County Healthcare Limited

Courtenay House Care Home

Inspection report

Fakenham Road
Tittleshall
Kings Lynn
Norfolk
PE32 2PF

Tel: 01328700646
Website: www.fshc.co.uk

Date of inspection visit:
30 August 2017
07 September 2017

Date of publication:
31 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 30 August and 7 September 2017 and was unannounced.

Courtenay House Care Home provides accommodation and personal and nursing care for a maximum of 46 older people, some of whom may be living with dementia. At the time of this inspection, there were 35 people living in the home.

We had previously inspected the service in February 2017 and had identified five regulatory breaches. This inspection identified 14 regulatory breaches, five of which the provider had been in breach of at the February 2017 inspection. These repeat breaches related to safeguarding people from harm, staffing arrangements, person-centred care, the governance of the service and the requirement to report incidents to the Care Quality Commission (CQC). You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager in post. 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 time of our inspection, the registered manager was absent from the service.

Incidents that required reporting to the local authority's safeguarding team were not always reported. Statutory notifications of certain incidents that are required in law to be notified to the CQC were not always completed. Risks to people's health were not always identified. When they were identified, the service did not always take appropriate actions to minimise the risks to people's welfare.

The numbers of staff on duty and their deployment was not effective in ensuring people's needs were met in a timely way. People often waited for their care. Some care staff had been recruited without providing sufficient evidence to show they were suitable for the role. Medicines and prescribed supplements were not always managed safely so that these were available when people need them.

Staff training and checks of their competency, to ensure that they could meet the needs of people living at the home had not been fully completed. Staff had not had supervision to support them in their role, since our last inspection in February 2017.

There was limited understanding and application of the Mental Capacity Act other than at a basic level. Where significant decisions needed to be made assessments had not been carried out appropriately. Where people who had an application to deprive them of their liberty authorised, the conditions under which this was granted were not always followed.

Staff did not always respect and maintain people's dignity, people received personal care that could be

observed by others because doors were not closed.

People's care plans did not contain accurate, up to date or clear information for staff to help ensure that they provided a high standard of care and support to people. People's preferences had not been identified so that staff could provide care in the way people wanted.

Complaints to the service had not been managed in line with the provider's stated procedure. Complaints had not been thoroughly investigated, and responses to the complainant were not comprehensive.

The leadership within the home was poor. Effective communication was not always in place in respect of people's needs and practices that were taking place in the home. Staff felt the registered manager was not visible, and many did not feel comfortable raising concerns with them. Staff were not confident that any concerns raised with the registered manager would be taken seriously.

The provider's auditing system was not robust and had not identified the concerns we found during this inspection. The provider had not made improvements since the February 2017 inspection.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's welfare were not always identified. When they were identified, suitable actions were not always taken to help minimise them.

Safeguarding incidents were not always investigated or reported to the local authority.

Staffing levels and the deployment of staff was not always sufficient. Recruitment processes did not ensure that staff were suitable to work in the home.

Supplies of peoples prescribed supplements were not monitored to ensure they were always available.

Is the service effective?

Inadequate

The service was not effective.

There was limited understanding or practical application of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when significant decisions needed to be made. Conditions of authorised applications to deprive a person of their liberty were adhered too.

Where people were at risk of not eating or drinking enough, adequate monitoring and record keeping was not in place.

Staff training did not ensure staff had the knowledge and skills they needed to support people effectively. Staff did not receive supervision or checks of their competency to support people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring but this was not consistently applied.

Some people's dignity was compromised. People were not

always consulted about their care, preferences were not always known or recorded.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not contain clear instructions for staff to follow which meant that people might not have received appropriate care.

People had not always been asked for their preferences about the care they receive.

People did not always receive adequate levels of stimulation.

Complaints had not been managed within the providers own procedure.

Is the service well-led?

Inadequate

The service was not well led.

The systems to assess the quality of the service provided was not effective. Action was not always taken when areas for improvement had been identified.

The leadership in the service was poor. Communication was not always effective.

Notifications were not made to CQC when safeguarding incidents occurred.

Courtenay House 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 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 30 August and 7 September 2017.The first day of our inspection was unannounced.

On 30 August 2017, the team consisted of two inspectors, a specialist advisor in nursing care, and a medicines inspector. On 7 September 2017, one inspector returned to look at records associated with recruitment

This inspection was carried out in response to a serious safeguarding concern that had been raised about the home, and subsequent concerns raised by the local clinical commissioning group (CCG) and local authority. We also looked at any notifications the provider had sent us. The provider has to notify us of certain incidents such as serious injuries or allegations of abuse. We gained information about the home from the local authority and clinical commissioning group.

During the inspection, we spoke with two people living in the home and one visitor. We also spoke with a healthcare professional, three care staff, a nurse, the interim manager and the provider's interim regional manager.

Some people living in the home could not verbally tell us about their experience of the care they received. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also carried out general observation throughout the inspection. This included observation of people's experience during their lunch

and evening meal and how staff interacted with people.

The records we looked at included six people's care records, four staff recruitment files and medicine records. Records in relation to staff training, the management of the premises and how the quality of care was assessed and monitored were also reviewed.

Inadequate

Is the service safe?

Our findings

We inspected the home in February 2017 and rated it as Requires Improvement in safe. However, at this inspection further concerns have been identified and we have rated safe as Inadequate.

