient. As part of this inspection we asked staff about their knowledge of MCA and DoLS. Whilst some staff could explain what DoLS involved, most of the staff did not understand MCA and the requirement for capacity assessments to establish people's ability to consent to care.

We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were not always being followed correctly. For example, prior to our inspection we were contacted by a person's relative that they were concerned that their family members DNACPR had not been followed recently when the person became unwell and commented that they were misinformed by staff that they received lifesaving cardiopulmonary resuscitation (CPR). The relative of this person was informed by the homes nurse that a DNACPR was once in place, but this could not be located. At the time of these concerns the Care Quality Commission (CQC) put in a safeguarding referral. We looked into this matter during our inspection and could not find evidence that the person received lifesaving cardiopulmonary resuscitation (CPR) from paramedics or care staff when they became unwell. Although records were unable to confirm the family members concerns that CPR was attempted, there was a possibly of unwanted CPR attempts due to the missing DNACPR. The home subsequently arranged a meeting with this person's family and GP to ensure a new DNACPR was in place.

During the inspection we also came across another person who had a DNACPR recorded on their care plan, however we were informed by the nurse on duty they didn't have a DNACPR in place and this had been incorrectly recorded on the person's care plan. After making further inquiries we found a hospital DNACPR in this person's care plan that was only valid while they were in hospital. This confusion had caused one of the staff members working at the home to incorrectly record this information in the person's care plan. Subsequently, this person sadly passed away, and did received CPR, but this wasn't successful.

This meant the home failed to ensure decisions about people's DNACPR were correctly recorded and communicated to the staff team. Therefore this potentially left people at risk of receiving inappropriate or unwanted attempts of CPR as they became unwell.

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

The registered provider had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Staff had received supervision and appraisals to support them in their roles. Staff, with the support of their line manager, identified their professional needs and development and took action to achieve them, although we noted supervisions did not happen as often as stated in the provider's policy.

The previous registered manager was also a clinical nurse, and undertook a number of clinical supervisions for the nurses. However, during this inspection we discussed what new arrangements were in place for clinical supervisions. We were informed by the area manager they had arranged for another clinical manager from the providers other home to carry this role out. We will review this at our next inspection. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. It is a time nurses to think about their knowledge and skills and how they may be developed to improve care.

A four week rolling menu plan was in operation at Beech House Nursing Home which offered people a choice of menu and was reviewed periodically. We noted that a notice board was available outside the kitchen area; however the daily menu was not on displayed on this.

We asked people about the food that was served at the home and the feedback was varied. Comments received included, "I have sandwiches or omelette at lunch time; always a good choice. Can always fall back on an omelette", "The food is great, can't grumble", "The food is very good", "You don't choose (meals) you get what you are given. If you don't like it you just leave it, don't get anything in its place", "On St Patrick's Day we had a good afternoon. We had Irish stew, which was rotten. Nice desert and we had a glass of Baileys each, Irish coffee and records off the internet", and "St Patrick's Day the food was terrible. It should have been nice and special."

We received differing views from people's relatives, comments included, "The food's good, they seem to cater for all needs", "He (resident) never has a glass of water by him", "I think the food is adequate", and "The food is average at best."

Dining tables were set with place mats, cutlery and napkins. The main meal of the day was at lunchtime; people were asked in the morning if they would like the meal on offer and could request an alternative if they did not.

Lunchtime was a quiet occasion; there were varying degrees of interactions between people and staff. People were able to choose who they sat with and some people enjoyed their lunch together in the designated dining room that was the conservatory, or in their room. Staff were observed to be rushing around and at times this appeared chaotic. During our observation we noted people received their meals at different times with one person being served their meal at 1pm and the last person waiting until 1.35pm. On occasions we noted visiting relatives pouring drinks for people because staff were not always available. On another occasion we observed two residents arguing with each other, again staff were not present to deescalate this situation, a visiting family member intervened who was sat on the same table.

Part way through lunch time meal a member of staff observed a person becoming unwell when they were just about to support them with their food, the staff member quickly called for the nurse who then assisted this person back to their bedroom. Shortly after this intervention this person sadly passed away. The cause of this person's passing is currently being looked into by the coroner as this person had a DoLS and a DNACPR in place. The new manager will provide an update once this has been investigated.

