New Park House Limited

New Park House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 January 2018 and was unannounced. At our previous inspection in August 2017 we had serious concerns about the safety and welfare of people who used the service. We found 12 breaches of The Health and Social Care Act Regulations (Regulated Activities) Regulations 2014 and took urgent enforcement action and further enforcement action instructing the provider to improve. We placed the service into special measures. At this inspection we found that the provider had made improvements throughout. However, further improvements were required. We found a continued breach of four regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were still concerns about the safety and leadership of the service. The service will remain 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.

New Park House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

New Park House can accommodate 95 people in three units. At the time of the inspection 31 people were using the service, some of who were living with dementia. Only two of the three units were in use.

There was a new manager in post who was yet to register with us. 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.'

People's medicines were not always managed and administered safely as advice had not been gained on the safe administration of some medicines and staff did not always have the information they needed to administer medicines safely.

People were not always safeguarded from the risk of abuse as some unexplained injuries had not been investigated or reported to the local authority for further investigation.

Some of the systems the provider had in place to monitor and improve the quality of the service had still not been effective in making the required improvements.

Staff were not always aware of and did not always follow national guidance in delivering care that met people's needs in an effective way.

The provider was not effectively following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

The building and environment required improvement to meet people's needs in relation to their dementia.

People's right to confidentiality was not always respected and people were not always encouraged to be as independent as they were able.

People's diverse needs and preferences were not always identified to ensure a person centred approach to their care.

People were usually offered activities however a plan was not in place to ensure people remained active in the absence of the activity coordinator.

There were sufficient numbers of staff available to meet people's needs and reduce risks of harm.

Risks of harm to people were minimised and lessons were learned following incidents that had resulted in harm and infection control procedures were followed to prevent the spread of infection.

When people became unwell the appropriate health care support was gained in a timely manner and people were supported to eat and drink sufficient amounts to remain healthy.

People's relatives were free to visit and were involved and kept informed of people's wellbeing and people and their relatives were kept informed of any changes. There was a complaints procedure for people to use if they had concerns.

When accidents and incidents were reported to the manager action was taken to minimise the risk of it happening again.

The provider recognised the needs to improve the quality of care for people and was implementing new systems to bring about the improvements in a timely manner.

Relatives and staff respected the management and felt that improvements had been made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

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

People were not always safeguarded from the risk of abuse.

There were sufficient numbers of staff available to meet people's needs and reduce risks of harm.

Risks of harm to people were minimised and lessons were learned following incidents that had resulted in harm.

Infection control procedures were followed to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not always aware of and did not always follow national guidance in delivering care that met people's needs in an effective way.

The provider was not effectively following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

People's diverse needs were identified and assessed to ensure they were met.

The building and environment required improvement to meet people's needs in relation to their dementia.

When people became unwell the appropriate health care support was gained in a timely manner.

People were supported to eat and drink sufficient amounts to remain healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to confidentiality was not always respected.

People were not always encouraged to be as independent as they were able.

People's relatives were free to visit and were involved and kept informed of people's well being.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's diverse needs and preferences were not always identified to ensure a person centred approach to their care.

People were usually offered activities however a plan was not in place to ensure people remained active in the absence of the activity coordinator.

People and their relatives were kept informed and there was a complaints procedure for people to use of they had concerns.

Is the service well-led?

Inadequate

The service was not well.

There was no registered manager in post.

Some of the systems the provider had in place to monitor and improve the quality of the service had not been effective.

Audits and analysis of accidents and incidents were not all effective when the manager was made aware as lessons were learned and the quality of care was improved when concerns were raised.

Relatives and staff respected the management and felt that improvements had been made.

The provider recognised the needs to improve the quality of care for people and was implementing new systems to bring about the improvements in a timely manner

New Park House

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 3 January 2018 and was unannounced. The inspection team comprised 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.

We looked at notifications the provider is required to send us. These included notifications of significant incident such as safeguarding and serious injuries.

We spoke with five people who used the service and three visiting relatives. We also spoke with three care staff and two senior staff. We spoke with the manager, the nominated individual and provided feedback to the care management consultant.