At our previous inspection in February 2017, we found the provider had not ensured that risks to people's safety had always been assessed or were being adequately managed. We also found that the management of people's medicines was unsafe. This had resulted in two breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had not been made and that the provider continued to be in breach of this regulation. Furthermore, where assessments of risk had been made, these were not always robust as they did not contain all information for staff on what they needed to do to reduce risks to people's safety.

Immediately prior to our inspection, community health professionals had raised concerns to the CQC regarding the safe management and oversight of people's health and welfare at Courtenay House. The local authority had received safeguarding alerts relating to the safe treatment of people living at the home. This included the assessment, management and recording of risks to people.

Risk assessments for people's health and safety were generally reviewed monthly. However, they did not always clearly identify what actions should be taken to reduce the risk. For example, one person assessed as being at medium risk of choking did not have any actions identified to manage this. Their care record stated that a speech and language therapy (SALT) assessment was needed but the person continued to be given normal food and fluids. There was no information for staff about support required or monitoring of the person. Another person was identified as having a medium risk to their psychological and emotional state, but there was no information of the action to be taken to by staff reduce the risks associated with this. This meant that if that person was to become distressed, staff would not be able to respond appropriately or consistently and provide support to the person without delay.

Staff had completed a Waterlow assessment for another person, which identified them as being at high risk of developing a pressure area. A Waterlow assessment is a recognised tool used to estimate the risk for the development of a pressure area or sore. However, although the person had been assessed as being at high risk, the care plan did not identify and actions that staff should take to mitigate this.

We saw that interventions recorded in daily records, showed that support had not been given to mitigate the level of risk identified in the assessments. One person who was cared for in bed, had no record of positional changes despite them being at risk of developing pressure ulcers. There was a record of reddened areas of skin and the use of a barrier cream. Their tissue viability care plan stated a pressure-relieving mattress should be used and this was in place, but there was no mention of the need for re-positioning in their care plan. We saw that another person had a sign in their bedroom to prompt staff to support the person with a change of position. The person used a pressure-relieving air mattress, however, their bed sheet had become detached and ruffled up increasing the risk of skin damage. There were no entries on the records to show that checks had been made on the person, or position changes given on that or the previous day. This

presented a serious risk to the person's skin integrity.

Care plans were not sufficiently detailed, and it was not possible to gain enough information from some of the care plans for staff to be able to provide care safely and in line with people's needs. For example, A person with epilepsy had a care plan which detailed the medicines they took daily to reduce seizures. However, the person was also prescribed an emergency rescue medicine to be used in the event of a seizure. There was no information in the epilepsy care plan to indicate it was prescribed and when it should be used. This meant that staff may not of been aware that this rescue medicine was in place, or be able to use it safely and as prescribed. The service often used Nurses provided by an employment agency to cover staff vacancies or sickness. These Nurses would not always be familiar with the services or the people living there. Only one Nurse worked on each shift. This meant that in the event of a seizure for this person, a Nurse who was not familiar to the service would be unable to safely administer the rescue medicine.

There was no information in the care plan of a person with a urinary catheter. There were no details about the size and type of catheter the person required or how often the catheter should be changed. In addition, there was no information about how often the bag should be changed. However, there was a record of catheter changes and the batch number was recorded as required. We spoke with a nurse about the care of the person's urinary catheter as we noted it had required changing due to problems on a very frequent basis over a period of three months prior to the inspection. They told us it was raised when the GP did a regular visit and the person suffered urinary tract infections, but they had not considered factors that might be influencing this, or whether the most appropriate catheter was being used. A referral to the continence advisor had not been requested. We saw that this person's catheter bag had been placed on the floor, next to the person, and not in the bag stand, which was on the other side of the room. This put the person at risk of an injury if they or someone else was to trip over it. It was also undignified.

We saw that one person's moving and handling care plan and risk assessment was very limited in detail. It stated the equipment to be used and that two members of staff were required. However, there was no assessment of risk to the person or staff in using this equipment, or any descriptors about how the intervention should be undertaken. The person's preferences or the level to which they could assist were not identified.

We also looked at this person's nutrition plan and continence support plan. These had been handwritten but were not legible. Staff would not of been able to read the information and use this to ensure they delivered safe care. We brought this to the attention of the provider's regional manager who agreed that they would need to be completed again, and took action to address this.

At our last inspection, we saw that people were not always able to access their call bell to call for assistance. The registered manager told us that they would take action to ensure that all people who were able to use a call bell would have this to hand. Where people were not able to access a call bell, then this would be identified in their care record. During our observations, we saw that some people still did not have access to a call bell when unattended. On occasions we saw these had been left out of the persons reach or had fallen on the floor and been left after staff had been into the room. In one room, the call bell had fallen under the bed and was entangled in the mechanism. This meant that neither staff nor the person would be able to use this to call for assistance.

A care record contained a bedroom risk assessment which included information about the support the person would need in the event of an emergency evacuation. This record is called a personal emergency evacuation plan (PEEP). This was completed in 2013, the person's support needs had since changed, and the plan had not been updated. We checked the PEEP documents for other people living in the home, and

found that for 7 people, no plan had been completed. This meant that the assistance that staff would need to provide people to leave the building in an emergency had not been identified or assessed. Staff would not be able to help people in the safest possible way.

We concluded that systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment. Shortfalls identified at our last inspection in February 2017 had not been addressed and improvements had not been made.

