A D R Care Homes Limited

St Nicholas Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out a comprehensive inspection of this service on 17,18 and 20 November 2014. We found multiple breaches of legal requirements were found. The provider subsequently employed a crisis manager. On 18 December 2014 we were notified by the crisis manager that they had identified significant concerns regarding the competency of three of the nursing staff. As a result we undertook focused inspections on 19, 21 and 29 December 2014.

You can read a summary of our findings from all inspections below.

Comprehensive inspection of 17,18 and 20 November 2014

This inspection took place over 17 and 18 November 2014 and was completed by an early evening inspection on 20 November 2014. The inspections on the 17 and 20 November were unannounced, which meant that the provider did not know that we were coming. On the 17 November we told the manager that we had not completed our inspection on that day and would be returning the next day. The inspection was carried out over all three days by the same two inspectors.

Summary of findings

There were 32 people living in the home at the time of our inspection. Many needed nursing care and/or were living with physical disabilities. Some people were living with dementia.

During our inspection we spoke with five people living in the home and relatives of another four people. We were unable to communicate in detail with many people living in the home due to their complex needs. However, we spent time observing the day to day workings of the home and carried out a short observational framework for inspection (SOFI) to help us understand the experiences of people who could not communicate with us. SOFI is a method of observing how people using services engage with other people, their environment and the quality of staff interaction with them.

We also spoke with the registered manager, the deputy manager, five care staff and three ancillary staff members. Health care professionals familiar with the service also gave us their views.

A registered manager was 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.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People and their relatives held mixed views about the service they or their family member received. Whilst some people were very happy, others were not. Our own observations, those of health care professionals and the records we looked at were not always in accordance with the positive views held by some people.

People's safety had been compromised in a number of areas. For example, we found inadequate staffing levels, unsafe staff recruitment, hazardous cleaning materials left unsecured, poor pressure area care, inadequate monitoring of diabetes, unsafe medicines arrangements and infection prevention and control issues.

We had considerable concerns that people weren't being effectively supported with their nutrition or hydration needs and reported these concerns to the local authority. Meal times in the main lounge resulted in a poor experience for people who chose to eat there.

Although staff had received training in the Mental Capacity Act 2005, staff we spoke with didn't understand the requirements of the Act and how it affected their work on a day to day basis. The manager had not completed the necessary applications to the local authority as required by the Deprivation of Liberty Safeguards (DoLS).

People and their relatives that we spoke with told us that most staff members were caring and trying to do a good job. We observed both good and poor examples of staff interaction with people throughout our inspection. However, we had concerns that people were not always being cared for in a way that supported their dignity or privacy.

There was a general consensus from people we spoke with who had raised concerns with the manager that their efforts had proved to be ineffective in bringing about change for the better. These people living in the home, their relatives and staff members were dissatisfied and frustrated.

There was little to occupy people's time in St Nicholas Nursing Home. The time devoted to this was insufficient to effectively support people to maintain their own interests or occupy people living with dementia. These people needed to be engaged with meaningful social interaction to maximise the quality of their daily lives.

The service was poorly managed at both manager and provider level. This was evident from our findings throughout the inspection. There was little effective quality monitoring. We found a culture of blame within the home. When we discussed our concerns with the manager they accepted little responsibility for the failings we had identified.

Focused inspection of 19 December 2014

We found serious concerns about the safety of people living at the service, particularly those in need of nursing care. This was because following incidents under investigation sufficient numbers of competent nursing staff were not available. The provider's staff had worked with the local authority and North Norfolk clinical commissioning group (CCG) to ensure that suitable nursing cover would be provided over the coming weekend.

Focused inspection of 21 December 2014

Summary of findings

We carried out this inspection to establish whether suitable numbers of nursing staff were available to support people living at the service. Nursing cover was being secured on a day by day basis which wasn't sustainable or safe. The decision was taken by commissioners to relocate people with high care needs to other homes where a safe standard of nursing care could be provided for them. This was carried out over 23 and 24 December 2014. CQC carried out urgent enforcement action under Section 31 of the Health and Social Care Act 2008 on Tuesday 23 December 2014. This meant that with immediate effect, the providers were not allowed to provide nursing care at St Nicholas Nursing Home.

Focused inspection of 29 December 2014

This inspection was carried out to establish whether the people remaining at the home were safe and supported by adequate numbers of suitable staff. We were satisfied that suitable arrangements were in place to ensure that people's needs were met.

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?

Inadequate

This service was not safe. There were insufficient staff numbers. The service had not revised staffing levels despite a significant increase in the number of people living at the home in recent months. Recruitment practices did not provide us with assurance that the provider took all necessary steps to ensure that staff employed were suitable for their role or the responsibility it entailed.

Risks to people's health and welfare posed by the care they received, the way the service was managed or the environment were not always minimised effectively.

We found that staff we spoke with understood about types of abuse. They reported their concerns to the manager or a senior staff member and relied upon them to take the necessary action.

29 December 2014

We found that improvements had been made to ensure that people remaining at St Nicholas Nursing Home were supported by adequate numbers of staff. This meant that the provider was now meeting legal requirements in relation to staffing.

Is the service effective?

Inadequate

The service was not effective. We were concerned that people were not always supported to receive adequate nutrition and hydration. Where specialist advice had been received, it had not been acted upon.

Staff were not effectively monitoring people's healthcare needs, particularly when their needs changed.

The provider had not ensured that all necessary applications to the local authority had been made as required in relation to the Deprivation of Liberty Safeguards (DoLS). Staff did not understand their responsibilities under the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not consistently caring. Some people we spoke with were positive about the care they received, but this was not always supported by our observations or those of visiting health care professionals.

