Daughters of Mary Mother of Mercy

Waverley Care Home

Inspection report

14-16 Waverley Road
Sefton Park
Liverpool
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Tel: 01517274224

Date of inspection visit:
01 March 2017

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 01 and 08 March 2017 and was unannounced.

Waverley Care Home is located near to Sefton Park Liverpool and is close to local amenities such as cafes, restaurants, shops and public transport links. There is on street parking and a garden to the rear of the property. It provides residential and nursing care for up to 20 people; some people lived with dementia or enduring mental health needs. At the time of our inspection, there were 13 people living in the home.

At our inspection on 19 August 2015, we found that there were breaches of Regulations 11,12,15 and 17 of the Health and Social Care Act 20108. These related to consent, medication administration, premises and equipment and good governance. When we re-visited on 23 March 2016, we found that progress had been made and believed that this progress would continue. However, at this inspection we found that insufficient progress had been made and the provider was not meeting the requirements of the Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The service required a registered manager. 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. The home had a registered manager who had been in post for just over a year, at the time of our inspection.

Some people had not been appropriately assessed or regard taken of their cultural and language needs. This meant that the person was unable to communicate little with other people and had to conform to western styles of eating.

The care plans we looked at gave details of people's medical history and medication and information about the person's life and their preferences. People were all registered with a local GP and records showed that people saw a GP, dentist, optician, and chiropodist as needed. Some information in the care plans however was not clear and the records were difficult to follow.

The provider had partly complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and its associated codes of practice in the delivery of care. This was because a person's communication needs had not been met and therefore an assessment of their mental capacity or a best interest meeting might not be a fair representation of the person's ability to make decisions. Staff we spoke with had minimal understanding of what this meant or what their obligations were in order to maintain people's rights. Some people were deprived of their liberty unlawfully because they did not have free access to leave or re-enter the home.

People who used services were not protected from unsafe care because of poor staff recruitment checks, inadequate staffing levels, the lack of robust and regular risk assessments and inadequate checks related to

the safety of the premise's. People were not cared for by suitable and appropriately trained staff. People told us they felt safe with staff and this was confirmed by the relatives we spoke with

People received sufficient quantities of food and drink and had a choice in the meals that they received. Menus were flexible and alternatives were provided for anyone who didn't want to have the meal on the menu for that day. People we spoke with said they always had plenty to eat. However, mealtimes were set and drinks available only at certain times in the day. This meant that they could not access food or drinks other than water, when they wanted to.

The staffing levels were seen to be insufficient at times to support people and meet their needs, especially in relation to activities during the day. We observed that some staff did not interact or talk with people through much of the time we were in the home.

Some risk assessments had being revised, but some were very out of date. Accident and incident reporting was poor.

The medication storage and administration was appropriate and we found the stocks of medication tallied with the records.
There had been an administrator in the home who had left the service about six months previously. The registered manager was often busy performing the role of registered nurse in the home and records showed that there had been few meaningful audits of the service to ensure quality. Other records were haphazard and difficult to follow. This meant that the systems in place to identify and mitigate risks to people's, health, safety and welfare, were ineffective.

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.

Records did not demonstrate that recruitment processes were robust.

The building checks were inconsistent and risk assessments conducted by experienced external agencies had not been followed or followed up.

Medication storage and administration was found to be correct.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had not always followed the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards.

Most people said that the food was good, but we found that there were set times for eating and drinking. There were no opportunities for people to be independent where they could, in respect accessing food and drink.

Some staff were difficult to communicate with because of language and accent difficulties. This meant we could not effectively find out about their knowledge. It also meant that people using the service may have found it difficult to communicate with staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were treated with respect and their privacy was respected.

People who used the service had mixed views on staff and their caring abilities.

Mostly, staff did not engage with people or interact with them. This did not show that staff cared about people's emotional well-

being.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not all been reviewed or updated. They were not person centred and were confusing.

