Leafoak Limited

Beechlawn Residential Home

Inspection report

Elton Park Hadleigh Road, Ipswich, Suffolk IP2 0DG
Tel: 01473 251283
Website: n/a

Date of inspection visit: 15 and 17 December 2015
Date of publication: 16/02/2016

Ratings

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

Overall summary

This inspection took place on the 15 and 17 December 2015 and was unannounced. Our previous inspection of 18 May 2015 found the service did not do all that was practicable to mitigate risk associated with medicines and did not have systems in place to ensure that restriction on people for their safety were lawful. This inspection found that although some changes had been made the relevant requirements were still not being met.

Beechlawn provides care and support for up to 36 older people, some of whom may be living with dementia. At the time of our inspections there were 23 people living in the service.

The service is required to have a registered manager in place. The manager registered with the Care Quality Commission (CQC) works in the service but does no longer performs the role of manager. The provider has recruited a new manager who is not registered with the CQC to manage this service.

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.

Summary of findings

There were not enough staff to meet people's needs. Staff had not received training to ensure they could provide care in a safe and effective manner. Appropriate recruitment checks had not been carried out prior to staff being employed.

Staff had not received up to date training in protecting vulnerable adults from abuse and were not clear what constituted abuse. The senior staff team were not clear how allegations or abuse should be reported and managed.

Due to the low staffing numbers staff did not have time to give people the care and support they required in a caring and compassionate way. The routine of the service was task led and not centred on the people receiving care. Due to improvements being needed in staffing levels, and staff skills and knowledge with regard to dementia people were not provided with meaningful and caring interactions which they needed to reduce social isolation.

Risks to people were not always effectively assessed. Where the risks had been assessed as requiring measures to be put in place to mitigate that risk these were not in place.

People's medicines were not always administered and managed effectively and safely.

The service had made applications to the local authority under the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). However, the DoLS authorisations were not monitored as required. The service restricted access to the code required to open the front door thereby restricting some people's liberty without appropriate authorisation.

Care records did not adequately reflect the care people required and changes in people's care needs were not always reflected in their records.

The service's quality assurance systems were not robust. They failed to identify shortfalls in the care provided. Audits were not used to improve the quality of the service. Policies and procedures were out of date and did not reflect up to date practices.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff had not received training in safeguarding adults. Not all staff were aware of their responsibilities within both provider and national safeguarding procedures.

Risks to people were not managed appropriately. Risk assessments were not always effective and actions to mitigate identified risk were not always put in place.

Staffing levels were not sufficient to ensure people received safe care which met their needs.

Medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective.

Staff were not adequately trained or supported to provide effective care.

The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were not implemented effectively.

People's nutritional needs were not always met.

Inadequate

Is the service caring?
The service was not caring

Caring relationships had not been developed with people using the service. Care was task led and not centred on the person.

People were not supported to express their views and be involved in their care planning.

People's privacy and dignity was not always respected.

Inadequate

Is the service responsive?
The service was not responsive.

Care was not personalised and did not always meet people's needs.

People were not supported to take part in activities and follow their interests.

People's views and experiences, concerns and complaints were not sought.

Inadequate

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

The service did not promote an open person centred culture. Managers were not aware of the day to day culture in the service.

The registered manager was working in the service but not managing it. The new manager had not registered with the CQC to manage this service.

Inadequate

Summary of findings

Quality assurance processes were not established to ensure the service provided good quality care.

Beechlawn Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 17 December 2015 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for older people.

Prior to the inspection we reviewed information we held about the service and reviewed information supplied to us by the local authority.

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 spoke with 12 people who used the service and four relatives.

We looked at a range of records including six people's care plans and other associated documentation, four staff files, staff training records, the staff rota, a sample of policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in the service. However, we found that staff had not received training in safeguarding adults from abuse. Three staff spoken with during the inspection demonstrated a complete lack of knowledge and understanding of safeguarding procedures and their roles within both provider and national safeguarding procedures. Senior staff spoken with did not know who to make a safeguarding referral to. No contact details for local safeguarding teams were displayed in service. The training matrix given to us and confirmed by the manager as being up to date showed that of 22 care staff 11 had received training in safeguarding. No training dates were recorded for three senior staff or manager or deputy manager. The manager was unable to demonstrate how they would ensure that staff would recognise and take the required action in order to keep service users safe from avoidable harm, unsafe care and/or abuse. The training plan for 2016 given to us by the manager did not have any dates planned for safeguarding training. Staff who could not recognise the signs of potential abuse and did not know what to do when safeguarding concerns were raised would not be able to protect people from abuse and avoidable harm.