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 looked at five people's care records. We looked at the way medicines were managed and the systems the provider had in place to monitor and improve the quality of service. We also looked at staff rotas, training records and two staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that the service was not safe as care was not being carried out in a safe way and people had been harmed and were at continuing risk of harm. The safety of people's care had been rated as Inadequate. At this inspection we found that improvements had been made however further improvements were required.

Previously we had found that not all incidents of potential safeguarding incidents had been investigated or reported to the local authority. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Since the last inspection the provider had mostly ensured that safeguarding incidents had been reported. However we found two records which showed that two people had been assaulted by other people who used the service and these had not been reported for further investigation. Staff had recorded the incidents; however they had not passed the information on to a more senior member of staff to follow the safeguarding procedures.

We found that some unexplained bruising found on people were not always being investigated. This had been identified at our previous inspection and although improvements had been made there were still incidences of unexplained injuries and bruising to people which were not being investigated.

This meant that people were not always being protected from the risk of abuse. This was a continued breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We had previously found that people's medicines were not managed safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found that improvements had been made. However we found that two people who had their medicines administered covertly were having it crushed and mixed in yoghurt. Although having the medicine covertly had been agreed by their GP the mixing of the medicines in yoghurt had not been checked with a pharmacist to ensure it was safe and effective to do so.

We found that people who had 'as required' medicines such as pain relief or anti-anxiety medication did not have recorded instructions of when these medicines should be administered to them. Most people would be unable to ask for this medicine when they needed it due to their dementia and staff relied on signs and symptoms the person may exhibit. People's individual signs and symptoms were not recorded in the form of a protocol to ensure people received their medicines when they needed them.

We found that some people's prescribed topical creams were not being signed for by staff to state that it had been applied at the times required. This meant that the provider could not be sure that people had their prescribed creams and this put people at risk of sore skin.

This meant that people's medicines were not always being managed safely. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that risks of harm to people were not being managed, assessed and minimised. This was also a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we found that improvements had been made lessons were being learned and action taken when there had been an incident or accident that could have or did result in harm. We saw several examples where risks to people had been minimised. For example, we saw records that showed that one person had been falling regularly. We saw that the staff had contacted the person's GP and arranged for health checks to ascertain if there was an underling health problem that was causing the falls. A risk assessment had been put in place and assistive technology was now in use in the form of a sensor mat by their bed and attached to their chair in the lounge. We observed the chair alarm sound on a couple of occasions as the person moved in their chair and staff were quick to attend and support the person.

At our previous inspection we had found that there were insufficient numbers of staff to safely meet the needs of people who used the service. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014. At this inspection we had no concerns regarding the staffing levels throughout the service. We saw that there was a staff member allocated to the lounge areas at all times who responded when people required support to mobilise or had other requests. People were supported with their needs in a timely manner, one person told us: "The staff are quite busy but they will always get round to you quite quickly". Another person told us: "There is always someone there when you need them".

At our previous inspection we found that new staff were not being employed safely. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that new staff had been recruited through safe recruitment procedures. Pre employment checks were carried out before staff were employed. Pre- employment checks included the completion of disclosure and barring service (DBS) checks. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

We looked at how the service prevented the spread of infection and we saw that staff followed infection control procedures when going about their tasks. The new manager showed us that they planned to complete an infection control audit as this was overdue. We saw that staff used gloves and that there was antibacterial gel throughout the building. Infection control procedures were followed when laundering people's soiled laundry and the building was clean and hygienic throughout.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had concerns about the effectiveness of the service and had rated this area as inadequate. At this inspection we found that improvements had been made however further improvements were required.

At our previous inspection we found that the provider was not effectively following the principles of the Mental Capacity Act 2005 (MCA).This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The 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. At this inspection we saw that one person had been assessed as having mental capacity to make decisions yet had been referred for a Deprivation of Liberty Safeguards assessment. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This person would not require a DoLS authorisation as they had been assessed by staff to be able to consent to their care at the service.