There was a schedule of activities but we saw that the activities co-ordinator also was asked to assist some people to attend external appointments. This left the home without any activities to do and people told us they were bored.

Is the service well-led?

Inadequate

The service was not well-led.

There were insufficient resources made available to allow the registered manager sufficient time to effectively manage the home. This meant that people who lived in the home could not be assured of safe and effective care.

Quality assurance systems and auditing processes were erratic or incomplete. Because of this, issues we found during our inspection had not been identified or addressed.

The registered manager told us that they were committed to improving the service.

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

This inspection took place on 01 and 08 March 2017 and was unannounced.

The inspection was carried out by one adult care inspector, a specialist nurse advisor and an expert by experience who had experience of caring for someone who used this type of service.

Prior to the inspection, we reviewed our own records to check whether there were any issues reported about the service and to check that statutory notifications required by law to be sent to us, had been submitted. Statutory notifications need to be submitted to CQC when certain events occur, such a safeguarding allegation or concern, a death or serious injury, or some event which stops the service. We looked at the information contained on the Healthwatch Liverpool website. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We had not received any information of concern about the home prior to our visit.

We looked at and case tracked the records for four people. We talked with seven people who lived in the home, two relatives and six staff members including the registered manager. We also looked at seven staff recruitment files and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

We asked the people living in the home, what made them feel safe. One reply was, "There's always someone here". Another person told us, "I don't know, I just feel safe".

When we asked relatives if they had any concerns about safety they all told us they didn't. One replied, "None whatsoever".

Everyone we spoke with told us they felt safe, although two people told us that one particular staff member shouted and screamed at them. One of these people said, "I have terrible trouble with one staff member who tells me to do this and that. They tell me I have to be out of my room by certain times. They shout and scream that I have to be out of here for lunch".

Another person told us, "[Name] is quite nasty to me. They scream and shout at me. If I use the lift they tell me I should walk, but I have difficulty walking far. They are not nice; we come for our lunch but this staff member says don't come before 12. It's only them who shouts".

We checked our own records prior to the inspection and saw there had been no safeguarding incidents reported to us since the previous inspection in March 2016. The registered manager confirmed there had been no safeguarding incidents. We discussed this with the registered manager who told us that no one had mentioned anything to them about this staff member shouting at them. We advised them that this was an alleged abuse and the registered manager told us they would report the matter to the local authority safeguarding team and submit a statutory notification to CQC. This was done immediately.

Since our previous inspection, new recliner beds had been purchased for use throughout the home, but on this inspection we found there were still safety concerns with the environment and equipment.

Water temperatures had not been accurately or systematically recorded. These are required to check that hot water is not too hot to causes scalding and to check that all water is at the correct temperatures to prevent the occurrence of Legionella bacteria. The last legionella risk assessment had been carried out by a reputable firm in March 2013. This had recommended a review to be carried out in March 2014, due to the high risk of Legionella identified in the risk assessment. We found that this had not been completed and we could find no further evidence that any others had been done after that date. Other recommendations stated in the risk assessment had not been implemented.

The electric bath on the ground floor had not been repaired as required. It had a loose wire from it which could present a trip hazard. There was still the potential for slips in the communal toilets as the water pressure from the cold tap was strong and splashed over the rim of the small hand basin onto the floor. A radiator guard on the first floor was loose which made it a risk of falling. Window restrictors had been flitted throughout the home but we found one on the first floor corridor and one on the second floor corridor, which were not in use and had been left un-secured. This meant there was a risk that people or staff might fall from the windows. Where vulnerable people have access to window openings large enough to fall

through and at a height that could cause harm, such as above ground level, windows should be restrained and prevented from opening more than 100 mm.

The emergency lighting was recorded as checked on 09 May 2016 but there was no evidence to suggest that further checks had been undertaken. We found that records were erratic in relation to fire checks. There were conflicting records of when and what checks were done. We found that equipment such as hoists or the electric bath was not checked at all. This meant that the provider could not be sure they were safe and suitable for use.

In the kitchen some tiles needed to be replaced or re-grouted and this presented a hygiene hazard. One of the freezers in the kitchen was recorded as frequently running at temperatures between -9 and -12 C, when it should have had a temperature of at least -18C.This meant that frozen food was not being stored at the correct temperature in this freezer which might lead to its contamination or deterioration. Some routine cleaning and maintenance processes had not been carried out, an example was that the kitchen had its last full extraction duct cleaned on 06 March 2014. Non-domestic kitchen extract ductwork is sometimes referred to as grease ducting, and should be cleaned and maintained to prevent flammable grease from either catching fire when it passes through an adjacent area or, if the grease itself is already alight, causing a fire to start within the adjacent area by radiant heat. The next clean was due 6 months after that date, but we found no record that it had been done.

Risk assessments had been completed for some aspects of people's lives, but we found these had been haphazardly produced, acted upon or reviewed. We did see some examples relating to speech and language therapy (SALT) risk assessments.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008, relating to safe care and treatment. This was because the premises' safety had not been checked, people were left on their own without a call bell and there were insufficient staff. Risk assessments had not been completed and staff were not recruited safely.

We discussed our concerns with the registered manager. We have since been sent a document which indicates that many of these issues have been addressed.

We looked at staff rotas for the previous two week, the week of out inspection and the one being planned for the following week. There were usually three support workers and one nurse on duty throughout most of the day. One staff member told us the home was now fully staffed. However, we noted that the registered manager was often rostered as a nurse and that if the activities co-ordinator was out of the building, people were left alone in the communal areas. We asked all the staff during our inspection if they thought there were enough staff on duty. Staff comments included, "Normally, we have three in a morning, but someone rang in sick". Another confirmed this. A third staff member said, "The staff are trying their best, they do what they are supposed to do". We saw that people were often left on their own in the lounge or dining room. Many did not have access to a call bell. Some people told us they were bored because there were not enough staff available to provide activities for them.

We asked people living in the home if staff were able to sit and talk to them between tasks. We received a varied response. An example was that one told us, " No, they're very busy" and another said, "When they've got a bit of time". A third said, "They come and sit and have a chat with me". We observed that there was very little conversation between the staff and people living in the home during our inspection.

Many staff had not had recent specialised safeguarding training recently and we saw that training was

planned for 2017. One staff member told us, "I've been on courses, I'm responsible. If a residents not happy I'd ask questions". Another said, "It's the protection of vulnerable adults. I would report anything to the nurse in charge or the manager, but I've never seen anything"..

We looked at the medication administration record (MAR) sheets for the people we case tracked and they all tallied with the medication stored and were clearly signed. We saw that medicines were in date, were stored safely and storage temperatures were monitored daily to ensure medication was stored at the correct temperature.

Most of the medication at the home was dispensed by the pharmacy was in blister packs. We saw that PRN (as required) medication and homely remedies being appropriately stored and recorded. We were told by the manager they had a contract with local pharmacy and that there were no delays between GP's writing new prescriptions and the pharmacy delivering medication to the home. We observed a medication round. The nurse wore a 'do not disturb' apron when administering the medication to alert staff and people what they were doing.

One person was fed through a percutaneous endoscopic gastrostomy, which is a tube is passed into a person's stomach through the abdominal wall, usually to provide a means of feeding and medication when the person cannot take medication or sufficient food through their mouth. (This is commonly known as 'peg fed' or PEG). The person's MAR sheets were clear with good evidence of reviews and interagency working. This was important because of the medication which might be placed in the tube. The nurses in the home had attended a specialist course which had been run by the manufacturer of the PEG equipment.

We checked that each person had a personal emergency evacuation plan (PEEPS) in place. PEEPS provide staff and emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. They assist emergency service personnel to quickly identify those most at risk, where they are most likely to be in the home, for example their bedroom location and the best method by which to secure their safe evacuation. We found that some people's PEEPS were brief and lacked sufficient information about people's needs and mobility. We discussed this with the registered manager who told us they would be re-written.