People's privacy and dignity was not always respected by the way that care was provided.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. We observed that people living in St Nicholas Nursing Home were unoccupied for long parts of the day. Whilst staff were aware of people's preferences, and despite their best intentions, they were not always able to ensure that care was delivered in a timely manner that met people's needs.

Summary of findings

We could not establish that complaints were dealt with appropriately. Some people we spoke with felt that their concerns were ignored or not acted upon effectively. People new to living in the home were not aware of how to make a complaint, should they wish to do so.

Is the service well-led?

Inadequate

The service was not well led. The manager and provider had not ensured that effective systems were in place to identify and remedy areas of concern. We found serious concerns in many areas that had not been effectively addressed, or in several cases identified.

The manager had failed to notify CQC of events they were obliged to by legislation.

There was a poor culture at the service. Staff felt they were not listened to and were blamed when things went wrong. People we spoke with told us that leadership was poor and day to day staff guidance and support was not evident which affected the standard of care people received.

St Nicholas Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of four inspections of St Nicholas Nursing Home. We carried out each inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first inspection was a comprehensive inspection of all aspects of the service and took place over 17, 18 and 20 November 2014. This inspection identified multiple breaches.

The second, third and fourth inspections were carried out on 19, 21 and 29 December 2014 respectively and concentrated mainly on reports of inadequate and insufficient nursing provision. You can find full information about our findings in the detailed findings section of this report.

Comprehensive inspection of 17, 18 and 20 November 2014

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.

The inspection was carried out following concerns raised with us by the local authority's safeguarding team. At the same time we had received separate concerns that the service was often short of staff, which was impacting upon the quality of care that people received.

This inspection took place over 17 and 18 November 2014 and was completed by an early evening inspection on 20 November 2014. The inspections on the 17 and 20 November were unannounced, which meant that the provider did not know that we were coming. On the 17 November we told the manager that we had not completed our inspection on that day and would be returning the next day. The inspection was carried out over all three days by the same two inspectors.

Prior to this inspection we asked the provider to supply us with staffing rotas. We were supplied with staff rotas for the period Monday 20 October 2014 to Sunday 02 November 2014 and from Monday 10 November 2014 to Tuesday 11 November 2014. The service had been unable to locate the staff rota for the period Monday 03 November 2014 to Sunday 09 November 2014 so had provided daily fire register staff sign in sheets instead.

During the inspection we spoke with the registered manager, the deputy manager, five care staff and three ancillary staff members. We spoke with five people living in the home and relatives of another four people. We were unable to communicate with many people living in the home due to their complex needs. However, we spent time observing the day to day workings of the home and carried out a short observational framework for inspection (SOFI) to help us understand the experiences of people who could not communicate with us in detail. SOFI is a method of observing how people using services engage with other people, their environment and the quality of staff interaction with them.

We reviewed care plans and associated documentation in detail for three people living in St Nicholas Nursing Home and observed medication being administered. We looked

at the recruitment records of five staff members, medication records, menus, complaints the service had received and other documentation relating to the management of the service.

Focused inspection of 19 December 2014

We undertook an unannounced focused inspection of St Nicholas Nursing Home on 19 December 2014 following reports from the service's crisis manager of significant concerns regarding the competency of three nurses which impacted upon the standard of care people received. We only inspected the service against one of the five questions we ask about the service; is the service safe? This is because concerns had been raised about the competency nursing staff.

The inspection was undertaken by an inspector and an inspection manager. During this inspection we spoke with the crisis manager, the deputy manager, a visiting health care professional and two people living in the home.

We reviewed care records in respect of two people, records relating to concerns notified to us by the crisis manager and staffing rotas.

Focused inspection of 21 December 2014

We undertook a further unannounced focused inspection of St Nicholas Nursing Home on 21 December 2014. During our inspection of 19 December 2014 we found that some nurses had been identified as providing an unacceptable standard of nursing care. The service was having considerable and ongoing difficulties in ensuring adequate numbers of suitable nursing staff were available to support the needs of people living in the home.

The inspection was undertaken by an inspector and an inspection manager. During this inspection we spoke with the crisis manager, the deputy manager, two staff members and one person living in the home.

We reviewed care records in respect of three people and staffing rotas.

Focused inspection of 29 December 2014

We undertook this unannounced focused inspection of St Nicholas Nursing Home on 29 December 2014 to establish whether the people remaining in St Nicholas Nursing Home were safe and supported by adequate staffing arrangements.

The inspection was undertaken by an inspector and an inspection manager. During this inspection we spoke with the acting manager, who was a manager from one of the provider's other homes. We also spoke with seven people living in the home, one relative and four staff members.

We reviewed care records in respect of two people and staffing rotas.

Inadequate

Is the service safe?

Our findings

Findings from the comprehensive inspection of 17,18 and 20 November 2014

The service was not safe. We found considerable concerns across different aspects of the service provided to people that demonstrated to us that this service was not safe.

There were not enough staff to meet the needs of the people who lived in the home. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us, 'There's so few staff in they just don't have the time. They are still doing jobs at lunchtime that used to be done by mid-morning. They're all wearing out.' Another person said, 'They're always short staffed in the afternoon. I've been left longer than 30 minutes waiting for the toilet.'

Throughout all three of the days we inspected the home we found that call bells were constantly ringing, often going on to the emergency alert as they were not being answered promptly. Staff also told us they were very busy which we also saw for ourselves. One staff member told us they had not read any care plans because there was not enough time. Another told us they had no time to sit and speak with people or to effectively support them as their key worker. We saw that when people were up and dressed they were brought into the lounge if they wished. However, there was no staff member in constant attendance here despite there being eight people in this room at one point. There was a call bell in the centre of the room, but not everybody would have been able to get to it or be able to use it even if they could access it. People already in the lounge tended to wait for a staff member to bring someone else in to the lounge so they could ask for assistance, or relied on visitors to find staff members for them.