The most recent local authority food hygiene inspection was in December 2016 and Beech House Nursing Home had been awarded a rating of 3 stars. The provider was given actions they needed to address by the Food Standards Agency (FSA), such as replacing the flooring. During the inspection we spoke to the cook at the home confirmed a number of the actions had been addressed already and the home were eager to have another FSA inspection so the rating could be improved.

The regular cook at the home was not available during our inspection. We noted that the cook working on the first two days of the inspection also had a dual role at the home as a domestic staff member. The cook was aware of the people using the service who had specific eating or nutritional needs, such as diabetes and swallowing difficulties, and knew how to prepare foods for them.

On the third day we noted the activities coordinator worked as the cook. Shortly after our inspection we received the homes training matrix, which confirmed both staff members had not received any training on food hygiene. The new manager confirmed they were in discussion with the area manager to ensure this

training was provisioned.

Some people's care plans required that their food and fluid intake had to be recorded due to concerns about weight change or medical conditions such as diabetes. The recording of food and fluid intake is useful for care staff and dieticians to understand why people may be losing or gaining weight. For this reason it is very important that that the types and quantities of foods and fluids people consume are recorded and that fluid totals are calculated for each day.

During our last inspection in December 2015 we found there was poor monitoring of people's food and fluid intake, which put people at risk. We found during this inspection, even though some improvements had been made, fluid and food charts for people who required them were still not being completed accurately. For example, fluids charts were difficult to view as they were not stored in any particular order, and some entries had not been completed. We found three people's fluid charts only recorded small amounts of fluids that had been taken, we discussed this with the nurse who informed us the person was having enough fluids, but the poor recording from staff have not evidenced this. The nurse told us sometimes staff 'forget' to fill them in. This meant that people may be at risk of dehydration, weight loss or weight gain as their diet was not being monitored.

This is a breach of Regulation 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the care files that the people using the service had access to a range of healthcare professionals. People had seen GPs, opticians, podiatrists, a dietician, and people receiving residential care had seen district nurses.

During the inspection we observed on one occasion when a person using the service told care workers they didn't feel well. We noted the nurse on duty was informed and they took observations, such as blood pressure and pulse rate, which were then recorded. The person was reassured and spoken to with empathy until they felt better. This showed that care workers responded appropriately when people said they felt unwell and that individuals' health was being monitored.

We looked at records of training and saw training had been provided in areas including moving and handling, safeguarding adults, moving and handling, infection control, fire safety, food hygiene, health and safety, first aid and dementia awareness. However, we found there were a high level of gaps in the majority of training the home provisioned. For example out of the 31 staff listed on the training matrix, 22 (70%) had not completed safeguarding training, 25 (80%) had not completed dementia awareness, 27 (87%) had not completed mental capacity act and deprivation of liberty safeguards training, and no staff were listed as having received training in challenging behaviours.

There were also gaps in the provision of training in clinical procedures to nursing staff. Only two members of nursing staff working at the home at that time was indicated as having received training in catheter care, and from the training matrix it indicated no training for pressure management care had been completed by any of the nurses. It was acknowledged that some of the nursing staff had only been recently recruited. However, the provider was not able to explain how they ensured nursing staff were competent in these areas.

At the last inspection we noted the home had yet to implement the Care Certificate which started in April 2015; the Care Certificate is a set of standards against which the competency of staff new to health and social care can be assessed. It is not a legal requirement but if homes choose not to use it they must be able

to demonstrate how their own induction meets the needs of both people and staff. At this inspection we found no evidence the care certificate had been undertaken by any new staff, however we found the home were providing people with access to undertake level national vocational qualifications (NVQ).

We spoke with three members of staff about their induction at the start of their employment at the home and they said it was very good, however training was not always forthcoming. The induction had involved instructors and training videos and included all the mandatory training aspects, such as moving and handling, fire safety and infection control. The induction also required shadowing of senior care workers and new staff had to be assessed and signed off as competent before they could work independently. Comments from staff included, "I feel supported, I enjoy my job", "I have not done catheter training yet, I have been here a year" and "I enjoy training, but we don't get it that often."

The gaps in training of staff would mean the provider could not be certain that staff were adequately supported and skilled to provide effective support to people living at the home. The issues in relation to the competence and training of staff were a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the home there was little evidence of any attempts to create a dementia friendly environment. We saw a few picture signs and photographs of some occupants on doors, which were quite small, but little else. Nevertheless we did not see any people wandering about lost during the day of inspection. A member of staff informed us that there were plans to install dementia friendly signs to improve the environment and help people with orientation around the building.