We saw another person had been asked to sign a consent form, consenting to their photo being taken yet their capacity assessment stated they lacked the mental capacity to make decisions due to their dementia. We saw other examples of where people's mental capacity assessments did not coincide with the actions staff had taken when supporting people to make decisions. We saw a letter from person's doctor stating that the person could have their medicines administered covertly. However the person's mental capacity to agree to this had not been assessed and a meeting had not been held with the person and their representatives to ensure that this was in their best interests. This showed a lack of understanding of the principles of the MCA.

These issues constitute a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The assessment process to identify people's care and support needs required strengthening. We looked at people's care records and found that they lacked information on any recognised diverse needs including people's culture and sexuality. This meant that people's individual needs may not be being met. We also found that people with specific needs in relation to their dementia were not always being supported following good practise guidance. For example, several people at times became anxious and this could result in them harming themselves or others. Staff had not received training in supporting people during these times and clear and comprehensive plans were not in place to inform staff how to safely support people. This meant that these people's needs were not always identified and being met in line with current legislation and evidence based guidance to achieve effective outcomes.

At our previous inspection we found that staff were not being supported to fulfil their roles through effective supervisions and training. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.At this inspection we found that improvements had been made and most staff were receiving training and support fulfil their role safely and competently. However, further improvements were required as we spoke with one staff member who had been working at the service for almost 12 months. They told us that they had not received any training in caring and supporting people with dementia in a dignified manner and yet this was their primary role. The new manager told us that they had concerns about this staff member's performance and had addressed their concerns with them. However they had not arranged training to support them to complete their role. This meant that this staff member was not being supported to fulfil their role effectively.

At our previous inspection we found that people were not receiving safe care as their health needs were not being met. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made as when people became unwell they were supported to see their doctor or relevant health care professional. The doctor conducted regular visits to the service and staff contacted them in between times when necessary. We saw one person had become unwell and we saw that the staff took action to call for medical assistance. This person had been suffering from a side effect of their diabetes. We found that the person did not have a care plan in relation to their diabetes and the action staff should take when they were exhibiting signs of becoming unwell due to their diabetes. Staff had not received training in caring for people with diabetes. We discussed this with the manager and director who immediately sourced training for staff in caring for people with diabetes.

At our previous inspection we found that people's nutritional needs were not being met. This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and people were supported to maintain a healthy diet. We saw people were regularly weighed and where people had lost weight this had been reported to the doctor and action had been taken. People told us they liked the food, one person told us: "The food is very, very good. There is no need to go hungry as if we don't like anything they will offer us something else". We saw people had jugs of juice or water in their bedrooms which was dated so that this ensured it was fresh. We observed that people who required support with eating and drinking were supported to do so by staff in a timely manner. Special diets were catered for such as soft diets and there were utensils available to support people to eat and drink independently. This showed that people were supported to eat and drink sufficient amounts to remain healthy.

The building had been adapted to meet the physical needs of people who used the service and it was pleasantly decorated throughout. We saw there were grab rails and flat services for people to be able to mobilise safely throughout independently. The service would benefit from being further adapted to meet the needs of people living with dementia to support them to orientate to time and place and offer appropriate stimulation in line with current guidance.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found that people were not treated with dignity and respect and their right to privacy was not being upheld. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this this inspection we found that improvements had been made and the provider was no longer in breach of this regulation however further improvements were still required.

We observed people's care and saw that interactions between staff and people were kind and respectful. However we overheard some members of staff talking about people's care and needs in the communal areas where friends and visitors were able to overhear. The senior members of staff were also answering the telephone in the communal areas and having conversations with health care professionals and relatives about people's current needs. This meant that people's right to confidentiality was not always being respected.

We saw that people's right to independence was not always promoted. One person was asking to leave one of the lounges. The staff member present albeit in a pleasant manner kept asking the person to stay in the lounge until staff were available to support them. The person said: "I don't want to sit in a chair all day and I want my handbag". The member of staff told the person they would look for it for them when another member of staff became available as the person could not go alone. It was unclear why this person could not independently go and fetch their handbag and the request to do so was not achieved in a timely manner. We saw another person who was at high risk of falls and had a chair sensor to alert staff when they were attempting to get up. The staff responded to the person when the alarm went off however the person was asked to stay seated and they were not offered the opportunity to mobilise with staff support. This meant that people's right to independence and freedom was not always respected and encouraged.