We found that some of the staff recruitment files had been reviewed, but found that in many it was difficult to find information in them. An example was that in two of the staff files we could find no right to work in UK documentation and some files had only one reference. We noted that many of the longer serving staff had not had their criminal records check (Disclosure and Barring Scheme or DBS) renewed. We could not find evidence in some staff's files that DBS checks had been completed at all. This meant that staff might not be suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

One person told us, "The doors are all locked, and they have a code to get in".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 was 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 (DoLS).

We checked whether the service was working within the principles of the MCA and whether any authorisations or conditions to deprive a person of their liberty, were being met. Some people who had mental health issues that may have impacted on their ability to make decisions did not have mental capacity assessments in place to show that their capacity to make specific decisions had been assessed. Their care records were also not up to date. There were six people who had been referred to the 'supervisory body' (the local authority) for DoLS assessments. However we did not see robust evidence that staff had followed the correct process to assess their mental capacity. There was no evidence that any best interest meetings had taken place with other health and social care professionals, family or friends involved in the person's care to ensure that any decisions made on the person's behalf were made in their best interests.

One person's first language was not English and they had little comprehension of the English language. In their care record we noted that a mental capacity assessment had stated they were, 'unable to understand, weigh up, retain or communicate the information given regarding their care'. The records also noted, 'requires an interpreter during major interviews. There was no evidence that a suitable interpreter had been made available for this person during the assessment of their capacity in order that they were able to understand and participate in their own assessment. We discussed this with the manager who confirmed there had been no interpreter used for the assessment

One person told us, "You have to ask to go in and out; it's [the front door] locked all the time". A staff member said, "Some of the residents aren't on DoLS and we give them the keypad number, but they forget". We discussed ways of providing people with the key pad number with the registered manager who told us they would consider alternative arrangements other than telling people.

The staff we spoke with about MCA and DoLS were not able to explain to us about what this legislation was or what it was for. Staff had received no recent training in MCA or DoLS . We saw this had been put on to the training matrix for 2017, but there was no date or staff identified to undertake the training.

These examples are breaches of 11 of the Health and Social Care Act 2008, relating to consent. The registered person must act in accordance with Mental Capacity Act 2005 in order to make sure people or

people acting on their behalf, are asked for their consent and that information about any proposed treatment must be provided in a way they can understand.

We found that there were no consistent processes in place to monitor training. The records we were shown did record that some staff had completed the Care Certificate in November 2016, but other training was erratically recorded and difficult to monitor. A training matrix was not provided for 2016 and the matrix for 2017 included an entry for a date in 2016, was sent to us which recorded one training session on PEG feeding, for nursing staff. The training sessions and spaces for 2017 had not been filled in and we did not see any training matrices for any other staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008, relating to the requirement for the provider to ensure that people's needs are met by suitably competent and trained or qualified staff.

The kitchen prepared most meals from fresh ingredients. It appeared clean and tidy, but there were some tiles which needed replacement or repair. It had attained three out of a possible five in food hygiene.

We saw that there was a varied menu and the kitchen staff told us they were able to cater for special dietary requirements and people's cultural needs. However, there was no evidence of people's cultural needs being met on the days of our inspection. Other staff we spoke with told us there was no provision for any cultural diets on the menu.

People were able to choose their main meals at breakfast time. There were alternatives available if they changed their minds. We asked about the food and one person told us, "It's alright, they ask you what you want beforehand. I had toast with tomatoes for my breakfast. Lunch will probably be fish, because it's Ash Wednesday". Another said, "It's good, I've no complaints". A third person told us about a fellow service user, "They have put weight on since they have been here".

We joined people for their lunch on the first day or our inspection and sampled the food. Tables were laid with place mats and cutlery but there were no condiments on each table. We found the food was bland and tepid in temperature. We discussed this with the manager who told us they would investigate the matter.

Drinks were available at set times through the day. One person told us, "No, they don't give out tea in the middle of the night". Another said, "I've never asked, but no, they stick to the hours". This meant there was lack of choice about when people were able to have a drink or snack. Within the communal areas of the home there was nowhere where they could regain some independence and have the facilities to make a snack or a hot drink. Some of the people were mobile and able to go out into the community and they told us they did go to cafes for a drink.

We asked people if were able to talk to the staff and able to understand them. One said, "There are various ladies who can converse in various languages". We heard only English being used, but sometimes the staff were difficult to understand and when we were speaking with the staff, three of them had difficulty understanding us.

Parts of the home had recently been refurbished. We saw that this work was on-going. Most of the wooden windows had been replaced with UPVC ones as well as most of flooring and some of the furniture. One person told us they did not have sufficient storage space and the registered manager has since told us this has now been rectified. People were able to personalise their rooms with soft furnishings, pictures and other belongings.

Requires Improvement

Is the service caring?

Our findings

Everyone told us they were treated with respect and their privacy was respected. One person said, "The staff care"; however, another told us, "They are never nice".

A third person told us that "All the staff, bar one, were excellent".

Some staff commented to us about the people living in the home. We found these comments to show evidence that people were not accorded the individuality, dignity or respect they were entitled to. One comment we received from a staff member was, "When we have finished feeding them". Another staff member said, "It's [activities] from 3 p.m. for an hour and then we start taking them to the toilet before they have their tea at 5 p.m." These comments would be used to describe supporting a young child rather than an adult.

We saw that on the few occasions we observed interaction between the staff and people, some staff were caring. However, we observed that on most occasions staff did not talk with the people they were supporting, giving no explanation for what was happening or about to happen.

People were supported to attend healthcare appointments in the local community.

There was a lack of imagination and resource devoted to people's cultural needs, with a minimum of twice yearly trips to one person's preferred cultural community.

There was also little evidence that the home's staff had engaged with, or involved people with developments in the home, such as the redecoration programme.

People's independence was not promoted as there were no opportunities provided by the home, for people's life skills to be promoted and maintained..

The registered manager and staff told us that if any of the people could not express their wishes and did not have any family/friends to support them to make decisions about their care they would contact an advocate on their behalf. The provider had told us they had an effective system in place to request the support of an advocate to represent people's views and wishes if required. However, we were not shown any evidence that this had occurred or where the advocate might be sourced from in order to ensure people received the support they needed.

We observed that people were supported to make sure they were appropriately dressed and that if they needed assistance to choose clothing they were provided with it.

Requires Improvement

Is the service responsive?

Our findings

When we asked one person if they had been involved in the creation and review of their care plan, they told us, "I think I've seen it once or twice. I'm sure they review it, but I don't see it".

The registered manager told us that they were in the process of reviewing and updating all the care plans for people living in the home. We 'case tracked' four people which means we looked at all aspects of their care including plans and medication and daily records.

All the care plans we viewed contained a personal history called, 'This is me'. The care plans contained information about the person's needs, which had been assessed on admission to the home. Other information was also recorded, such as next of kin and any information about allergies.

In some care plans there were records of clear communication and contacts with community mental health teams, appointments/reviews with other services including diabetic services and other specialist medical services. There was evidence of bowel and continence assessments and people's weights were also recorded. However, in other care plans, records were incomplete. We saw statements such as 'requires regular dental reviews' and 'needs to see a chiropodist every three months'. There was no record that these requirements were followed up and no evidence that that any future arrangements had been made.

The quality of the entries recorded in care plans and daily records about people was poor and not informative. For example, we saw that one entry recorded, '[Name] is independent and follows own routine pattern in the home'. However, there was no evidence of what the routine was. We found that care plans were sometimes written in a paternal way, such as a comment, 'well behaved; no changes in mood'. In the care plan there was no evidence of what the person's mood was.

People told us they had not been involved in the formation of the care plan. None of the people we spoke with said they or their relative had been asked to contribute to decisions about their care. One person told us, "I've never seen it" and another person told us, "No; I have whatever they conjure up, I've no complaints". The two visitors we spoke with told us they had not been involved in care planning or review. Some care plans had been recently reviewed, but the efficacy of some care plans and of any reviews they had was in question as we found some aspects of people's lives and their needs had not been addressed.

Staff also told us that they did not often read the care plans as they knew people and their needs well, as most had lived in the home for several years. We saw that staff did record daily notes of any support given to them.

We discussed these concerns with the registered manager who assured us that all the care plans would be reviewed and brought up to date and involve the person and other relevant parties such as relatives and healthcare professionals.

When we asked one person about what they did each day, they said, "Very little; I find it a bit frustrating. I've

no hobbies but I read the paper every day, I'm bored". Another person told us, "I look at telly or I listen to the local radio and read the paper". A third person told us, "I'm only slightly bored".

We were shown and sent the activities plan which showed a range of activities. The activities coordinator told us, "We talk about current affairs, everybody has a newspaper. We have an armchair exercise programme. In the afternoons we do puzzles, colouring, play snakes and ladders. We go to the local over 60s club and local restaurants. We take taxis and the residents pay for themselves". Another staff member told us, "There's a lot of interacting, washing and dressing, meals, reading the paper with them". However, we did not see any member of staff reading a paper with any person living in the home.

The activities coordinator was enthusiastic about their role and told us they provided as much person centred one to one care they could. However, because the activities co-ordinator was often engaged in other things, such as taking people to see healthcare professionals or to other appointments, sometimes these plans were not followed. Another staff member said, "When we've finished with the personal care, then we do activities", but we did not see any evidence of any support staff being involved with any activities. Another staff member told us they often did not have the time to stand in for the activities co-ordinator.

Inadequate

Is the service well-led?

Our findings

We found that the registered manager was rostered to work as a nurse 'on shift'' and 'on the floor' for a substantial part of each week. This meant that the administration and running of the home received only a small amount of time from the registered manager.

We talked with the registered manager and they told us how committed they were to providing a quality service. Whilst we saw that efforts had been made by the registered manager to ensure good governance, neither the time nor resources had been made available to assist this legal requirement, which had resulted in poor quality assurance and auditing processes. The home had also been without administrative support for approximately six months. The home had recently appointed an administrator. It appeared that the provider had not understood the requirement to provide sufficient time to ensure that quality assurance and auditing processes were in place and monitored.

As a result of both the lack of the registered manager's time and the lack of administrative support we found that the required and promised improvement to the home had only in part, been achieved since our last follow up inspection in March 2016. We felt that people were still at risk from insufficient, unresponsive or ineffective systems.

We found that there were no consistent processes in place to monitor training, health and safety, care plans, infection control, falls and safeguarding concerns. Staff recruitment records were not robust. Staff training needs had not been identified, recorded or planned. There were incomplete routine checks of the home completed and the monitoring and checking of the building's safety was poor. Policies had not been updated and records were incomplete and haphazard This meant that people who lived in the home could not be assured of the quality and safety of the support provided.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008, relating to good governance. This was because systems or processes must be established and operated effectively at all times, to ensure that people are assessed and the service is monitored to ensure that safe care and accommodation is achieved.

We saw that the registered manager and the staff had, in most cases, worked in partnership with other professionals to make sure people received the support they needed.

Staff told us that the registered manager was approachable.

We found that the registered manager was open and transparent with us about the homes aspirations and the current situation and they told us they were committed to ensuring the home improved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not been appropriately assessed or regard taken of their language needs. People were deprived of their liberty unlawfully.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used services and others were not protected because of poor recruitment checks, inadequate staffing levels, the lack of robust and regular risk assessments and inadequate checks related to the premise's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that people's needs were met by suitably competent and trained or qualified staff.