We asked the manager what systems and processes were in place to immediately investigate allegations of abuse and ensure any such allegation was reported to the appropriate investigating authority. They initially told us there was no system in place, however they came back to us later during our inspection and said they did keep a record of abuse allegations and showed us a record of recent allegations being investigated by the local authority. However, there was no system in place to review the allegations and ensure that action plans were developed and monitored.

This was a breach of Regulation 13(2) and (3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people from receiving care were not managed appropriately. Care plans contained risk assessments for some aspects of the care provided such as manual handling and pressure ulcers. However, actions to mitigate the risk were not always put in place. For example, the risk assessment for one person of developing pressure ulcers showed the risk was medium but no actions had been put in place to mitigate the risk to this person of developing pressure ulcers.

Where risk assessments had been carried out and actions recorded to mitigate the risk these actions had not been carried out. For example, one person was assessed as needing a pressure pad next to their bed to alert staff that they were up as they were at high risk of suffering further falls. When this person's bedroom was checked during the inspection we noted that the pressure pad was not in place. Staff spoken with had no knowledge of the assessed need for a pressure mat. The manager told us that the mat should be in place as per the risk assessment. This person was mobile and the use of a pressure pad in their chair to alert staff if they got up from their chair had not been considered. The manager said that the service did not possess pressure pads of this type. During the inspection we observed the person was trying and get up and walk from a chair in the lounge on three occasions. On each occasion the person attempted to get up, we had to intervene to ensure person did not fall.

This was a breach of Regulation 12(1) and (2) (a) and (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that there were sufficient staff to meet their needs. One person said, "They always come on time." However, another person told us when they pressed their call bell for a staff member; "I can wait between 15 to 30 minutes for a response." This meant that people may not receive the support they needed in a timely manner and in case of an emergency could compromise people's safety.

Concerns had been raised to us by care professionals regarding staffing numbers at the service prior to our inspection. They cited an example of where nurses from the district nursing service had to support a person with personal care before carrying out their nursing duties because no member of care staff was available. During the inspection we also identified instances where the lack of staff on duty had potentially impacted on people's care. For example, we observed that as a result of a lack of staff an emergency ambulance called to the service had to wait several minutes before the door was opened and they were allowed access.

Inadequate

Is the service safe?

During the lunch period we saw that staff did not have sufficient time to interact with people and were just placing meals in front of them and leaving. People were not being supported to eat and drink their meals. One person looked at their meal and said, "But I don't like broccoli," but the carer bringing the meal had left the dining room. The senior carer administering medicines had to stop and assist a person to re-position a cushion as there were no other carers available. There were not sufficient staff available to meet people's needs.

We completed an observation for three hours in the main lounge. During this period there were between three and four people present, no staff came into the room to check on people and none were offered drinks. We had to intervene on three occasions when a person tried to stand and was at risk of falling. Another person who had limited sight had no interaction with carers. Any interactions between people and staff only took place when carers needed to perform a task such as personal care.

Staff told us there were insufficient staff on duty with appropriate skills to provide care which met people's needs. The three care staff on the early shift on the day of inspection had less than three months experience. The manager told us that each person had a needs assessment which the provider used to decide on how many staff the service required. They also said they had recently used agency staff to supplement the number of staff assessed as being required by the provider. We spoke with the provider regarding the system they used to decide on staffing levels. They were unable to demonstrate to us how this worked to meet people's changing needs and how they assessed that the staff on each shift had the appropriate experience and skills to meet people's needs safely.

This was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always follow safe recruitment practices. Not all the staff files we looked at contained a full employment history and satisfactory references for the service to be assured that the person was suitable to work in the type of employment offered.

Our inspection of 18 May 2015 had identified that medicines for external use were not stored securely. On this inspection we saw that this had been rectified. One person told us, "Medication is usually on time; they don't stay and watch while I take it." Another said, "The medication is usually on time and they always make sure that I've swallowed it."

One relative told us that they had recently found medicines in the pocket of their relative's clothing. Visiting care professionals told us that during visits they had seen medicines on the floor in people's bedrooms where it had not been taken by the person. They also told us about two incidents where emergency medicines had to be ordered and collected by the service because they had not re-ordered medicines.

Care plans relating to the administration of medicines contained PRN (as required) documents but these did not adequately detail when a person should receive their PRN medicines. For example what behaviour a person with dementia may exhibit when they required analgesia. We spoke with a member of senior staff responsible for administering medicines and they were unable to explain how they would know if a person with dementia required analgesia.