People who used the service told us that staff treated them well. One person told us: "It's not like home but I am well looked after, the staff do a wonderful job". Another person told us: "The staff are excellent, specially chosen". Relatives told us that staff were kind and caring. One relative told us that on one occasion they had observed one person had fallen over. They told us that the staff member who attended to the person provided comfort and support by lying on the floor with them until the paramedics arrived and stayed well after their shift was over. This demonstrated a caring and compassionate approach to people who used the service.

People were offered choices and were involved in the planning of their care when they were able. We saw staff offered people choices throughout the day such as where they chose to sit and what they would like to eat. People were able to wake up when they wished, we heard one staff member said: "I can't believe how long [Person's name] has been in bed today a proper nice lie in". Staff we spoke with knew people well and knew their likes and dislikes. One staff member told us: "Even though I know people I always ask them what they want". This demonstrated that people's choices were being respected.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that the service was not responsive to people's needs. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had made and they were no longer in breach of this regulation, however further improvements were required.

We looked at several people's care plans and we found that people's diverse needs such as their culture and sexuality had not been identified and people's preferences about how they wished their care to be delivered were not always sought, for example if people preferred male or female carers. This meant that people may not receive care that met their individual needs and preferences. The manager told us that they planned to implement new care plans which would ensure that people's needs and preferences were met.

At the time of the inspection there was no one receiving end of life care. We found that some advance plans were in place and information had been gained from some people or their relative's that stated specific wishes and preferences at their end of life. These plans included details such as; family contact and the person's wishes after their life has ended such as burial or cremation. However questions about how people wished to be cared for at the end of their life were not routinely asked. This meant that if a person passed away suddenly their wishes may not have been identified and staff would not have the guidance they needed to provide end of life care according to people's individual preferences.

Relatives we spoke with told us that there was a staff member responsible for organising activities such as shows and events and people had really appeared to enjoy the Christmas pantomime. However, on the day of the inspection the staff member who coordinates the activities was absent from the service. We saw in one lounge that a member of staff facilitated a few games of bingo. However within the other lounge area where people were living with dementia there were no activities and people spent time sitting and sleeping with little interaction. We observed that at one point a senior member of staff asked a staff member to facilitate an activity however the staff member did not follow through on this request. Plans to arrange and carry out activities in the absence of the activity coordinator had not been made and people lacked social stimulation. One person who chose to spend time in their bedroom told us: "I get very bored as I can't join in on group activities due to my poor eyesight". It was unclear as to whether one to one activities were available to this person. We fed this back to the manager at the end of the inspection and they informed us that they would arrange to ask the person what they would like to do. However, prior to our feedback consideration had not been given to providing individual social activities for people who did not wish to partake in group activities.

Relatives were free to visit at any time and the relatives we spoke with told us that they were involved in their relatives care. One relative told us: "I'm here every day but when I'm not here and there is a change to my relative, the staff always contact me". There were regular meetings for people and their relatives to be able to have a say in how the service was run and to be kept informed of any planned changes to the service.

At our previous inspection we found that people's complaints had not been listened to and acted upon. This

was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made. Relatives told us that they felt that the management were approachable if they had any concerns. One relative told us: "The owners are 100 per cent approachable". The provider had a complaints procedure and we saw a recent complaint had been investigated and responded to according to the policy.

Inadequate

Is the service well-led?

Our findings

New Park House had been rated as requires improvement or Inadequate at four previous inspections. This highlights that the provider is unable to implement sustainable improvements to the care and support that people receive. At our last inspection in August 2017 we had serious concerns about the management and leadership of the service. We had taken urgent enforcement action and asked the provider to improve. At this inspection we found that although some improvements had been made throughout the service further improvements were still required and there were continuing breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This showed that the provider had not been able to improve the quality of care to ensure people were receiving 'good' care and sustain the improvements.

Several new audits had been implemented to monitor and improve the service. However not all the audits had been effective in ensuring that areas for improvement were identified and acted upon. For example, some people's topical creams were not being signed for and this had not been identified and addressed via the medication audit.

The systems to report potential abuse and harm to people were still not always effective as we found several records of unexplained bruising to people which had not been reported to the manager, investigated and reported to the local safeguarding authority. This meant that people were still at risk of harm through potential abuse.

Since the last inspection the provider and manager had managed several staff members' performance to ensure staff were providing a high standard of care. However, we saw an example of where one staff member had been told to improve their practice in certain areas using the provider's disciplinary procedures. We found that this staff member had not received training in the areas that they were being asked to improve and this would not support them to improve and be effective in their role.

This meant that some of the systems the provider had in place were still not effective in assessing and, monitoring and mitigating the risks relating to the health, safety and welfare of people who used the service which arise from the carrying on of the regulated activity. This constitutes an on-going breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider was failing to comply with a condition of their registration as the service had been without a long term registered manager for three years. This means that the home has been without effective, stable leadership for over three years. At the time of this inspection there was still no registered manager in post. This was a breach of Section 33 of The Health and Social Care Act 2008.

Since the last inspection the provider had employed a consultant to help and advise them in making improvements to the quality of service. We found that this had resulted in some improvements in the quality of care being provided. Relatives we spoke with told us that they had seen improvements since the last inspection. One relative told us: "There has been a change over the six months; the owners make the time to talk to you". Another relative told us: "My confidence in the owners has grown enormously".

Relatives told us that they had been invited to and attended several meetings and their feedback about the care was being sought. One relative said: "The owners were very open about the problems the home was experiencing and updated us on what they were doing in response to the CQC report". We saw that people's and their relatives views were listened to and acted upon. For example, we saw that a relative had requested that people had access to more fluids throughout the day. We saw that the provider had implemented jugs of juice and water which were put fresh into people's bedrooms every day. We saw there were labels on the jugs stating when they had been put in to ensure its freshness. This demonstrated that the provider had listened and responded to our concerns in an open and transparent manner.

There was a new manager in post who had previously been a deputy manager at the service. They were yet to register with us as is required. A relative told us: "I find the new manager thorough and caring". Staff we spoke with told us that they liked and respected the manager. One staff member told us: "The manager is hot on getting things right and is very efficient. They will tell you if things aren't right".

We saw that accidents and incident control sheets had been implemented and we saw that when an accident/incident had been reported to the manager there were records of what action had been taken to minimise the risk of it happening again. The manager told us and showed us that they conducted weekly walk around with the head of housekeeping to monitor the environment and action any necessary requirements.

The provider had worked closely with the local authority improve the quality of care for people and had an action plan in how they planned to continue to improve. The manager and nominated individual were responsive on the day of the inspection, taking action to implement new systems as we feedback our findings. This demonstrated that the provider was working towards continuous improvement.

At our previous inspection we found that the provider had not been notifying us of all significant events that had happened within the service as they are required under the registration to submit. We use this information to monitor the service and ensure they responded appropriately to keep people safe. This meant we could not always be assured they were dealing with incidents and issues in an appropriate way as the CQC was not always being informed of incidents. This was a breach of Regulation of 18 of the (Registration) Regulations 2009. Since the last inspection we had received the necessary notifications as required and the provider was no longer in breach of this regulation.

At our previous inspection we found that the provider was not displaying their most recent inspection rating as they are required to do. Ratings must be displayed in the premises where a regulated activity is being delivered from within 21 days of the report being published on the CQC website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that the provider's rating was clearly visible in the reception and on their website.

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	Section 33 HSCA Failure to comply with a condition There was no registered manager in post.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not always following the principles of The MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always being managed safely.

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 Safe safeguarding procedures were not always followed to prevent the risk of harm or abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the providers systems to monitor and improve the service had not been effective.