We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

We saw from observation and from support plans that the people who used the service had complex health needs which required input from a range of healthcare professionals. In the four support plans we looked at we noted individuals had been seen by a range of health care professionals, including GPs, opticians, dentists, a physiotherapist, chiropodists and other specialist healthcare professionals. Visits were recorded in the daily records for each person and upcoming appointments were recorded in their care files.

Requires Improvement

Is the service caring?

Our findings

We asked the people using the service if the staff were caring. Comments received were positive, they included, "On the whole they are very good. You couldn't wish for nicer girls", "We are all looked after well. The staff are lovely" and "They (care staff) are treating me very, very well. I'm doing alright. Can't complain."

During the inspection most of the interactions we observed between care workers and the people living at the home were warm and friendly. We did, however, observe occasions when people's privacy and dignity were not promoted. For example, during the morning of our first day we observed two care workers who were supporting people with their moving and handling having a loud conversation across the room with each other instead of speaking with the people they were assisting. We noted this was the theme throughout our inspection, due to staff constantly rushing to complete care tasks and shouting out to each other who needed supporting next. This showed that care workers did not always respect the privacy and dignity of the people they supported and the environment did not lend itself to this.

People told us the staff were kind and caring. However, all the people we spoke with said the staff were always rushed and didn't have chance to just sit and have a chat. Comments included, "They work very hard here, very little time to sit down and have a chat", "They (staff) are rushed of their feet" and "Nice people, but they have very little time to sit down and have a cup of tea with me."

We did see some positive interactions between staff and people when direct care was being provided. For example, one staff member supported a person with their morning medicines in their bedroom. They made sure the person was happy with their care and had friendly conversation while the care was being provided. Two staff members were observed on a number occasions supporting people with hoist manoeuvres, this was done safely and the staff interacted with the person in a kind and reassuring manner. However, we saw staff were often very rushed and did not spend time sitting with people when care was not being provided. We saw staff rushing from one room to another not always smiling or acknowledging people as they went by. Staff said they felt there was a focus on tasks and said they knew they spent very little time just sitting and getting to know people.

This meant people did not always receive caring interactions with staff and people were not always engaged or re-assured when support was provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people and their relatives had not always been involved in the planning of their care. At this inspection we found this was still the case. We saw the electronic care files contained limited information about people's personal history or likes and dislikes. This meant the staff did not have the background information to talk with people or support them if they had some memory loss, especially when they first moved to the home.

The feedback we received during the inspection was varied in relation to people and their relatives being involved in the care planning. Comments received included, "I don't think I have had a review, but I'm sure

the home know what they are doing", "I don't remember being involved in any care plans", "I never saw the discharge notes from my hospital stay. I would like to sit down and discuss the care plan, I don't feel part of it" and "We should be involved in mum's care planning, but we never get the opportunity, I do hope this changes." This meant that people's involvement in their care planning, and that of their families with the person's permission, was not consistent and people were not always consulted on aspects of their care that could affect them.

This was a breach of Regulation 9 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we received negative comments about the laundry at the home. At this inspection we found some improvement's had been made, but people's relatives still felt the laundry needed improving. Comments included, "The laundry situation is stable for the time being, I label all my mums clothing, that has helped", "There has been some improvement, I don't think the home has an easy job" and "I take all my [person's name] home, it's not that I don't trust the home I like to still feel responsible for [person's name] care." We discussed the historical issues of the laundry with the new manager who felt the service had made a number of improvements in this area.

We saw that people looked well cared for. They were dressed in clean clothes and their hair had been brushed or combed. We asked people if they were happy with the support they received with their personal hygiene. However, one relative was concerned that their relative had not received a shower or bath for over a month. We discussed this person with the new manager who acknowledged the relatives concerns and commented that the staff have attempted on numerous occasions to assist this person with their personal care, but they declined and at times presented challenging behaviours towards staff. The home felt this person now required specialist dementia care and commented they were attempting to assist the relative with this process of having the person reassessed.

We saw that people's bedrooms had been personalised with their own furnishings, ornaments and pictures; they were also clean and tidy. This showed us that people were encouraged to individualise their rooms and that care workers respected people's belongings.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so. We saw that no one was accessing these services during our inspection.

We asked about the end of life care that was provided by the home. End of life care relates to people who are approaching death; it should ensure that people are as comfortable as possible and can make choices about their care. We were informed by the new manager no person at the home was receiving end of life care at the time of our inspection. In the new electronic care plans we found there was a section for people's future wished to be recorded. Out of the four care plans we viewed, we noted only one end of life care plan had been completed. The new manager commented this would be an area they wanted to develop in the forthcoming months, we will review this at our next inspection.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found care files were not consistent; for example they contained information that was duplicated and were always not up to date. At this inspection we found improvements to care plans had been made. We reviewed four people's care plans; the care plans were written and stored on an electronic system called Care Docs that was introduced just after the last inspection. We found that people had multiple assessments for different areas of their care. They also included a person-centred dementia care plan section which reflected how dementia affected the well-being of the person living with it. As already mentioned the care plans did not always capture people's historical information and this needed to be improved to ensure people's care plans were person centred. We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information.

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. This had been done wherever the person was; this included their own home and other care settings such as respite centres or hospital. We looked at the pre-admission paperwork that had been completed for people currently living in the home and could see that the assessments had been completed.

We saw that the on-going review of the risk assessments and care plans led to referrals to other services such as tissue viability and hospital clinics in order to ensure people received the most appropriate care. We saw evidence of correspondence within the care plans which confirmed this.

We were informed by the management team that staff received training on to use the new computer system. However, we found the home only had access to one computer that stored people's care plans. At times during the inspection we found staff needed to use the computer, but it wasn't always available due to visiting professionals and the management team accessing the care records. The area manager confirmed the home was looking into this matter further to see if they could provide a second computer available for staff to use.

At the last inspection we received negative comments in relation to the activities on offer at the home. At this inspection we found activities were still not effective and the provider had not done enough to keep people socially stimulated.

The home appointed an activities coordinator who worked three days a week. The activities coordinator role included, supporting people to plan outings, there was knit and natters sessions, and sing along. The activities coordinator also provided 'one to one' time with people. We found the activities coordinator worked three days a week on activities, and therefore the remaining four days no activities were planned at the home.

People were very positive about the activities coordinator; however people felt more activities were needed at the home. Comments received included, "I can't get to church anymore and there is no service here, I would like that", "I watch TV and sleep in the chair; nothing else to do", "Not much going on, apart from the

TV" and "[activities coordinators name] is great, but she is only here a few times a week, we need more activities to stop us from going mad."

One member of care staff we spoke with about the activities on offer at the home said, "We do our best to interact with residents, but as you can see we are rushed." Another care worker agreed with this sentiment. Two other members of care staff described how they had to prioritise people's personal care and that there was no time left for them to provide activities.

During the three days of inspection we saw no involvement of people who preferred to stay in their rooms or who were nursed in bed in any activities or interactions other than those related to care interventions.

Our observations and people's records showed that daily activities and stimulation was not available to everybody living at the home. This was echoed by the people we spoke with, their relatives and care workers.

The lack of meaningful activities at the time of our inspection was a continued breach of Regulation 9 (a), (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a system of reporting and responding to complaints and concerns in place at the home. Information on how to make a complaint was located next to the visitors signing in book and there was a framed cartoon on the wall in the reception. We asked people and their relatives if they had ever made a complaint. One person told us, "I have complained about the small pads, the bed is always wet. I have had one or two large pads since. What can I do, argue in the middle of the night?", "The new manager seems approachable and will listen to any complaints we have" and one relative said, "If I say anything (to complain re care or lack of communication), they are funny with me." We brought this concern to the area manager who commented that they would arrange a meeting with this person to discuss further.

We checked the complaints file and noted that relatives that had made a complaint either verbally or by email had been asked to make a formal written complaint. We saw that written complaints were investigated promptly and in depth by the last registered manager and documentation was kept which showed the date each complaint was deemed to be resolved.

Inadequate

Is the service well-led?

Our findings

The service had a new manager in place who was in the process of registering with the Care Quality Commission (CQC). The new manager had only been in position at the home since January 2017, and was supported by the area manager for a number of weeks until they were comfortable with systems in place at the home.

We asked people and their relatives about the management at Beech House Nursing Home. Comments from people included, "The new manager seems nice, I am still getting to know her", "We have a new one (manager) she is very nice", and "We have a new manageress; she appears to be very, very nice, hope she won't be a disappointment." Comments from people's relatives were also positive, they included, "The new manager appears approachable and much more professional", "She doesn't have an easy job, but I hope they can get the staff levels sorted" and "[Manager's first name] is very nice, she always says hello."

We also spoke with staff about the management at the home. One care worker said, "The new manager is spot on, she is firm but fair", "We are still getting to grips with the changes, but they seem positive so far" and "The management team are generally approachable, but they have been aware of the staffing issues for a while and we are still struggling."

At the last inspection we found the information held within the home and associated audits did not correlate. Information was contradictory and did not identify risks and issues as effectively as they could. As a consequence, actions to improve the service may not be identified. At this inspection we saw a number of systems and audits had been introduced to allow the new manager to effectively monitor the quality and safety of the service. There were a wide range of audits and checks carried out including, infection control, the environment, medicines, and accidents and incidents. We saw that audits had been completed regularly, however areas of improvement that had been identified were not always actioned. For example, monthly medicines audits picked up on similar discrepancies we also identified during our inspection, but no action had been devised to remedy these issues. We also noted a number of health and safety issues that had not been captured in any of the audits. We found a comprehensive training matrix was only implemented when we asked for the data, therefore the registered provider did not have a clear overview on what training and development staff needed.

The area manager carried out frequent 'compliance visit record checks' and made a record of their findings, with what action was needed to rectify any issues that had been identified. We looked at the most recent compliance visit, which were carried out over a number of days in January and February 2017. The compliance visits had not identified areas of shortfall we picked up during this inspection in relation to in inadequate staffing levels, poor recording of people's DNACPR, training shortfalls, and a lack of activities.

People were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed. When we checked the records for three newly recruited members of staff we saw that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with

vulnerable groups.

Two personnel files we looked at all contained a copy of the original application form and two written references were obtained before the staff member started work. There was also a record of the interview on file and we could see that any gaps in employment had been explored. However, one staff member's personnel file we looked at did not contain a reference from their previous job role. The two references captured were not acceptable due to both being classed as character references. Furthermore, we noted there had been no discussion to why the applicant did not provide their reference from their previous job role.

Over the past two inspections of this service we have found several breaches of the regulations since 2015. We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

We concluded this was a breach of Regulation 17, (Good governance); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a number of surveys and questionnaires were completed by people with an interest in the home. We found the surveys were not monitored and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided then the feedback has not served its purpose.

Staff meetings were held for care workers with the registered manager on a monthly basis. We saw that meetings were minuted and care workers we spoke with confirmed they attended them.

We checked the notifications that we had received from the home for Deprivation of Liberty Safeguards application approvals, deaths, safeguarding incidents and serious injuries, all of which the service is legally required to report to CQC. They correlated with the records we saw at the home. This meant that the home was reporting to CQC in line with legal requirements.

The new manager held meetings with the people at the home and their relatives in order to find out what they thought about the service. The last meeting was held in February 2017 and was well attended. This meant that the new manager listened to people and their families and had put a system in place whereby people and their relatives could discuss issues or provide feedback at times that suited them.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's involvement in their care planning was not consistent and people were not always consulted on aspects of their care that could affect them. and People's involvement in their care planning was not consistent and people were not always consulted on aspects of their care that could affect them.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People did not always receive caring interactions with staff and people were not always engaged or re-assured when support was provided.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We observed a number of manoeuvres that were carried out safely, however on the second day of our inspection we observed one staff member supporting a person with their wheelchair in an

unsafe way.

and

During our tour of the home we noted three potential safety hazards that were not picked up on by the provider.

and

Decisions about people's DNACPR were not correctly recorded and communicated to the staff team. Therefore this potentially left people at risk of receiving inappropriate or unwanted attempts of CPR as they became unwell.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	We found there was poor monitoring of people's food and fluid intake, which put people at risk.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Over the past two inspections of this service we have found several breaches of the regulations since 2015. We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.

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 By speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the home, it was clear that whilst people's basic care needs were largely being met, there were not enough staff to support all of the people as they needed. In addition, staff did not have time to provide engagement and stimulus to the people living at the home. and The gaps in training of staff would mean the provider could not be certain that staff were adequately supported and skilled to provide effective support to people living at the home.

The enforcement action we took:

We served an Notice of Proposal to cancel the providers registration. The provider submitted representations that were not upheld, therefore a Notice of Decision was adopted the cancel the providers registration.