We observed medicines being administered and saw that on this occasion the member of care staff ensured that the person had taken their medicine. They also explained to us the re-ordering procedure. However, the examples given above demonstrated the service approach to the administration of medicines was inconsistent and not always safe.

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

Inadequate

Is the service effective?

Our findings

People did not receive effective care based on best practice, from staff that had the knowledge and skills they needed to carry out their roles and responsibilities.

Staff did not undertake a formal induction into the service. One new member of staff told us they had shadowed for two weeks and been trained how to use the sling and hoist prior to providing care. Another new member of staff said they shadowed for two shifts and received training in manual handling and dementia.

Records did not show that staff were provided with regular supervision sessions to enable them to discuss their development needs and areas for improvement. The manager advised that staff had not received any formal observation or supervision in the three months since they had been at the service. The manager said they intended to conduct formal observations of practice but had not had the time.

Staff training was not planned and monitored effectively to ensure that staff had the necessary skills to provide safe and effective care. Records showed that some areas of staff training such as safeguarding, manual handling and infection control had either not been undertaken by staff or were out of date.

Three episodes of poor manual handling techniques were observed during the inspection which could have caused injury or discomfort to people. The training matrix showed of 22 care staff nine have received manual handling training. The service's training plan showed the next manual handling training had not been booked in until September 2016. The service policy stated staff should undergo initial training in the moving and handling of people as part of their induction programme and refresher training at least once a year. Lack of training in manual handling techniques exposed people to risks associated with unsafe or inappropriate moving and handling techniques such as discomfort and injury.

This was a breach of Regulation 18(2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so. We asked the manager if any applications had been made to the supervisory body to restrict people's liberty. They told us that there had and that a number of authorisations had been granted. They were unable to tell us how many applications had been granted and whether any conditions had been applied to the authorisations. Care staff told us that there were a number of DoLS in place but they were unable to tell us the number of authorisations or who they applied to.

Care staff spoken with did not show an understanding of the MCA. Training records did not demonstrate that staff had received training in the MCA. All the DoLS applications had been made by one member of staff and knowledge of the MCA and DoLS was not evident throughout the service. The front door of the service was locked and could be opened using a number key pad. Only care staff had access to the number to open the door. This could mean that some people, who were not subject to a DoLS had their liberty restricted.

This was a breach of Regulation 11 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed the food provided by the service. One person said, "The food is quite nice and there is plenty of it. I have no complaints." Another person said, "They bring a menu round the day before and you choose one of the other." People could choose to eat in their bedroom or in the communal dining room.

We observed the lunch meal in the dining room. We saw that this was not an overall enjoyable experience. Carers were rushed placing food in front of people and leaving

immediately, food was served to people on the same table at different times making social interaction difficult. The medicines trolley was located in the dining room and the lunch time medicines were being administered from the trolley while lunch was being served. This meant that the carer administering medicines was constantly coming and going from the dining room causing disturbance to people eating.

Prior to our inspection we had received information from healthcare professionals visiting the service that the nutritional needs of people with diabetes were not being met with blood glucose levels being erratic as people were being given food with high sugar content. We spoke with the cook who was aware of which people were diabetic. However, care staff we spoke with did not display knowledge of what foods people living with diabetes could eat. One person told us that, "They give me biscuits, but I'm not allowed to eat them, so I offer them to staff." Care plans did not contain information about how people's nutrition should be managed. This meant that people's health may be put at risk by receiving an inappropriate diet.

This was a breach of Regulation 14(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two medical practitioners from the local GP surgery who visited people in the service when they became acutely unwell, and attempted to prevent hospital admission by assessing people in a timely manner, and starting treatment as appropriate. The practitioners spoke positively of the home, and said that the staff routinely referred people to them, and the referrals they received were appropriate. However, feedback received from the district nursing service did not confirm this view. They told us that people's health needs were not met in a timely manner and that sometimes they had to instigate GP referrals. This demonstrated that the service approach to making referrals to other healthcare professionals was inconsistent which meant the people may not be referred to healthcare professionals when appropriate.

Inadequate

Is the service caring?

Our findings

Positive and caring relationships were not developed with people using the service. One person told us, "I feel staff know me as a person and they treat me with respect," but another person's relative said, "Staff do not know [relative]," and went on to describe several incidents which supported this statement.