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

At our last inspection in February 2017, we found that the management and storage of medicines did not properly contribute to people receiving safe care and treatment. This was a further breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that sufficient improvements had not been made and that the provider continues to be in breach of this regulation.

At this inspection, a member of the CQC medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines.

Audits were in place to enable staff to monitor medicine administration and their records. Records contained personal identification, information about known allergies and medicine sensitivities. There were additional records in place for high-risk medicines and medicines with more complex dosage regimes to ensure safety. For people prescribed skin patches there were also additional records showing they were applied to people's bodies in a rotational manner and also confirming they were later removed before the next patch was applied.

However, for people who were prescribed medicines on a when-required basis, there was not always written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. This meant that staff did not have all the information they needed to ensure that medicines given this way were done so safely and as the prescriber intended.

For people with limited mental capacity to make decisions about their care or treatment and who would refuse their medicines, there were records of assessments of their mental capacity and best interest decisions to give them their medicines crushed and hidden in food or drink (covertly). However, there was a lack of written information available to show staff how and when to give them their medicines in this way to ensure they were given consistently and appropriately. This also meant that staff did not have all the information they needed to ensure that medicines given this way were done so safely and as the prescriber intended.

We saw areas of the clinic room used for the storage and preparation of medicines that were unclean and in a state of dis-repair. This included the sink area used for washing equipment, and surfaces above the sink area that were extremely dirty. Unused or rejected medicines were disposed of in purpose made waste bins for return to the pharmacy for destruction. However, the security lid of this bin was broken, which meant that its contents could have been removed.

Staff authorised to handle and give people their medicines had received training but we saw they had not recently had their competence assessed to ensure they managed people's medicines safely. The registered

manager or provider had not identified this.

Records showed that on some occasions, the home ran out of supplies of prescribed items for people, which were essential to maintain their health. A person, who was unable to eat orally, had ran out of their prescribed liquid food and the supplier had to be contacted for an emergency supply. The record stated that the supplier asked why it had not already been ordered as the order was overdue. The member of staff recorded they had 'been on holiday and no one had mentioned it.' For another person who was prescribed a catheter for continence care, records showed that staff had been unable to change a person's urinary catheter when it was not functioning correctly. This was because they had run out of catheters. The homes system for ensuring that prescribed items were in stock and available for use was not adequately monitored and checked. Staff did not always pass on or share information between themselves or the registered manager to ensure that there was a continuity of supply.

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

Prior to our inspection, we received concerns from community professionals regarding the reporting of safeguarding concerns within the home. There were concerns that potential incidents and allegations of abuse reported by staff were not notified to the relevant safeguarding authority or the CQC as is required by law.

At our inspection, we reviewed people's records of when they had received an injury. This included records of when a noted injury could not be explained. We saw that were this had occurred, then action was not always taken to fully investigate the circumstances or the factors that could of contributed to its occurrence. Some of these incidents were serious in nature, and should have been notified as is required as a safeguarding alert but were not. Some staff that we spoke with told us that they had raised concerns regarding injuries sustained by people, or the treatment of people by staff to the registered manager. They told us that they felt that these concerns were not taken seriously by the registered manager, and that these had not been reported to external bodies as is required. At our last inspection, we found that the provider did not notify us of other events that are required to do so in law.

For example, one person's care record showed that staff had identified that they had bruising in three separate places. The record stated the person could not remember what had happened and staff reported they didn't know how this could of occurred. The person was cared for permanently in bed so these injuries should have raised concerns as to how they occurred. There was also a record of old bruises noted in other places. We asked the regional manager to check the homes records as to whether any investigation had taken place, who informed us that there had not been. No action had been taken to investigate possible causes for this injury. The incident was not reported to the local authority safeguarding team or the CQC.

The care record for another person showed that they had sustained severe bruising to their arm and hand which was unexplained. Body maps were completed and a photograph had been taken of the injury, but there was no record that an investigation had been undertaken as to the potential cause of the injury. The Acting Regional Manager confirmed that the organisational system did not indicate an investigation had taken place. This was not reported as a safeguarding concern to the local authority or the CQC. The care record for this person also showed that they had also sustained an unexplained skin tear and bruising to their left elbow. No investigation was undertaken as to how this injury may have occurred, and the incident was not reported to the local authority safeguarding team or the CQC. Providers are required to notify us by law of these events so that where needed, we can take follow-up action.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked the provider to raise these incidents as a safeguarding alert to the local authority. We also asked the provider to review the care records for all people living at the home, and check whether there were any further incidents of injuries that had not been investigated or reported to local authority safeguarding team. The provider did this as requested, and later informed us that further incidents had been identified, which they had reported to the local authority.

We concluded that the providers systems for the management of safeguarding concerns had not ensured that people were protected from abuse and improper treatment. When direct concerns had been raised to the registered manager, these had not been reported as is required to external bodies. Unexplained injuries although identified and recorded in peoples care notes, had not been investigated. Actions had not been taken to establish any potential cause. The providers systems for the checking and auditing of peoples care records, were not effective in identifying when actions had been missed or not taken place.

This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with had a good understanding of how to protect people from the risk of abuse. They understood the different types of abuse that people could experience and had received training in relation to this. A relative we spoke to told us that they had no concerns for the relative's safety. They said, "He feels safe."

Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care. We found that the employment histories of staff, gaps in employment and reasons for leaving previous employment had not been explored with two new staff when they applied to work in the home. References had not been sought from suitable people. This information is required by law. We raised this with the regional manager for the home. They explained that providers systems for the recruitment of staff included uploading the date from the recruitment process on to a central database. This information is then checked and audited by the provider's human resources team. For the two records we saw where appropriate checks had not been made, this information had not been uploaded and therefore was not checked. The provider was aware that some administrative systems had not been followed by the homes management, therefore had already arranged for a full audit of all staff records to take place.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a recognised staffing calculation tool to establish the levels of staff required in the home. We reviewed staffing rotas for the previous 4 weeks, and saw that the planned levels of staff had been provided, except for one day where 2 members of staff were unwell at short notice. The home used an agency to provide cover for any vacancies or ill health, however staff told us that annual leave and holiday cover was not organised effectively by the registered manager, meaning that the home relied on the use of agency staff more than should be necessary. They felt that this had an impact on teamwork and the efficiency of meeting people's needs.

Although the planned levels of staffing were provided, we found that staff were not always deployed or managed effectively to ensure people's needs were met and their safety maintained. For example, we saw

that two members of staff working in one area of the home took their break together. This then left that area of the home with only one staff member supervising the communal area and being available to respond to peoples request for help. We observed that one person who had pressed their call bell was left waiting for 10 minutes. When the staff member did attend to the call bell, people were left unsupervised in the communal area.

A relative we spoke with told us that their family member's needs were met, but that they sometimes had to wait. A person we spoke to told us that they often had to wait, but somebody eventually came when they pressed their call bell. They told us that they sometimes waited for up to an hour for someone to help them, and that this made them frustrated. They told us that the thought the home was short staffed, and that staff did not have the time to help people. They said, "I am learning to walk with a frame, but the staff don't have time to help me. Some are good but some just whizz me round and plonk me down".

All of the care staff we spoke with told us that they felt the home needed more staff. One staff member told us, "I think they're (people) safe but not given the care they need." They told us that there was not enough staff to give people baths when they needed them, and staff were not always available to supervise communal areas.

Another staff member told us that they there were not enough staff to look after people properly. They said, "[Person] down the corridor hasn't been touched all day today and that's because we haven't got the time. 90% of residents need two staff to help them to go to the toilet, there are only five people needing one member of staff. I feel bad because I know I haven't got time to help them." They also told us that they did not have enough time to ensure people had enough to drink. Staff told us that they had raised concerns to the registered manager and the provider before about staffing levels, but they did not receive a response and no action was taken.

We concluded that there were times when the providers assessed level of staffing did not always ensure people's needs were met in a timely way that promoted their safety. People who needed observation in communal areas to keep them safe did not always have this provided. Poor oversight and deployment of staff meant that people were at risk of coming to harm.

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

Inadequate

Is the service effective?

Our findings

We inspected the home in February 2017 and rated it as Requires Improvement in effective. However, at this inspection we have rated effective as Inadequate.

At our previous inspection in February 2017, we found that the provider had not ensured that people living at the home received enough to eat and drink in order to maintain their health. This had resulted in a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that sufficient improvements had not been made and that the provider continued to be in breach of this regulation.

Nutritional risk assessments were completed and people's weight was monitored monthly. Where people were had begun to lose weight, a referral was made to the person GP. People told us that they liked the food they were provided with, and could have as much as they wanted. We observed that when people had finished all that was on their plate, they were offered more helpings. Relatives we spoke with told us that they thought the food was of good quality. People were able to choose their meal from two options. Photographs of these were provided in the dining areas for people to look at to help them choose.

Prior to our inspection, the local CCG had raised concerns regarding the quality and accuracy of assessments completed in relation to people's nutrition and hydration welfare. In response to this, the registered provider had arranged for additional resource to be deployed to undertake a review of all of the existing assessments that had been completed. This work was in progress at the time of our inspection. The registered provider confirmed to us that the work was to be completed by the end of the following week. Actions were underway to review the assessments to include information that is more detailed, so staff could be clear as to the levels of support required.

However, even where assessments had been reviewed and improved, where people were at risk of not eating or drinking enough, their intake of food and fluid was not always recorded or monitored effectively. For example, we saw in one person's daily notes, significant gaps in entries made by staff. Daily targets for the amount the person should attempt to drink had not been entered. Staff had not always recorded when the person had a drink or how much they had drunk. At the end of the 24-hour period, the amounts the person had drunk had been totalled incorrectly. On days where records indicated that the person had not drank enough to maintain their health, no actions had been recorded by staff to counter this. We saw that for one day that week, records showed that the person went for a period of 11 hours without a drink being offered, and in a 16-hour period only had 50mls of water to drink. On another 24-hour period, their record showed that they only received one 200mls drink of tea, and that they had nothing to eat. The person was at risk of not eating enough, and had been prescribed supplements by their GP. Their record of food intake had significant gaps where staff had not recorded when or what the person ate.

This meant that people at risk from not eating or drinking enough, were not adequately monitored to promote their health. Actions could not be taken by staff or medical professionals because there was not accurate information to enable them to do so. At our last inspection in February 2017, we identified the

same concerns and the registered manager sent us an action plan to tell us what they were going to do to ensure that improvements were made. In that action plan they stated that peoples food and fluid records would be checked by senior staff in daily walk rounds that take place twice a day. However, the records we saw had not been checked.

This was a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 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 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had policies and procedures on the MCA and staff had received training in this topic.

However, staff we spoke with had varying degrees of knowledge and understanding of the principles of the Act. They understood how to support people to make certain decisions, for example showing them clothes to wear so that they could make a choice. However, where people did not have capacity to make decisions, staff where unable to describe how they should support a person in their best interests.

Staff told us they asked for people's consent before providing care, explaining the reasons behind this and giving people enough time to think about their decision before taking action. However, we observed that staff did not always ask people for consent before performing certain tasks and did not always offer choice. Some staff practice we saw demonstrated that staff might have assumed the person could not consent. This was because we observed some of them making decisions for people without asking them or supporting them to make a decision. For example, we saw a person being moved in their wheelchair without being asked first. People had a drink given to them by a member of staff who did not ask them first if it was okay to do so, or offer them a choice of what they might like to drink. We saw that on occasions, staff entered people's room without knocking first, or seeking people's permission to enter.

We saw that a person that had a DoLS authorisation in place, which came into force over six weeks prior to the inspection. There were a number of conditions attached to this authorisation and some of these had not been actioned. One of these impinged on the physical safety of the person as it stated the managing authority should seek advice regarding moving and handling, as staff were unable to use the provided hoist and slings due to the person's contractures. The person's care plan still stated they should be moved with the provided hoist. In one section of the care plan, it stated a full body sling was to be used, whilst their PEEP stated staff should use a toileting sling. The records showed a lack of clarity as to how the person should be moved and the failure to record if advice had been sought regarding the correct hoist and sling to use. This meant that it was not clear that they were being moved correctly. Without a clear assessment, they were at risk of being moved unsafely and uncomfortably.

We concluded that staff did not always seek peoples consent before providing them with support. Although staff had undertaken training in the principals of the MCA, their knowledge was not sufficient to ensure that

these principals were always followed. Where an application to deprive a person of their liberty had been authorised, conditions that had been attached to this had not been adhered to.

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

Staff we spoke to told us that although they received regular training, they felt that this was not effective, and did not give them the skills they required to undertake their role. Staff felt that training in supporting people living with dementia and good pressure area care were particular areas where they needed more development. Staff we spoke to told us that they had raised this with the registered manager but had not had a response. Staff told us that they had undertaken training in a number of areas essential to their roles, and records we viewed confirmed this. However, they told us that the majority of this training was on line and of poor quality. They told us they felt this was not an effective way for them to learn.

Staff told us that they had not had a recent supervision, so that they could raise their concerns about training to the registered manager. Records we looked at showed that staff received supervision regularly up until February 2017. Since then, the records showed that no supervision sessions had taken place with staff. We did see that three members of the 33 staff had an annual appraisal in July 2017. Some staff had not had not received supervision in the whole of 2017. The providers audit system of the home, had not identified that staff supervisions and appraisal had not taken place as expected. Staff usually had a supervision session every six weeks.

At our last inspection in February 2017, we identified that people were at risk of not eating or drinking enough to maintain their health. We asked the provider to submit an action plan that identified the improvements they would make to address this. The action plan stated that staff would receive training in the hydration of people, and reducing the risks of urinary tract infections. The plan stated that this would be completed by 28 April 2017. However, this training was not arranged. The subsequent updated plan stated that the need for this training had been escalated and arranged for 26 July 2017. We checked whether staff had undertaken this training, we were told that it had not.

Registered nurses had undertaken training over the last year in venepuncture and urinary catheterisation. They had also attended a tissue viability forum held by the community tissue viability nurse. They said the enteral nutrition supplier provided training on enteral nutrition. We asked where they obtained their clinical and professional support at work and they said, "We don't really have anyone at the moment, we used to have the deputy manager and the manager." We also saw that nurses had not had their annual competency for administrating medicines assessed, this was due to have been completed five months previously.

We concluded that although staff received training, areas in which staff felt they needed further development were not provided. Staff did not receive regular supervisions, and competency of their practice was not assessed within the period set by the provider. Where shortfalls in the provision of the care had been identified as being in part to the training needs of staff, this had not been completed. Assurances made to the CQC that this would be completed had not been met.

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

We identified medical advice was not always sought in a timely manner when a person's health deteriorated or they suffered an injury. On the morning of the first day of our inspection, we observed a person had dried blood down their face, which appeared to come from the corner of their eye. It was noted by a housekeeper

and reported to a nurse. When we asked the nurse about it, they told us they knew about it and the GP was due to do a round that evening, and the person would be added to their list of people to be seen. At 30 minutes after the housekeeper reported it, we had to ask the nurse to clean the blood from the person's face. We were not confident the nurse had examined the person and tried to identify the cause of the issue. Without carrying out their own prompt assessment of the person, the nurse could not be assured if the issues were more significant and therefore necessitated more urgent medical intervention.

We looked at a person's care record that was in hospital at the time of our inspection. We saw that although a full set of observations were completed on the day of admission to hospital, which led to the paramedics being called. It was recorded that the person, "Looked poorly from yesterday." However, there was no record of the person being unwell on the previous day or any actions including taking observations had been done at that time. This meant that timely action was not taken when the person was first noticed to have become unwell. This placed them at unnecessary risk of harm.

People and their relatives told us they could see their GP or other healthcare professionals if they needed to. Records showed that people were supported to attend hospital appointments and receive advice or support from other health professionals. This included the district nurse, optician and their doctor. However, prior to our inspection, community healthcare professionals raised concerns with the CQC that this was not always completed in a timely manner. The regional manager told us that they were looking into these concerns as part of the wider response to concerns raised about the home.

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

Requires Improvement

Is the service caring?

Our findings

We inspected the home in February 2017 and rated it as Requires Improvement in caring. The rating remains the same following this inspection.

At our previous inspection in February 2017, we found that the provider had not ensured that people living at the home received their care in a dignified and respectful way. This had resulted in a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that sufficient improvements had not been made and that the provider continued to be in breach of this regulation.

At this inspection, we found that staff did not always approach people or carry out support in a caring manner. There were incidences where people's care was task-led. These practices did not uphold people's dignity or show respect. Staff we spoke with were able to tell us about the importance of maintaining people's dignity and treating them with respect, and gave us examples of how they would do this. However, we saw that they did not always provide this in practice when supporting people. Some staff told us that they were concerned that some of their colleagues did not treat people with dignity and respect.

We received mixed feedback from people and their relatives about how caring the staff working at the home were. One person told us, "Some [staff] are kind, some are not, but I do get a bit upset when they say, we can't run around just for you, it's not very respectful."

Many of the people living at the home were unable to share their views about the care and support they received, or to be actively involved in the planning of their care, due to their dementia. There was variable practice in the way people's views were taken into account in planning their care, with the support of their relatives if this was needed. One visitor to the home, whose relative was unable to express their views, told us that they had never been asked about their preferences. We did not see any evidence of the involvement of people their relatives in the development and review of their care plans.

Staff did not ensure that people dignity and privacy was maintained. We saw that staff openly discussed people's personal care needs in front of others. We saw incidences where staff left people's daily care records containing confidential information on display in public areas, such as corridor windowsills. Staff did not always knock on people's doors before entering or ask if it was okay to enter.

People were not always supported at meal or drinks times in a way that promoted their dignity. We observed that some staff had little or no interaction with the person they were supporting. We observed a member of staff provided drinks for people in the lounge but did not ask people if they wanted one, or give them a choice. They prepared them and placed them on the table in front of the person with little or no interaction.

During the lunchtime meal, we observed a staff member supporting a person with a drink, and had very little interaction with the person. They repeatedly offered the glass to the person's lips, saying, "have a drink", but

the person put the head back and said, "No". Despite this, the staff member continued to offer, eventually pouring some drink into the person's mouth. The staff member offered no other conversation or explanation about what they were doing. We also observed that one person had a meal plated for them, which was very hot. The staff member blew on this meal to cool it down, rather than put in a safe place to cool over time, free from the risk of cross contamination.

We saw that support with personal care given by staff did not promote peoples dignity. We saw that one person was left with very dirty fingernails, despite having received personal care. Another person had been dressed with their shirt on the wrong way around. We saw on two occasions, people had been left in bed without wearing clothing or underwear and were uncovered. Their bedroom door had been left open, meaning that people, staff or visitors walking past the room could see they were naked.

People were not always encouraged to be independent where they could be. We say that some peoples walking frames, or cups of drink were left out of reach. One person told us, "I try and do what I can for myself and help them [staff], most of them are alright but some get a bit impatient." They went on to say, "The only thing I want to do is walk, but they haven't got the staff, they come a couple of times a week. Not all of them [staff] do what they should." Some staff we spoke with told us that they did not have the time to sit with people, or to carry out their support without having to rush. One staff member told us that they could not get to people to support them when requested in a timely way. They told us that people often had to wait. A person we spoke with told us they had to wait for up to an hour for continence care. As well as being a risk to people's safety, this also meant that people's dignity was compromised.

This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's rooms contained items that were of importance to them. This included photographs, pictures and various ornaments. Visitors to people at the home were encouraged and made to feel welcome by staff.

Inadequate

Is the service responsive?

Our findings

We inspected the home in February 2017 and rated it as Requires Improvement in safe. However, at this inspection further concerns have been identified and we have rated responsive as Inadequate

At our last inspection in February 2017, we found that the care provided was task-based and did not always meet people's individual needs. We found gaps in the recording of people's daily interventions. Care records did not detail the care people required so that staff could provide this. We told the provider they needed to improve the quality of care provided within this area and they submitted an action plan to show us how they would address this. However, at this inspection the required improvements had not been made.

People gave us mixed views as to whether the care they received met their needs and individual preferences. A relative we spoke with told us that they or their relative had not been asked about any food or drink preferences. We saw a dietary notification form completed for each person, this gave information on any special diets or modified texture requirements. However, the section for people's likes and dislikes mostly stated, 'likes all food', and did not detail people's favourite food items.

Care plans were in place and provided basic information about peoples support needs, but all of the appropriate information regarding how these needs were to be met had not been recorded. This is important so staff have correct and appropriate information available on how to meet people's needs. When people refused personal care or had behaviours that others may find challenging, care plans did not provide guidance for staff on how to respond. For example, one person's communication care plan stated they could be verbally aggressive toward staff and other people, It stated that the person would 'accuse others of things from their own imagination.' There were no strategies for managing the situation or how to respond to the person to calm and reassure them.

Care plans did not contain sufficient information relating to the support and management of people's health needs. For example, there was no information regarding how to support someone with their diabetes in the care plan for one person with tablet-controlled diabetes. Therefore no information about monitoring of blood glucose levels, signs of hypo and hyperglycaemia and action to be taken, or the need for annual diabetic reviews and eye screening available for staff to use. We saw another person had a large number of pressure ulcers. The assessment by the community tissue viability nurse was the main source of information to determine the number of ulcers and their grade. There was some wound assessment and treatment plans in which staff recorded dressing changes, but it was difficult to assess progress of wound healing from them because of the lack of detail recorded.

We found significant gaps in times and dates between entries generally in people's daily records. Continence charts for some people were not fully completed, some people who required regular turning whilst in bed did not have charts to show this had been completed. We saw that the last recording of an entry was over 24 hours previously for two people. For another person, an entry 48 hours prior to our inspection stated that the person's catheter was not working properly. There had been no further entry to say that this issue had been addressed, or that the person was passing urine as they should. Checks that

would normally be undertaken by the senior staff in the home to ensure records had been completed had not always taken place.

We concluded that peoples care had not always been planned and delivered to meet people's individual needs. Inconsistent recording of care given by staff had not been identified.

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

We saw that some people spent long periods in the same areas such as the communal lounge. They had little stimulation and spent most of their time staring around the room. There was a lack of tactile objects for people to access and touch to help stimulate their senses. Staff did not ask people what they wanted to do or if they wanted to move to another area of the home. We saw that when some people had finished their meal, they waited for 45 minutes before being attended to and asked if they wanted to move to another part of the home. We asked staff about this. They told us that if people asked to be moved or made any other request such as for a drink, that they would respond. However, a number of people living in the home may not have been able to make such a request without prompting.

There was an activities co-ordinator employed by the home. On the first day of our inspection we saw that they were organising a coffee morning that people were invited to attend. One person told us that they had been asked but did not want to go, because they did not know anyone. They said that it was their choice not to go and was not made to feel under pressure to do so. We saw that other people did attend and were engaged in the activity. Staff told us that they felt that people received little stimulation and interaction. They said that this was because they did not have the time to do this. One staff member told us, "There is an activities co-ordinator, but there is not much for them [people living at the home] to do."

The service had a complaints policy and procedure in place. However, we found that complaints had not been investigated thoroughly and in line with the providers stated procedure. For example, we saw a complaint raised by a relative regarding the quality of care provided, the availability of the registered manager and the numbers of staff on duty. The registered manager had responded to this complaint, but was dismissive of the complainants concerns without detailing or evidencing how they had investigated these.

We saw another complaint raised by a relative into concerns that the quality of care provided had declined. They were concerned that their relative was not receiving all the personal care that they required to stay healthy. Again we saw the response to this was dismissive, and did not evidence what actions were taken to investigate their concerns. We spoke to the interim regional manager about this, who agreed that the outcomes in the managers' response were not sufficient or appropriate. On further investigation, we saw that these complaints had been dealt with by the registered manager outside of the providers own process. The complaints had not been logged on to their data system, which meant that the usual process of the response and investigation being overseen by the regional manager and providers complaints manager, had not taken place.

This meant we were unable to see that complaints had been responded to and investigated properly. People and their relatives who had raised a complaint would assume that this complaints process had been followed in full by the registered manager when it had not. The provider's complaints system could not give us an accurate account of how and when complaints were addressed. Any actions that would have been taken by the provider to monitor the quality of care at the home would have been impeded, as they were not aware of all the complaints that had been raised. The providers system of checks and audits had not

identified that the registered manager had not recorded or investigated complaints within the providers stated procedure.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We inspected the home in February 2017 and rated it as Requires Improvement in Well-led. However, at this inspection we have rated Well-led as Inadequate.

At our previous inspection in February 2017, we found that the provider had not ensured there were robust and effective governance systems in place. This meant that some people received poor quality care. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the necessary improvements had not been made. Systems that were in place remained ineffective at identifying and mitigating risks to people's safety. This placed people at risk of avoidable harm and had not ensured they received consistently good quality care.

There was a registered manager in post who was absent during our inspection. The same registered manager was in post at our previous inspection in February 2017. During our last inspection in February 2017, we rated the service 'requires improvement' in well led. This was because the systems and processes were not always effective at monitoring and reducing risks to people. During this inspection, we found similar concerns and other breaches in the regulations. Action taken to address previously identified breaches of the regulations had not been sufficient and the service remained in continued breach of all of them. The systems and processes put in place by the provider since the previous inspection had not been effective in supporting the registered manager to ensure the service was safe, effective, caring, responsive or well led.

The provider told us they had recognised immediately prior to our inspection that the service had been deteriorating. During the inspection, the provider updated us on the actions they had taken to improve the quality and safety of the service moving forward. The clinical lead responsible for overseeing people's nursing needs had recently left the service and the provider had seconded a clinical lead from another of their homes to undertake a reassessment of all people's clinical needs. In addition, they had seconded a registered manager from another home to provide managerial support. Following serious concerns being raised, there was regular senior manager presence within the home, however this had not been immediately effective and improvements had not been made. Immediately after the inspection, the CQC imposed an urgent condition that the provider sends us a detailed action plan with set timescales to reassure us the concerns we raised during the inspection were continuing to be addressed. The CQC also imposed on urgent condition to restrict new admissions to the home.

Staff told us that they not confident that the registered manager would take concerns they raised seriously. They felt that the registered manager was not approachable and that they received little information and guidance from them. Monthly staff meetings had only taken place in May and June since our last inspection in February and staff supervision had ceased to take place since then. One staff member told us, "It has changed recently, it's gone slowly downhill. Staff don't get leadership which has quite a lot of impact." They went on to tell us that the registered manager had lost interest in the home, and was not available or visible to people living at the home or staff. Other staff we spoke to confirmed this.

There were systems in place to monitor the service. These included a range of audits completed by the senior staff and the provider's regional manager. The audits covered areas such as medicines, care planning, tissue viability, incidents, accidents and nutrition and hydration. Whilst we found some of these audits were identifying shortfalls in the service and the action required to remedy them, the systems in place were not effective in identifying all of the shortfalls we found during our inspection. An audit was in place to check that staff had undergone the required checks before they started working in the home. However, these had not identified that all of the required checks had not been made.

The provider's senior manager also completed a monthly audit of the service called the quality of life audit. This audit covered the environment, health and safety, care plans, records, the Mental Capacity Act 2005 (MCA), nutrition and hydration, dignity and medicines. Recent audits identified areas of improvement for example, checks of the mealtime experience for people and checks on people's fluid intake being completed. This system had been ineffective in ensuring improvements had been made because we found similar concerns during our inspection.

The systems for assessing, monitoring and mitigating risk were ineffective. The registered manager had not reviewed incidents and accidents since February 2017. Actions had not been taken by them to investigate the cause of unexplained injuries. This had impacted on people negatively. It had not been recognised that staff were not always taking the correct action to ensure people's safety. Action had not been taken to analyse incidents to see if further incidents could be prevented.

Systems to ensure people received the care they needed were ineffective. Care planning audits had not identified shortfalls in relation to the care people received. We found shortfalls in the numbers of staff deployed to support people and people were not always receiving social stimulation.

Systems to ensure staff were adequately trained and supported were ineffective. Staff had not received all of the training they required to meet people's health needs. Training identified by the provider in response to meeting the shortfalls found at the inspection in February 2017 by the Care Quality Commission, had not been completed despite assurances that it would be. Some staff did not think they had all the support and training required to carry out their role effectively. The systems had not ensured all staff had the skills and knowledge to be able to care for people living with dementia.

Systems to ensure people received consistent caring and compassionate support were ineffective. People were not consistently treated with dignity and respect and their privacy was not always considered. Staff did not always respond to people appropriately when they became unwell which had a negative impact on the care their wellbeing. Records did not always refer to people in a dignified way and people were not always supported in line with their preferences.

Systems to monitor quality had not identified that some people were unhappy with the support they received. The systems in place did not fully enable any verbal concerns raised to be responded too. Systems for ensuring people had a good quality of life that responded to their individual needs and received person centred support had not been effective. People told us they did not always receive support when they wanted it.

The systems had not ensured all of people's individual health needs were assessed and planned for which impacted negatively on people. Systems for ensuring that people were supported to have their human rights upheld had not been effective in ensuring people's rights were fully protected. People's rights were not fully protected because the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always met. There was an institutional culture within the home that led to some people having a

lack of choice or control over their lives. Some people's freedom was being unnecessarily restricted and some practices that were in place compromised people's dignity.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission without delay of any allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Peoples care had not always been planned and delivered to meet people's individual needs. Inconsistent recording of care given by staff had not been identified

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where an application to deprive a person of their liberty had been authorised, conditions that had been attached to this had not been adhered to. Staff did not always seek peoples consent before providing them with support.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment. There were risks to people's safety associated with the way medicines were managed. Actions were not taken to investigate all accidents or injuries. Timely action was not taken when people required receive care from community professionals or hospital treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The providers systems for the management of safeguarding concerns had not ensured that people were protected from abuse and improper treatment. Concerns that had been raised to the registered manager had not been reported as is required to external bodies. Unexplained injuries although identified and recorded in peoples care notes, had not been investigated. Actions had not been taken to establish any potential cause.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People at risk from not eating or drinking enough, were not adequately monitored to promote their health. Records were incomplete and checks on these did not always take place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not been responded to and investigated properly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The providers assessed level of staffing did not always ensure people's needs were met in a timely way that promoted their safety. Staff did not receive regular supervisions, and competency of their practice was not assessed within the period set by the provider. Where shortfalls in the provision of the care had been identified as being in part to the training needs of staff, this had not been completed. Assurances made to the CQC that this would be completed had not been met.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were risks to people's safety associated with the way their support needs were managed. Risks to people, and the planned actions to help mitigated them were not adequately planned, adhered to or monitored. Regulation 12 (1) and (2) (a) (b) (c) (d) (e) (f) (g) and (I).

The enforcement action we took:

Urgent Notice of decision served on provider to impose conditions restricting new admissions and requiring them to submit weekly reports showing peoples needs had been reassessed and monitored to ensure they receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. Regulation 17 (1) and 17 (2) (a), (b), (c), (d), (e) and (f)

The enforcement action we took:

Urgent Notice of decision served on provider to impose conditions restricting new admissions and requiring them to submit weekly reports showing peoples needs had been reassessed and monitored to ensure they receive safe care and treatment.