At the time of this inspection 32 people were living in the home. We last inspected the service in July 2014 when there had been 24 people resident. Staff and people we had spoken with at the time felt that staffing levels were about right. However, the staffing arrangements were still the same despite there being eight more people to care for. The manager had told us during the July 2014 inspection that they had the discretion to increase staff numbers if occupancy levels or people's needs changed. We asked why they hadn't done this and were told that they were utilising a dependency tool which indicated their staffing levels were appropriate. Conversely, they then went on to say that the nurse on duty was overworked, they needed a second nurse and they were looking to recruit a carer to cover a daytime 9:00 am until 6:00 pm shift.

The cook was visibly upset when we spoke with them. They told us that they were struggling to cope with the numbers of people they had to cater for with increasingly different nutritional requirements on their own. This meant that meal times were often late and people were becoming frustrated waiting.

We reviewed staff rotas for the period covering 20 October 2014 to 11 November 2014 and found that 13 out of 23 early shifts and 9 out of 23 late shifts were short staffed. This equated to 48% of day time shifts not having sufficient staff according to the provider's own current staffing requirement.

Seven people required full assistance with meals. At lunchtime two of these people were assisted by relatives who came in every day. Staffing numbers were higher in the early shift and ancillary staff also assisted people with their lunch. However, at tea time if the afternoon shift was short by just one staff member and another staff member was required to prepare the tea, the number of staff available to assist people with their meal could be down to three. The staffing arrangements in place at St Nicholas Nursing home were not acceptable and placed people at risk of inadequate and unsafe care.

On the ground floor we found that the cleaner's cupboard was unlocked and the door did not close flush to the frame. This cupboard contained several bottles of cleaning fluids including 'safeclean', a cleaning product with bleach, that if ingested would be hazardous to people's health. We were told that one person living at the home was mobile and particularly at risk because they tended to drink anything they could access. We alerted the manager to this issue, but found that when we inspected on the third day, this still hadn't been rectified. We ensured the products were moved to a safe location before we left the premises.

On the first day of our inspection we noted one bedroom was in the process of being refurbished. This room was not locked. The pedestal from the sink was lying in the middle of the floor as were various lengths of pipe and plumbing equipment. A bottle of 'safeclean' was on the floor as were bottles of turpentine and white spirit. On the second day of

our inspection the room was in the same condition, but the door had been left open. However, by the third day the room refurbishment had been completed and was no longer a danger to people living in the home.

Upstairs, opposite the lift, was a broken plastic clock on the wall above a handrail. The bottom edge was broken in several places and was very sharp. This would be at head or shoulder height for anyone walking along the corridor using the handrail for guidance and posed a risk to people's welfare.

Accidents and incidents were not effectively monitored to identify patterns or trends to help reduce re-occurrences. For example no reviewing was undertaken to map where the accident took place, what time of day it occurred and whether any staff were present at the time. Individual forms were retained in people's care records and if repeated incidents occurred the manager told us they would be dealt with. The manager also told us that patterns could be identified from care plan reviews which they carried out. However, the last care plan audit had been completed in June 2014 which had reviewed twelve residents. Consequently, the care plan audit wasn't an effective method to identify patterns from accidents and incidents.

These issues presented significant risks to people's safety and welfare. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had significant concerns about the recruitment processes utilised at the home. Shortly before this inspection we had been contacted by a health care professional. They informed us that they had been unable to communicate with a nurse at the home due to the nurse's poor spoken English. During our inspection the manager told us that they interviewed the nurse on Skype but had not kept a record of the interview. They said that the nurse's English during the interview was 'not bad' and better than other candidates they had spoken with. However, they went on to tell us that about a month ago the nurse's English had deteriorated. The manager said they had spoken with the nurse and had formed the view that the nurse was homesick. Having a nurse on duty with poor communication skills put people at risk of receiving unsafe care. One person had not been given paracetamol to reduce a high temperature and the person was subsequently admitted to hospital. However, the nurse had been reluctant to call the emergency services or inform the person's family that they were unwell. As a result of a request from the health care professional the nurse was no longer providing nursing care at the home.

We reviewed a sample of five staff recruitment files. Three staff members had commenced duties without any references having been received for them. According to recruitment checklists Disclosure and Barring service (DBS) checks had been completed, but the supporting documentation itself wasn't on record at the time of the inspection. This was forwarded on to us after the inspection was completed.

Two of the DBS certificates were accompanied by DBS check risk assessment forms that were completed by the manager. These had not been on the two individuals' recruitment files when we reviewed them during the inspection. One of these DBS check risk assessment forms indicated that two references were on file when they were not and that the referees had been contacted by telephone. There was no record of any telephone conversations with the referees on the person's recruitment file either. We raised our concerns with the provider who subsequently took appropriate action to ensure that people living in St Nicholas Nursing Home were not put at risk from inappropriately recruited staff.

People living in St Nicholas Nursing Home could not be assured that they were supported by staff that had been fully and effectively vetted before commencing duties. This put them at risk of receiving support from staff members who may not have been suitable for their role which could compromise people's welfare and safety.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person had been assessed as being at risk of developing pressure ulcers. We noted in the wound records that they had a pressure ulcer on their sacrum. The records contained no information to show the size or depth of the ulcer or what dressings were used to treat it. There were no photographs or wound mapping. Consequently, from the records it was not possible to establish whether the ulcer was healing or deteriorating. There was conflicting information about how frequently the dressing was changed. The dressing was last recorded as changed on 30 October 2014. Consequently, we could not be sure that the person was receiving appropriate care.

Inadequate

Is the service safe?

During our inspection we raised concerns with the local authority's safeguarding team and the North Norfolk Clinical Commissioning Group (CCG) whose role is to make sure that appropriate NHS care is in place for people. As a result health professionals commenced visits on 21 November 2014 to review the care that people received. When they visited they found the person's pressure relieving mattress had been set to 'hard' which was inappropriate. The person had also been sat on a chair without a pressure relieving cushion. An overlay mattress was placed on top of the static mattress. This reduced the effectiveness of the bedrails because the height differential had been lowered which meant the person could be at risk of falling out of the bed.

Another person had been assessed as being nutritionally at risk and was losing weight. The service had been offering them prescription nutritional supplements. However, these had not been prescribed for the person. There was a risk that this un-prescribed supplement could result in adverse interactions with other medicines the person may have been taking or result in undesirable side effects. Under no circumstances should the service have administered prescription supplements to someone who had not been prescribed them.

A third person who was living with diabetes was supposed to have their blood sugar levels monitored weekly. This had last been done on 13 October 2014. When we asked why this hadn't been done we were told by the deputy manager that it was the night nurse's responsibility to do this. Regular blood glucose monitoring provides immediate information on how effectively diabetes is managed. Failing to do this presented a risk that the person's health could be deteriorating which the service would have been unaware of and consequently unable to respond to.

These people's needs had not been effectively assessed and/or the planning and delivery of their care did not ensure their welfare or safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the medication room we found that the fridge temperature was being recorded and was within the required temperature range. However, the medication room felt very warm and this was not being monitored. Our inspection took place in November 2014, so it was likely that the room would have been even warmer in the summer months. Some medicines and creams are not stable or effective at higher temperatures. The service needed to ensure that the temperature in the medication room was not excessive.

We found that people's photographs were not on the Medicines Administration Record (MAR) charts. This posed a risk that someone could be identified incorrectly and given the wrong medicine. We observed the nurse on duty carry out the medicines round. When they were administering medicines to people in the lounge the trolley was left open with tablets left on the top of the trolley. Many of the people living in the home had dementia. There was a possibility that people's medicines could be removed from the cabinet and therefore not be available for them and/or taken by someone accidentally which could be detrimental to that person's health.

One relative we spoke with told us their family member had been prescribed medicine by their GP. However, the service had not collected this from the pharmacy on the first day it had been made available. This meant that the person did not receive the relief from their symptoms at the earliest opportunity.

These findings meant that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The main lounge gave off an unpleasant odour which was apparent to anybody walking in to the home as the lounge was near the main entrance. One person told us the smell was '….overpowering. But I'm afraid I'm getting used to it.' The first day of our inspection was a sunny day and because of the large glass windows in the lounge it was quite warm. The odour was particularly offensive on this day. We had been told by the manager on the previous inspection in July 2014 that the carpet would be replaced by vinyl flooring but this hadn't been done. Carpets are difficult to clean effectively and can harbour micro-organisms which can be a source of cross-infection. This was not a pleasant environment for people to spend their time, particularly as several people ate their meals in this room.

People living in St Nicholas Nursing Home told us how the weekend immediately before our inspection the home had run out of disposable gloves. One person living in the home said, 'There were no rubber gloves yesterday. [A home nearby] lent them two boxes. Staff were opening dressing

packs for the gloves.' This was confirmed by staff. We spoke with the manager who confirmed that the order had not been placed in time to ensure delivery before the current stock had run out. The order had been emailed from the manager to the provider on the Thursday afternoon which meant that the stock would not be received in time for the weekend. The manager told us they had not been given the order from the maintenance staff member in time. However, the maintenance staff member told us that the manager had been given the order on the Monday, which was the same day they gave the order list to the manager every week.

The provider was not ensuring that people were protected against the risk of infection or cross-contamination. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with, including a new staff member, had a good knowledge and understanding about protecting people from abuse. Staff told us they would report any concerns to a senior staff member or the manager and were reliant upon them to take the necessary action. Some of the staff we spoke with were aware of failings within the service. However these failings were seen by staff as a result of inadequate staffing levels rather than from the perspective of people who were not receiving the standard of care to which they were entitled.

We observed that people were relaxed in the company of staff. People we spoke with did not express any concerns about their personal safety. Three relatives we spoke with told us they had no concerns about their family member's safety. Two relatives told us they didn't think their family members were at risk of physical abuse, but that they didn't always have confidence that their family members were always looked after in a manner that ensured their safety or welfare.

Findings from the focused inspection of 19 December 2014

The crisis manager told us that they had identified significant concerns regarding the competency of three of the nursing staff. Two separate incidents had been reported to the local authority's safeguarding team.

Staff had worked with the local authority and North Norfolk clinical commissioning group (CCG) to ensure that suitable nursing cover would be provided over the coming weekend. In addition the provider gave assurances that they had arranged for cover from an agency nurse who was due to arrive on Sunday 21 December 2014.

We spoke with a visiting health care professional who told us that they found that one person had a long standing wound on their knee which required dressing. The staff at the home had not advised the community nursing team about this wound which had been sustained several months earlier. This wound was not reported to us as required. Neither had it been referred to the local authority under the safeguarding adults procedure when clearly it should have been.

Findings from the focused inspection of 21 December 2014

Our inspection of 19 December assured us that adequate nursing provision had been in place for the weekend commencing Friday 19 December 2014. However, we did not know whether suitable nursing cover could be obtained to ensure that people were safe beyond 21 December 2014. As a result we carried out a further inspection on 21 December 2014.

We were satisfied that sufficient care staff were on duty over the coming weeks. Nursing cover had been organised for that evening's night shift and the agency nurse was due to arrive later in the day. It was expected that they would be covering four night shifts a week. Nursing cover was also in place for the following day. However, adequate arrangements were not in place to secure nursing staff for three night shifts and several day shifts for the weeks ahead. The crisis manager advised us that they had been unable to obtain suitable nursing staff.

Nursing cover was being secured on a day by day basis which wasn't sustainable or safe. On the 22 December 2014 it was established that the agency nurse who arrived the night before was not registered to practice in the UK. The majority of nursing shifts did not have cover for the coming weeks. The decision was taken by commissioners to relocate people with high care needs to other homes where a safe standard of nursing care could be provided for them. This was carried out over 23 and 24 December 2014. CQC carried out urgent enforcement action under Section 31 of the Health and Social Care Act 2008 on Tuesday 23

Inadequate

Is the service safe?

December 2014. This meant that with immediate effect, the provider was no longer registered to provide nursing care at St Nicholas Nursing Home. Enforcement action was also taken to restrict the number of people living in the home.

Findings from the focused inspection of 29 December 2014

This inspection was carried out to establish whether the people remaining at the home were safe and supported by adequate numbers of suitable staff. There were 12 people living there on the day of our visit.

We met with the acting manager, who normally managed one of the provider's other services. They advised us that four staff would be on duty on both morning and afternoon shifts. Two staff would be on duty overnight. The provider had previously sent us details of needs assessments for each person and had calculated that they only needed three staff on duty during the day. However, during discussions with us and the service commissioner at the local authority they agreed that for the stability of the service they would keep four staff on duty for the time being.

The acting manager was training senior carers to administer medicines. Previously this task had been carried out by the nursing staff. As nursing staff were no longer employed at the service alternative arrangements needed to be made. Until senior care staff had been trained and had their competency in administration of medicines tested, the acting manager would remain on site and would ensure that people received medicines safely.

People we spoke with were generally happy about the care they received, but were unclear about why some people had moved out or staff changes had taken place. One person, who was cared for in bed told us, "I've no idea what happened, why other people went. But staff have more time to spend with me now which is lovely as I don't feel so lonely." One person told us, "It's nice and quiet now, not so much [call] bells ringing." Another person said, "Oh yes, staff have enough time for us now."

Inadequate

Is the service effective?

Our findings

Each person's care records included a care plan covering their dietary needs. However, we had concerns that the service was not meeting people's needs effectively. Staff did not always make sure that people were eating or drinking enough or that nutrition was provided in accordance with guidance from health care professionals.

One person had been assessed as nutritionally at risk and required assistance to eat and drink. A speech and language therapist had recommended that the person required small meals frequently. We saw that where food charts had been completed, they were being given meals three times a day. On the first morning of our inspection we looked in this person's room four times. On each occasion a cereal bowl and a full beaker of tea left over from breakfast was on their table. No jugs of juice or any other drink was on the table on each occasion we looked in the room. This indicated that this person had not been offered a drink since breakfast. Neither had they been offered a small meal in accordance with the health professional's guidance.

According to the fluid records available the person's fluid intake varied between 230 millilitres (mls) and 2100 mls a day. The manager told us that this was down to poor recording by staff. However, due to our own observations we were not satisfied that this was always the case. This person had not been assisted with adequate nutrition or hydration. We reported our concern to the local authority's safeguarding team.

We looked in detail at the food and fluid records over a two week period for two people who were nutritionally at risk and were losing weight. There was nothing to show what the optimum fluid intake level was for each person. We found that records for several days were missing for both individuals. When we asked the manager about this they told us, 'Staff probably didn't complete them because they weren't eating or drinking much.' Where records had been completed there were often large gaps in the recording and it was rarely recorded if someone had been offered and subsequently declined food or fluid.

The cook had previously told us that they enriched meals to help counter poor dietary intake and reduced appetites which can occur with elderly people. A staff member told us they were concerned that people were being offered low fat yoghurts. We confirmed this was the case with the cook.

When we asked why we were advised that the 'value' range of food ordered by the provider only offered a low fat yoghurt option. Low fat yoghurts were not suitable for the needs of all people living in St Nicholas Nursing Home, some of whom required calorie dense nutrition.

We observed that lunchtime in the lounge was disorganised and resulted in a poor experience for many people eating there. Five people did not have drinks with their meals. These were provided after about 15 minutes but people were not offered a choice of what to drink. One person who did have a drink to start with had finished it and was not offered a top up. Three people had been given their dessert at the same time as their first course which meant that some people didn't eat much of their main meal and went straight for their dessert, which may have been of less nutritional value. One person's food had been delivered to their table but they were struggling to reach their plate as their table hadn't been moved near enough to them.

People told us that sometimes staff were too busy to ensure that people had a cup of tea mid-morning and mid-afternoon. The tea trolley had only started its round at 11:30 am on the first morning of our inspection. One relative told us how sometimes there was no tea trolley at all in the afternoon although people were provided with cold drinks.

These failings were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

If people's health needs changed referrals were made via the person's GP for specialist support. However, we found that the service did not pursue this any further when no action was forthcoming in respect of one person, even though their health was declining. We found that health updates were not always recorded and there was conflicting information about what date this person had received a visit from the GP and what the outcome was. We saw from their records that blood tests had been carried out; however no outcome was recorded for this. We later spoke with the person's relative who told us that the results were known and this had been relayed verbally to the manager two weeks previously.

Inadequate

Is the service effective?

Accurate records were not kept in relation to people's care. This could result in people receiving unsafe or inappropriate care. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Many of the people living in the home were living with dementia. Some of them had the mental capacity to make their own decisions on a day to day basis, but sometimes this fluctuated. Some people did not have the mental capacity to make their own decisions. We found that although staff had undertaken training in the Mental Capacity Act (MCA) 2005 they had little practical knowledge of it. For example, staff spoken with did not know who was able to make decisions for people who lacked the mental capacity to make their own decisions. Consequently, we could not be sure that decisions were being made in accordance with legal requirements.

The manager was aware of the changes in criteria for applications to the local authority in respect of the Deprivation of Liberty Safeguards (DoLS). Two applications had been made. The manager was also aware that applications needed to be made in respect of several other people living in the home, but these hadn't yet been made.

Where people did not have the mental capacity to consent the provider was not acting in accordance with legal requirements. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had mixed views about the food they received. We were told, 'The food is good, I have no complaints.' 'The food is alright, but it's not like home cooking.' 'Everyone returned the stew and dumplings a few weeks back as it was inedible. The menu is boring and tends to be fish fingers, fish cakes and mince in every guise.' The manager told us that following feedback received about the menu they were due to implement a revised menu the week following our inspection and provided us with copies of this. The revised menus showed a reduced reliance on the foods complained about.

The staff training matrix showed that staff training was up to date. However, we found that a new staff member had not undertaken moving and handling training so was limited in what they were able to do, but had been put on the staffing rota nonetheless. We reviewed this staff member's induction training and spoke with them. It was clear they had learnt a significant amount in a short time and were still going through their induction. They told us they were enjoying their new role.

Two relatives we spoke with felt that staff didn't receive enough guidance or day to day supervision from more senior members of staff. They felt that because staff were too busy completing tasks, they were not observant and didn't pay enough attention to detail. For example, staff not noticing when someone was trying to read in a dark corner in the lounge.

Staff told us that there were not enough flannels to wash people with. They were not supplied with wipes to assist people with personal care. The manager had previously told us this was because they had not been disposed of appropriately in the past and this had resulted in the mascerator burning out. Consequently, a system of colour coded flannels was in use. However, we were told by staff that there were never enough flannels. Staff had taken to ripping up towels to use instead. We saw ripped towels in with the few flannels we did find in the linen cupboards. One staff member asked us, 'Would you want your relative cared for like this? It's not very dignified is it?' Flannels can be abrasive for people with skin that is prone to tearing or shearing. The use of flannels, even if clean and hygienic, was not suitable for everyone. Staff had raised their concerns about the use of flannels with the manager but had been told that the decision had been taken by the provider and was final.

Findings from the focused inspection of 19 December 2014

One person required full assistance with eating and drinking. Their fluid chart for the previous day, the 18 December 2014, showed they had consumed a total of 560 millilitres (mls) of fluid over the day, which was not enough to keep them adequately hydrated. On the day of this inspection we reviewed their fluid and nutrition charts at 11:20 a.m. The fluid chart showed the person had taken 20 mls of juice at breakfast and 100 mls later on in the morning. No other fluids had been recorded. A beaker of lukewarm tea was on their bedside table which was approximately three quarters full. Given this poor fluid

Inadequate

Is the service effective?

intake we would expect to see records showing that the person had been offered further drinks and declined them. Consequently, there was a risk that the person was not being effectively supported with their fluid intake.

Inadequate

Is the service caring?

Our findings

Not everybody was able to tell us about their experience of living in St Nicholas Nursing Home so we undertook a short observational framework for inspection (SOFI) to help us understand the experiences of people who could not communicate with us. We sat in the lounge for one hour and 20 minutes one morning. We observed staff interventions with people living in the home to help us determine whether people were treated with dignity and in a caring manner.

The television was on but no-one was watching it. People were sat around the perimeter of the large lounge so were either too far away to see it clearly or sat at an uncomfortable right angle to it. One person was sat behind a pillar. Two staff members entered the lounge and didn't acknowledge people as they were busy talking between themselves. We observed these staff members hoisting one person into a chair with barely a word spoken with the person, other than to say 'Okay?' once the person was settled into a lounge chair.

One relative told us that they had arrived at the home to find their family member sat in a chair in the lounge retching. The relative had asked the manager for their family member to be taken back to their room for some privacy as they were unwell. The manager had stated that the person had '…only needed to ask.' The relative had explained to the manager that their family member was unwell and unable to wave their arms about to get attention as they normally would. The person was then assisted back to their room.

We spoke with health professionals who had visited the service shortly after our inspection had been completed. They told us they had found two people with faecal matter under their nails. This is indicative of a lack of care. In two rooms people were being cared for in bed. Their catheter bags were lying on the floor with staff members routinely stepping over them. This demonstrated that the service was not upholding people's dignity.

On the second day of our inspection a GP and a nurse visited the service. They discussed one person's health with the deputy manager outside of the main lounge. We could hear what was being discussed from the dining room, so it was likely that other people in the lounge could hear the discussion too. The person's health was being discussed with little regard to confidentiality or the person's privacy.

These issues were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was general praise for the staff and acknowledgement that most staff members were trying to do a good job but were short of time. One person told us, 'The staff are brilliant. They can't do enough for us but they get pulled back all the time.' Another person told us, 'The staff are kind, so wonderful, but there's little time to chat with me.' A third person told us, 'I think it's marvellous here.' Another person said staff were '…not nasty, all okay.' One relative told us their family member was receiving '…the best care and I defy anyone to say otherwise.'

We saw that on some occasions staff interacted with people well. We overheard one staff member talking with someone who wasn't able to communicate verbally. The staff member spoke soothingly and gave the person time to indicate a response if they were able to do so without bombarding them with questions requiring answers or putting the person under strain. This staff member made sure the person was as involved as was possible whilst they were assisting them to change position and maintained an easy dialogue as they did so.

During our SOFI we noted some positive interactions. Two staff members came into the lounge and chatted with people cheerfully, displaying kindness and compassion. They spoke with people individually and assisted them if they needed anything. It was clear that staff who did engage with people knew them well and were able to refer to their likes and dislikes in general conversation to which people responded positively.

Findings from the focused inspection of 29 December 2014

Staff we spoke with were positive about the level of support and attention they were able to give to people. When we arrived a member of staff was in the lounge playing a board game with one person. Another staff member told us how they felt they were getting to know people better and were having more meaningful conversations with them rather than brief discussions about tasks whilst the task was being carried out.

Inadequate

Is the service responsive?

Our findings

We asked people how responsive the service was to their concerns. One person told us that they had raised a concern with the manager but the manager had told them, 'Never mind.' Another person told us, 'The manager doesn't do what they say they will do. They tell you one thing but in the next conversation it's slightly different.' Other people told us raising concerns didn't result in changes for the better. If there were improvements they didn't last very long. Some staff were reluctant to approach the manager because they felt they would get told off or have their concerns ignored.

Two people who had recently moved in to the home told us they had no idea how to make a complaint. Neither were they aware of the complaints procedure. However, they also told us they had no cause for complaint.

We reviewed the complaints records for the last twelve months, which comprised of three complaints. However records were not clear as to what action had been taken to remedy the concerns raised. Two complaints did not contain a written response although notes of conversations had been made. Consequently we were unable to determine whether all complaints had been dealt with appropriately.

Complaints were not being dealt with effectively. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The atmosphere in St Nicholas Nursing Home was not stimulating and provided little opportunity for people to undertake activities. One person told us, 'Days are long and boring.' Another person told us, '[The activities co-ordinator] has little time for activities as they have to take [person's name] out. Sometimes there's bingo or a quiz. But they have to do the tea trolley too.' The activities co-ordinator worked four hours a day on five afternoons a week. We had spoken with them on previous occasions and they had told us that group activities weren't always very successful, so they often spent their time with people on an individual basis. However, the number of people living in the home inevitably meant that some people received little support to undertake their preferred activities.

We saw that some people spent their time reading, doing embroidery or knitting. However, many people sat in the lounge just stared into space, watched what was happening in the room or slept intermittently. Some people spoke with others, but were only able to do so with those seated nearby because the positioning of peoples' chairs in the lounge didn't make conversation easy. People's needs in respect of being meaningfully occupied were not being met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care records included personalised information, for example the name people wished to be known by. We also noted good information about people's life histories and their likes and dislikes. This helped staff members to understand and communicate with people so that personalised care could be given that met the person's individual needs.

Staff were aware of people's individual preferences, for example what time people liked to get up or go to bed. People and their relatives told us that staff did their best to meet people's preferences, but were not always able to do so because they were busy elsewhere within the home.

Most people living in St Nicholas Nursing Home would have been unable to participate in any detail about the planning of their care. However, we did find that people's relatives or representatives had been involved. We saw records indicating that people's relatives were involved in discussions regarding their family member's care and support. This was most noticeable when people moved in to the home, but we were satisfied that this was on-going.

Findings from the focused inspection of 19 December 2014

We reviewed the records of one person who was living with diabetes. Their care plan stated that their blood glucose levels should be checked on a weekly basis. We found that there was a four month gap from 05 August 2014 until their blood was tested again on 08 December 2014. Failure to monitor people's diabetes was a recurrent theme at this service which put people at risk of an unidentified deterioration in their welfare.

We reviewed another person's observation and repositioning chart for 18 and 19 December 2014 which was kept in their room. There was no record of repositioning between 21:30 on 18 December until 05:15 on 19 December. No record of hourly checks had been recorded between 17:00 and 20:45 on 18 December. However, two

Inadequate

Is the service responsive?

blank line gaps had been left in the chart between these times, possibly so the chart could be filled in retrospectively. The shift change had taken place at 20:00, so the staff who were on duty during the period where the chart had not been recorded would be reliant upon memory if they were to subsequently complete the chart. Consequently, we could not be sure that the person was being observed and repositioned in accordance with their care plan, which was not effective care and presented a risk to their welfare.

Inadequate

Is the service well-led?

Our findings

We found substantial failures in the management of St Nicholas Nursing Home attributable to both the registered manager and the provider. Several serious and widespread concerns referred to throughout this inspection report had not been identified and been allowed to continue unchecked. Some of these issues had been identified at previous inspections and had subsequently been remedied. However, the service had been unable to sustain or build upon progress made.

Where concerns were known about, for example insufficient staffing, no effective action had been taken. The provider had over relied on information supplied by the manager. If the provider had carried out their own checks to ensure the service was operating in a way to ensure people were safe and received a good standard of care and support, these checks had proved ineffective.

During our July 2014 inspection we found that food and fluid charts were being checked for satisfactory completion at the end of each shift. This was no longer happening and this had not been identified by the manager.

The last care plan audit had been carried out in June 2014. The manager confirmed that no subsequent checks had been carried out. This was a poor quality audit and only referred to the main care plan record, not all records associated with people's care. There was no record to show what elements of the care plan had been considered during the audit. Records of twelve people had been checked with actions needing attention recorded. However, there was nothing to say whether the required actions had been completed. We spot checked three of these records and found that whilst some actions had been completed, some had not.

We asked for an infection control audit and were told that this had been done by Norfolk County Council over two visits in May and July 2014. We asked how the manager was ensuring that progress had been maintained and any new issues were being identified. We were told that the manager did a 'walk around' periodically, made notes of their findings and made sure that action was taken. However, as no notes were available for us to look at we were unable to confirm what, if any actions had been taken in this regard.

We asked how the manager monitored health and safety and premises related issues. We were told that the provider did this during their monthly visit. We asked for records of the last provider visit and this was supplied. This record was not very detailed and there was nothing to show what elements of health and safety had been considered in this review. Some required actions had been recorded as completed, whilst progress was underway with others.

These issues represented breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was not reporting all incidents to us as required by regulations. Certain incidents which affected people's welfare, safety or health needed to be reported to us so that action could be taken if necessary. For example, an incident we were advised of by the local authority's safeguarding team should have resulted in a formal notification to us, as should a person who had a grade three pressure ulcer. We noticed that there was a list on a noticeboard in the manager's office of categories of incidents that required notifications to be made to us. We were not given a satisfactory response as to why these incidents had not been reported to us.

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

A culture of blame and avoidance of responsibility had taken hold. When we discussed our concerns arising from the inspection with the manager the blame for any failure was placed squarely with staff who were '..not doing what they're supposed to do. I'll be speaking with them.' The manager did not consider contributing factors as to what had prevented tasks being completed satisfactorily, whether there more effective ways of working or their own level of responsibility.

Three of the care staff we spoke with told us they felt there was often little shift leadership or organisation on occasions. One staff member told us they didn't have confidence in all members of the nursing staff. Another staff member told us they felt there was no point approaching the manager because they were defensive and shut down any attempts to raise concerns. However, one staff member said the manager had been very supportive of them.

The poor culture and lack of sustained improvement over time was evident to some people living in the home and/or

Inadequate

Is the service well-led?

their relatives, several of whom we had spoken with on more than one occasion over the last 20 months. Some people who had once been keen to tell us their experiences were now less keen. They had become apathetic. This was also indicated by no-one attending the last resident and relative meeting arranged in September 2014. People did not believe that the service would improve.

Findings from the focused inspection of 21 December 2014

We met with the crisis manager and the deputy manager during this inspection. The crisis manager told us that the provider had sourced one nurse who would arrive later on in the day. We asked the crisis manager about this nurse and asked to see documentation about the nurse in order to verify their suitability. The crisis manager told us they knew nothing about this nurse and they had not seen any supporting documentation because it had arranged by the provider. It was anticipated that this nurse would cover four night shifts a week. The provider had been unable to source any other suitable nursing staff to ensure people were safely and effectively supported.

We attended a meeting with the provider the following day, on 22 December 2014 which was also attended by representatives from the local authority and North Norfolk Clinical Commissioning Group. We were informed that the nurse who had arrived the previous evening was not registered to practice in the UK. The provider had failed to carry out adequate checks to ensure this person was able to work at the home as a nurse as intended.

It became clear during this meeting that the provider had been unable to source adequate nursing staff to lead their service through the current difficulties. The provider had no contingency plans in place and stated that their intention was to carry on the service as a residential home only.

During the period from the inspection in November to the crisis situation in December there was a lack of strategic action by the provider to make decisions about the service. It was their intention not to provide nursing care at the service in the future but they did not take steps to communicate this to people or families. The lack of communication with people and their representatives resulted in people making significant life changing decisions in a hurried and unplanned way. This was not representative of an open and honest culture where people were involved in the decisions about the service.

The provider didn't take action to address staff competency issues which left people exposed to risks of continuing inadequate nursing care. At our inspection on 19 December when we raised issues about the staffing cover they did begin to address these concerns. The resulting staffing shortage meant that they were unable to cover nursing shifts and had no viable contingency to cover the service over a peak holiday period. This meant that people who required nursing care had to be moved from the service to be provided with care that met their needs.

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 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use the service were not supported by adequate staffing numbers to ensure that their needs were met. Regulation 22 **29 December 2014** The provider is now meeting this regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use the service did not receive care that met their needs or ensured their welfare and safety because hazardous substances were not secured, people's health, care and social needs were not met. Regulation 9 (1)(b)(i)(ii)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People who use the service were not protected from the risks associated with unsafe recruitment of staff. Regulation 21 (a)(i)(ii)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected from risks associated with medicines because appropriate arrangements were not in place to ensure people's medicines were stored correctly or administered promptly. Regulation 13

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use the service were not protected from the risks associated with cross-contamination because the lounge carpet wasn't clean and disposable gloves were not always in stock. Regulation 12(1)(2)(a), (c)(i)(ii)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People who use services were not protected from the risks of malnutrition because they were not always enabled to eat or drink sufficient amounts for their needs. Regulation 14(1)(c)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	People who use services could not be assured that accurate and complete records were held in respect of the care and support they received. Regulation 20 (1)(a)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who use services were not protected because the provider did not act in accordance with legal requirements relating to consent. Deprivation of Liberty Safeguard applications to the local authority had not been made in all cases. Regulation 18

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who use services could not be assured there were suitable arrangements in place to ensure their dignity and privacy and that they would be treated with respect in the way that their care was delivered. Regulation 17 (1)(a), (2)(a)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Enforcement actions

People who use services could not be assured that the complaints process was brought to attention of people or that concerns or complaints would be acted upon appropriately. Regulation 19(1)(2)(a), (c)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services could not be assured that the provider had effective systems in place to assess the quality of the service, the safety of the service provided, took regard of people's views or heeded health professionals advice. Regulation 10 (1)(a)(b),(2)(b)(i)(iv)

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents People who use services could not be sure that important events affecting their welfare, health and safety were reported to CQC so that action could be taken if necessary.

The enforcement action we took:
We took urgent enforcement action against ADR Care Homes Limited to protect the safety and welfare of people living in St Nicholas Nursing Home.