Staff did not have time to interact with people other than when they were providing care. For example we observed the main lounge during the morning or our inspection. There were between three or four people sitting in the lounge for most of this time. Care staff did not enter the lounge other than to bring people to sit in there. We observed one person came into the lounge accompanied by a member of care staff. The member of care staff asked the person if they wanted the television on and they said they did not. Shortly afterwards another person entered the lounge with a member of care staff. The member of care staff turned the television on with no reference to anybody in the lounge and left. We were aware that another person already in the lounge could not see the television and had not expressed a wish to have the television on. This did not demonstrate a caring compassionate attitude from staff.

We saw that care staff sat in the corner of the lounge to complete paperwork and did not interact with people. We spoke with two care staff asking if they knew people's likes and dislikes and if the care plans gave them sufficient information about people's preferences and personal history to understand how people wanted to be supported. They told us they had not read people's care plans and did not know where they were kept. We also observed staff serving lunch to people in the dining room. Staff did not have time to interact with people while serving lunch simply placing the meal in front of the person and leaving. Staff routines took priority and staff had little understanding of the impact of this approach on the wellbeing and needs of people using the service.

Relatives also gave us examples of when their relative had not been supported in a compassionate manner by staff. For example, a relative had requested that a person living with dementia be ready to go to a special family event this had not been done and they had had to provide personal care before taking the person out.

This was a breach of Regulation10 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe individual carers display a caring attitude in the way they supported people. For example, we observed one member of care staff assisting a person to move in a caring and supportive manner explaining what they were doing and encouraging the person. However, this was due to the efforts of the individual member of staff and was as part of a task which needed to be carried out.

People were not encouraged to express their views and be actively involved in decisions. One person said, "They tell me when there is a residents' meeting but I don't usually go." We asked the manger when the last residents' meeting had taken place and they told us they did not know when the last one was but were planning to hold one in the near future.

The service operated a keyworker system which was mentioned in the Statement of Purpose. People did not know who their keyworker was. A key worker is a named member of staff who works closely with the person and can act as a link with their family. This provides an opportunity for people, and their relatives, to have a say about their care, interests and what is important to them. On two occasions, people pointed to a picture on the wall of their keyworker, but indicated that they never saw them; one person said, "I think that's her, I never see her."

People told us that staff treated them with dignity and respect. We observed that staff treated people with dignity and respect when providing care by closing bathroom and bedroom doors and knocking before entering people's bedrooms. However, the lack of information in care plans and lack of knowledge of people's abilities by staff meant that because they were not aware of what people were capable of doing for themselves it was not possible for them to promote independence effectively.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. For example one person was admitted to hospital in December 2015. The hospital raised safeguarding concerns after identifying the person as having an infectious disease. This person had been admitted to the service in February 2015. The undated front page of their care plan identified they had recently had an infectious disease. The assessment for this person carried out prior to their admission did not mention this disease and there was no care plan to direct staff as to how this should be monitored. Staff had not recognised that the person had developed an infection and had therefore failed to take any action to treat the infection and protect others. This was only acted on when the person was admitted to hospital. This demonstrated that regular assessments of people's care needs were not being carried out.

One relative told us that they had not been consulted about their relative's care plan. They did display knowledge of the care plan, giving us examples of how it was not relevant to their relative. However, another relative told us they had been consulted about their relatives care plan and had contributed to the review. This demonstrated that the service approach to regular reviews of people's care was inconsistent.

One person nearly fell on two occasions during our inspection; the person's records identified that they were at high risk of falls, yet there was no appropriate equipment in place to mitigate that risk. An 'Information for Hospital Admission' pack was also held on the person's records, which incorrectly stated that they could mobilise independently without any aids. This evidenced that people's records were not updated regularly and subsequently put people at risk of harm.

Care documentation seen during the inspection did not contain care plans specific to people's needs. For example, where a person lived with diabetes there was no plan detailing specific care requirements such as foot care. This meant the care staff may not be aware of how people's care needs were met, putting people at risk of inappropriate care.

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

People were not supported to follow their interests or take part in any activities both within the service and externally. People told us that, "Staff are just too busy to do this." One person stated, "It would be nice to do more, we need something to do; I came to my room as there is nothing else to do." Another told us, "I do wish there was more to do here, I would love to go outside." This directly contravened the service's 'Statement of Purpose' which said, "Our home will offer a range of social activities which meet the needs of residents."

Care plans did not contain information on a person's interests to enable staff to provide activities which interested them. On the afternoon of our inspection the activities co-ordinator from the provider's other service visited the service. They did not know people or their interests. This was demonstrated when they sat with one person and said, "And what is your name?" The manager, and records demonstrated that this activities co-ordinator visits to the service were irregular and adhoc. This meant they were unable to get to know people. They did record that they had spoken with people during their visits. The record we saw for one person stated that they had said, on two occasions, once in November 2015 and once in December 2015, that they liked playing scrabble and doing quizzes. Subsequent records did not indicate that scrabble or quizzes had been facilitated. The only records said, 'Had a chat.' This demonstrated that people's individual preferences and interests were not being met.

We observed people sitting in their bedrooms for long periods, and choosing to remain in their bedrooms to eat. People who came out of their bedrooms sat in silence in the lounge areas or dining room. We observed people sitting alone, sometimes for over three hours, without any interaction from staff. When staff were present in the lounge, they were observed to be sat in the corner writing up notes, not interacting at all with the people in the room.

Some people at the service were living with dementia. The service had not made reasonable adjustments to accommodate the needs of people who had dementia. The environment was not dementia friendly. For example, how people living with dementia might struggle to navigate the service as the dining area had only neutral colours and the tables were set very close together. Additionally we found

Inadequate

Is the service responsive?

no evidence of best practice for those people living with dementia, and no consideration of providing opportunities for social engagement, despite the symptoms associated with dementia.

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

The service did not routinely listen and learn from people's experiences, concerns and complaints. The manager told us that there had been no residents' or relatives' meetings in the three months they had been working at the service and were unable to provide us with records of any previous meetings. The service's Statement of Purpose described arrangements for resident consultation being a residents' committee and regular consultation. We confirmed with the manager that neither of these were taking place. This meant that people were not encouraged to provide feedback on the service.

Inadequate

Is the service well-led?

Our findings

The service did not promote a positive culture that was person-centred, open, inclusive and empowering. For example the provider had employed a new manager three months before this inspection. People told us that they did not know who the new manager was. Comments included, "I haven't seen the new manager she never seems to pop in or anything," and, "I don't know who the manger is." We asked the manager what they had done to introduce themselves to people and their relatives for example holding a residents' meeting and explaining the changes. They said that despite being in post for three months this had not been done but that they planned to hold a meeting to do this in the near future. In addition, as the previous manager had carried on working at the service as a senior carer, people were confused about the roles of the management team.

The person who was registered with the CQC to manage the service was not managing the service but working as a member of senior care staff. A new manager had been in post for three months. They had previously been registered as a manager at a different care service but did not have a current application to transfer their registration with the CQC. The roles and responsibilities of the manager and senior care staff were not clearly defined. During our inspection we observed a senior member of care staff admonishing a member of care staff in front of people. Visiting professionals also told us about inappropriate actions and communications between staff members. Care staff told us they did not always receive feedback from the provider and management team in a constructive and motivating way. We were told about a particular example of this during our inspection.

Due to the lack of staff knowledge of the safeguarding procedure we were not assured that the service has sent statutory notifications regarding safeguarding incidents. Lack of notification would mean that safeguarding incidents were not investigated.

Staff did not receive regular supervision sessions and staff meetings were not held regularly. This meant that there were no clear and transparent processes in place for staff to account for their decisions, actions, behaviours and performance.

The provider told us that they visited the service weekly. However, the manager and the provider confirmed there were no records of any formal audits or plans for improvement to the service. We asked for any records of discussions that happen between the manager and the provider but there were none provided to us.

Records of accidents and incidents were kept but these were not monitored for trends to help support areas for improvement in quality and safety. The manager was unable to supply any quality assurance discussions or work between the service, service users, relatives etc.

A monthly management audit by the manager dated October 2015 identified actions that needed to be taken in several areas, including equipment, environment and a review of care records. However, the manager told us that they had not taken action on the issues identified as they had not had time. One of the issues identified in this audit was that the service's stand aid was not working. Staff told us that the stand aid had not been working for approximately six months. One person had been using the stand aid and their relative told us, "[Relative] would be much happier and feel more secure if they used the stand aid again." The lack of understanding of the principles of good quality assurance meant that this person had not received the care and support they required."

This was a breach of Regulation 17(2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse. Systems and processes were not established and operated effectively to investigate abuse.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The risks to the health and safety of people from receiving treatment were not assessed. The service did not do all that was practicable to mitigate risks. Medicines were not managed and administered safely.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment There was not sufficient suitably qualified, competent, skilled and experienced staff deployed. Staff did not receive appropriate support, training, professional development, supervision and appraisal.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent was not obtained before care and treatment was provided

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Nutrition requirements were not met.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care An assessment of needs and preferences was not carried out collaboratively with the relevant person. Care and treatment was not designed to meet service users' needs and preferences

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems had not been established to monitor and improve the quality and safety of the services provided.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions.