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Firtree House Nursing Home

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 was an unannounced inspection which took place on 9 January 2017.

Firtree Nursing Home is registered to provide accommodation for elderly people who require nursing or personal care. The home provides care for up to 35 older people, some of whom are living with dementia and some of whom have specific nursing needs. Accommodation is arranged over two floors. At the time of our visit there were 26 people living at the home.

During our inspection the registered manager was present. 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 that there were not always enough staff employed to safely meet people's needs. Whilst on the day of inspection we found that there were sufficient numbers of staff that attended to people promptly our analysis of the staff rota showed that the required number of staff was not always maintained. Feedback from relatives was that this was an issue, particularly at weekends. Agency staff were used regularly to help maintain staffing levels. Not all staff were recruited safely and recruitment checks had not been fully completed.

There were assessments made of risks to people's health and safety. Whist these identified risks action to reduce the likelihood of harm occurring was not always taken. One person was at risk of developing a pressure sore and had asked to stop using a special mattress that would have helped to reduce one developing.

Not all staff had received relevant training or supervision to help themto do their job well. Training records detailed that most staff had not completed mandatory training despite this needing to be done every year. This resulted in staff not always having the skills and competencies to do their job well. Feedback from healthcare professionals was that staff were not always aware of people's needs or how to treat specific conditions they may have.

The application of the Mental Capacity Act was not consistently followed and applications that were needed to authorise a deprivation of liberty had been made that were not appropriate. Best interest decisions were not always made with professionals involved in people's care.

There were mixed views on the quality of food in the home. Whilst people nutritional needs were met there was an inconsistent approach to mealtimes and the types of food that people could safely eat. Where people had specific dietary requirements such as allergies or for those with diabetes these were catered for.

People and relatives told us that staff were kind and caring however these comments were not consistent.

Some relatives felt that some staff appeared not to treat people with dignity and respect. We saw that, whilst staff spoke kindly to people, there were occasions when staff missed the opportunity to sit and talk to people.

People were not supported to engage in meaningful activities and spent most of the time sitting watching television. Staff did not spend time sitting and talking with them when they had the chance to.

The care plans we viewed were not always accurate and did not provide staff with detailed information about people's most up to date needs. People and relatives had made complaints but these had not been responded to or investigated in line with the providers' complaint policy.

There was a lack of oversight from the provider about the quality of the care people received. Where quality assurance systems had been used they had not been effective as they had not identified the shortfalls we had found. Important notifications about incidents in the home were not submitted to CQC in a timely manner.

Medicines were administered safely. There was safe storage and disposal of medicines by qualified nursing staff who had been trained to give medicines to people. Medicines records were clear and had been completed appropriately. People were protected from harm and safeguarding incidents were reported appropriately to the local authority by the registered manager. Staff knew what to do if they suspected that abuse was occurring.

People had access to other healthcare professionals to help maintain their wellbeing. There were regular visits from the local GP to help ensure that people were treated in a timely manner.

Staff told us that they felt supported by the registered manager and relatives told us that the manager had made improvements in the home.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to safely meet people's needs. Recruitment practices were not robust.

Risks to people were identified however action was not always taken to mitigate them.

Medicines were administered safely. There was safe storage and disposal of medicines.

People were protected from harm and safeguarding incidents were reported appropriately to the local authority.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the skills and experience to carry out their role. Training and support for staff was not up to date.

The principles of the Mental Capacity Act were not always followed and applications to deprive people of their liberty had been made that were not appropriate.

People had mixed views about the quality of the food. People's nutritional needs were met.

People had access to other healthcare professionals to help maintain their wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not consistently treat people with dignity and respect.

Relatives told us they were involved in people's care and were able to visit them when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities available for people.

Care plans did not always reflect people's most up to date needs.

People and relatives told us they knew how to raise a complaint however these were not always responded to in line with the providers' complaint policy.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of oversight from the provider and quality assurance processes were not effective in identifying shortfalls.

Important notifications about incidents in the service were not submitted to CQC.

Staff told us that they felt supported by the registered manager.

Firtree House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 9 January 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom had a nursing background.

Before the inspection we had received information of concern in relation to the care and treatment of people living at the service which meant we brought forward our planned inspection. We reviewed information that we had on the service which included any notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we observed how care and support was delivered. We spoke to three people who used the service, five relatives, three members of staff and the registered manager. We reviewed five care plans, two staff recruitment files and other records relating to the running of the service such as audits, policies and procedures.

After the inspection we spoke to two healthcare professionals to obtain their view on the quality of the service being provided to people. We also asked the registered manager to send us further information which they did.

Requires Improvement

Is the service safe?

Our findings

There was mixed feedback from relatives about how safe people were. One relative told us that they visited every day because they were concerned that their relative was not safe, Another relative told us that they were happy and told us "I have not had cause to think X is unsafe."

Concerns also included the amount of staff on duty particularly at weekends. One relative told us there was "Generally enough staff", but that weekends could be "A bit dodgy". They said they had visited on one occasion and found that people had been put in one lounge as there were not enough staff. Another told us that their family member had been in bed until midday and then put back to bed in the early evening.

People were at risk of not receiving adequate care and support due to unsafe staffing levels. The registered manager told us that staffing levels were going to increase due to two people being admitted to the service. The amount of staff were determined based on people's nursing needs and were reviewed regularly. We looked at the staffing rota for the previous four-week period, the usual staffing levels during this time varied due to the amount of people who were living at the home. For the month of December 2016 the registered manager told us that there should be one nurse or deputy and eight care staff, including two senior care staff, on duty during the day. The registered manager was also a nurse who was supernumerary. In addition during the day there were ancillary staff working such as a chef, kitchen staff, domestic staff, laundry assistants and an activities co-ordinator. At night we were told that there should be one nurse and four care staff. These staffing numbers were what had been determined to be needed to meet people's needs and to keep people safe.

We found that staffing levels during the day were not met over the 28-day period we looked at whilst at night there were eight occasions when the required staffing levels were not met. On five occasions during the same period there were more than two staff less than was required to keep people safe. There was only one nurse on duty at any one time with little or no overlap between them finishing their shift and another nurse starting theirs. Staff told us they thought there was enough staff but added, "It can be quite stressful, but the manager is there."

Failure to ensure that safe staffing levels are maintained is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On the day of the inspection we saw that there were adequate staff working at the home and people were not waiting for care to be given. However we could not be assured that this was the usual amount of staff on duty as when we looked at the rota there were less than the required number working in the home. The registered manager told us that where there had been shortfalls in staffing they employed agency staff to help fill any gaps. However this had still meant that staffing numbers were below what the registered manager told us were needed. Wherever possible the same agency staff were booked to help maintain consistency.

People were not always protected from being cared for by unsuitable staff because robust recruitment

checks were not in place. In both files viewed, references had been requested but not provided. There was no detail about who the referee was or how they knew the person, only their name and telephone number. There had been criminal convictions (DBS) checks for both. One DBS check identified a criminal conviction which had been declared on the application form but no risk assessments had been completed by the registered manager about why they felt the applicants were suitable to work at the home. In addition there was no evidence of staff identity in one file. Both staff members had been working in the home although the registered manager told us that one of the applicants had been working with supervision.

As there were not robust recruitment procedures in place this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst risks to people had been identified there was an inconsistent approach to managing this to protect people from these risks. One person lacked capacity to make decisions in relation to their care and was at risk of developing pressure sores. They had been sleeping on a pressure-relieving mattress to minimise the risk of a sore developing but had asked for this to be removed as they found it uncomfortable. This request had been actioned and staff had continued to remind the person of the risk of them not using the mattress. We were told by the registered manager this person's behaviour could become challenging when staff spoke to them about this but there was no challenging behaviour care plan or any mention of challenging behaviours recorded that related to them. On the day before our inspection they had developed a pressure sore which needed treatment.

Another person was at risk of choking and chose to eat their food in a way that increased this risk. They had capacity to make this decision however there had been no steps taken to address this with them other than staff advising them it was unsafe for them to eat the way they preferred.

Failure to provide safe care and treatment is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were managed well, for example where people had been identified as being at risk of falls, assessments were carried out to minimise the likelihood of them occurring. Staff appeared knowledgeable about people and what they need to do to support them to keep them safe. Equipment such as hoists and wheelchairs were available to help staff move people safely. The registered manager told us that she reviewed incidents and accidents regularly so that any patterns or trends could be identified quickly and action taken where needed.

There was safe management of medicines, these were acquired, administered and disposed of safely. The Medicines Administration Records (MAR) for all people living at the home. The administration of medicines followed guidance from the Royal Pharmaceutical Society. We noted the medicines trolley was locked when left unattended and staff did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts and we found MAR charts contained relevant information about the administration of certain drugs. For example in the management of anti-coagulant drugs, such as warfarin and in the administration of medicines for Parkinson's Disease. The MAR charts contained PRN protocols, used for people taking medicines on an 'as needed' basis. These describe the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. Staff were knowledgeable about the medicines they were giving.

Medicines were delivered and disposed of safely by an external provider. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when

administered and safely stored. Other medicines were safely stored in lockable cabinets and medicines requiring refrigeration were stored in a fridge, the temperature of which was monitored daily to ensure the safety of medicines. Staff received regular training or updates in medicines management and all staff had their competency checked by the registered manager as part of the supervision process.

The registered manager ensured that staff understood safeguarding adult's procedures and what to do if they suspected any type of abuse. There were many people at the service who were unable to verbally communicate, staff were aware of what signs they should look for should they suspect abuse. One member of staff told us, "II would always go to the manager if I witnessed abuse." Staff had received safeguarding training and were able to describe the different types of abuse that could occur. Staff were aware of the safeguarding adult's policy and this was displayed in the registered managers office which staff all had access to. Safeguarding incidents had been reported to the local authority appropriately.

Requires Improvement

Is the service effective?

Our findings

Some relatives told us that staff were "Well trained "and "Know their responsibilities" whilst others said that staff provided care that was "Not very good". Staff told us they felt supported and had access to regular training and supervision however we found that not all training was up to date.

From records provided to us we saw there were shortfalls in the training provided to staff to help them to perform their role well. For example 26 of 37 staff had not received training in safeguarding, 30 of 37 had not received dementia awareness training, 30 of 37 had not received training in privacy and dignity. Other areas of mandatory training which should be completed yearly had also not been completed fully or was out of date. This meant that staff would not always know the latest guidance or best practise when providing care to people.

One healthcare professionals told us that staff often 'Didn't know patients' and that when they visited staff were not always aware of peoples up to date healthcare needs. Another healthcare professional told us that nursing staff would benefit in training related to wound care management and how pressure wounds should be treated. They added they were sometimes asked questions by nursing staff that they would expect nurses to know. In addition we found that staff did not have a clear understanding of the Mental Capacity Act 2005.

When new staff were employed, they spent time on an induction where they shadowed a more experienced member of staff to gain an understanding of how the home was run. Clinical staff told us that they received regular clinical supervision from the registered manager to keep up to date with current nursing practice. Care staff also told us they received regular supervision with the registered manager where their performance and training needs could be discussed. The registered manager told us that each member of staff should receive supervision every three or four months and that all staff should have six supervision meetings each year. From records we found that 12 staff had either not had any supervision meetings at all or had none since July 2016. This contradicted what we had been told and meant that staff did not have the opportunity to speak about their performance or have their competencies reviewed.

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

We checked whether the home was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us that DoLS applications had been submitted for all people living at the home as people lacked capacity to consent to their care and treatment. However not every person lacked capacity to make this decision.

We were told that three people had capacity to make decisions however they all had a DoLS application made to the local authority. The first part of the DoLS application process is to assess the person's capacity; if they have capacity the application should not be made. This highlighted a lack of understanding of the MCA. One person who lacked capacity was being given their medicines covertly (without their knowledge). There had been consultation with the person's family but appropriate professional advice had not been sought and no best interest decision had been made or recorded. The registered manager told us they would speak to the GP about this.

We recommend that the provider ensures that capacity assessment are only completed when a specific decision needs to be made and there is reason to belive the person lacks capacity. We also recommend that best interest decisions are held where necessary.

There were mixed views about the quality of the food provided to people. One relative told us that food was "A bit basic" whilst another told us the food was "Very good". People and relatives wanted there to be more fresh fruit offered and one relative whose family member was on a softened diet said that their food did not look appetising when it was served to them.

Staff used a meal request form which they gave to the chef in advance of mealtimes. However the chef told us that this system was not in use currently and people, relatives and staff would advise him verbally with what they wanted to eat. This led to the mealtime we observed not being as well organised as it could have been as it was not clear to staff who had ordered what food. One person was given food they did not want and had to wait whilst a replacement was cooked. The chef told us that people's specific dietary needs were recorded in their care plans however there was no information written down that was accessible to kitchen staff for them to refer to. The chef told us that there were "Three or four" people who were diabetic and eight people on a softened diet but wasn't able to tell us who these people were. This lack of guidance placed a reliance on the chef and staff knowing people's nutritional needs however with the high use of agency staff in the home there was a risk that people might not get the right type of food.

People that needed them were provided with plate guards to help them eat their meals, others that required it were provided with specialist cups to drink from. Mealtimes were held in the two lounges of the home, there was also the option for people to eat in their rooms. The mealtime we observed was quiet and staff did not always engage with people when they had the opportunity to do so. Relatives were also present in the lounge and helped their family members eat their meals. Where people required their food and fluid intake monitored this was completed by staff, people were weighed regularly and appropriate action taken when there had been a significant weight loss.

People were supported to access healthcare services and to maintain good health. This included calling a GP promptly as required, the local GP also visited the home every two weeks to review peoples health.There was also input from the Speech and Language Therapy team when needed.

Requires Improvement

Is the service caring?

Our findings

People told us they enjoyed living at Firtree House. One said "It's lovely here. I wouldn't be here if I didn't like it. They look after us well", another told us "Staff are good and nice." Despite this relatives did not always share these views. One told us that when they visited they found their family member with dirty fingernails. Another relative told us that their family member didn't have a bath regularly which concerned them. Others commented that the standard of care was "Exemplar, kindness and compassion. Mum always said staff were wonderful. They always have been" and "They staff know what they are doing and she knows what the staff are doing."

When personal care was given staff were seen to make sure that people's privacy and dignity was respected however there were occasions when this did not always happen. For example we saw that one person was receiving their medicines in their room with the door wide open so they could be seen by those walking past. They were lying on their bed without any cover and had their stomach exposed. This did not promote their dignity. On another occasion one person was using a cushion as comfort but staff took this from them and put it on a chair next to them without speaking to them or telling them why they had done this. There had been an incident involving one person who had not been treated in a dignified or respectful way.The registered manager had written in the staff handover book to all staff reminding them of their responsibilities and advising nursing staff to make sure care staff treated people with dignity and respect at all times.

Throughout the day we saw several instances of staff providing care to people in a gentle and respectful way. When one person was getting agitated staff took time to sit down with them and talk them appropriately by maintaining eye contact and speaking to them in a clam voice. The person became less agitated as a result. On another occasion staff were walking with one person who needed support and we saw they took their time to walk at a slow pace and talk with the person as they went. We regularly heard staff asking people if they were okay and if they wanted a drink.

One person was slipping in their chair, staff spotted this and took time to explain that they were going to make them more comfortable in their chair. On other occasions staff noticed when people required assistance to maintain their dignity. For example, one person had spilt food down themselves which was seen by staff who discretely cleaned this up.

Relatives told us that they were involved in the planning of their family members care and had the opportunity at the residents and relatives meetings to give feedback. One told us they went through a review of their family members' care each year whilst another said, "I'm involved in reviews and care planning". Where people needed advocacy services, the registered manager told us that they would contact them to ensure that people's views were taken into account.

There were regular relatives and residents meetings held at the home. At the last meeting in September 2016 activities that were being planned were discussed as were other matters such as staffing levels, laundry and mealtimes. Relatives told us they could visit the home when they wanted with no restrictions.

Requires Improvement

Is the service responsive?

Our findings

There were mixed views from people and relatives about activities in the home. Comments included; "The home isn't as active as it should be. The elders dance not happening anymore. They do quizzes, drawing, bingo, artwork and put on a dvd. They have two singers that come in every two weeks", "The activities co-ordinator gets taken off to do other jobs." One relative when asked what activities there were replied "None. Not a lot of stimulation" whilst another relative said, "They get entertainment once a week. There is sometimes a quiz and bingo, other times they sit and watch the television." Staff we spoke to told us that activities could be improved for people and there was "Not really enough going on". This was confirmed throughout the day of our inspection.

We spent time observing the care and support that was provided and whilst staff did engage with people when they were completing tasks such as helping at mealtimes opportunities were missed by staff to spend time socialising with people. During the afternoon there were eight people sitting in the lounge, one member of staff was sitting talking to one person however two other members of staff were talking between themselves and did not spend time speaking to people which meant people were left sitting in their chairs with nothing to do. This was raised with the registered manager who told us this was because the activity that was planned had been cancelled. This cancelled formal activity would not prevent staff realising that just sitting and chatting to people is a valuable activity which would respond to people's need for interaction.

There was a lack of stimulation for people on the day of the inspection. The activity timetable was out of date and there were no specific times for the activities taking place. The timetable was still advertising an activity that had been cancelled several weeks prior to the inspection. One person had their nails painted and a quiz and reminiscence session was provided in the lounge but this only lasted for one hour.

The registered manager told us that when people were admitted to the service they would complete a pre-admission assessment to ensure they could meet their needs. Once this had been completed a care plan would be developed with the involvement of the person where possible and those important to them. This was reviewed regularly and should include important information about the person, their life story and how their needs would be met.

We found there was a risk that staff would not have the most up to date and appropriate information available to them to deliver responsive care due to limited information being available in the care plans we looked at. Where a need had been identified there was not always guidance or a detailed care plan for staff to follow. Staff told us that one person had a history of challenging behaviour. There was no care plan about the behaviour or any mention of challenging behaviour in their care notes. The care plans we reviewed did not contain information around people's preferences and people's social and personal backgrounds were missing. One relative told us that they felt the need to write a summary of their family member's needs which they put on the wall in the family member's room to inform staff on how to care for them.

A failure to plan and deliver person centred care and meaningful activities is a breach of Regulation 9 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were staff 'handovers' at the end of each shift where changes in people's needs were discussed and any relevant information was provided to the staff coming on duty. Relevant information was recorded in the handover book which was the responsibility of the nurse in charge.

We asked people and relatives whether they felt their concerns and complaints were responded to and we had a mixture of responses. Comments included that the response to complaints was sometimes "Defensive One relative told us, "I made a recent complaint about a toilet, which needed a damn good clean. This was sorted immediately" whilst others told us, "I'm confident about raising any issue. If I wasn't happy, I would have removed (the family member)".

The registered manager told us that there had not been any formal complaints made since the last inspection however we found that this was not the case. There had been three complaints since August 2016, two of which had been responded to by the registered manager. The third had been made in November 2016 and related to a number of issues that the registered manager told us needed a response from the provider before they could respond. The providers' complaints policy detailed that an acknowledgement should be provided within 48 hours of the complaint being received and an investigation should take place with a report produced when this has been completed. The registered manager told us she had acknowledged the letter and attempted to contact the complainant however there was no record of this provided to us. Whilst some of the issues raised in the letter needed a response from the provider other concerns could, and should, have been responded to in line with the provider's complaints policy. This had not happened.

As complaints were not always investigated or responded to this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There were mixed responses from people and relatives about how the service was managed. Negative comments included, "(The registered manager) is not very good to talk to, she does not listen", "I don't think the manager manages very well", "(The registered manager) doesn't come and speak to people or relatives", "It's not very well run. The manager never seems to be here" and "(The registered manager) doesn't speak to people, she is in the office all the time."
Other comments from relatives were more positive about how the home was run and included "I can approach the manager if I have a complaint. When raised things are dealt with", "Now it's under new management it's a hell of a lot better", "They have a good manager, she is approachable in every way", "They are good here. They have access to the manager to discuss the wellbeing of people",

Healthcare professionals told us that they sometimes had difficulty contacting the registered manager and that communication could be improved. Another told us that there had been improvements in their dialogue with the registered manager who they felt was "Good" at their job. They added that the atmosphere in the home had changed for the better and become much "Lighter".

The registered manager told us that they completed regular audits across a variety of areas to ensure that the quality of care was maintained. These audits covered different areas of the service such as peoples weights, complaints and laundry. There were aspects to the quality assurance that were not effective and had not identified the gaps that we had identified on the day or the breaches of regulations. For example there had been a staff file audit completed which had not identified concerns in relation to recruitment practice. Complaints had not been recorded or responded to appropriately and issues in relation to staffing levels and activities had not been identified or addressed.

The provider was using an external auditor to check on the quality of the service up until June 2016. This had stopped and the registered manager told us the provider had not yet told her who would be doing these external checks. The provider visited weekly and the registered manager told us that she felt supported by them. However there were no formal quality assurance checks completed by the provider which should have identified the shortfalls in quality we found.

We observed a handover between a member of staff and the registered manager. This took place in the corridor of the service. People's health and wellbeing were discussed by room numbers. Although the information discussed was relevant there was a risk that people and visitors could hear confidential information about others being discussed. For example, they spoke about one person who was at the service on respite and how they were settling in.

As systems and processes were not established and operated effectively to maintain quality this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us surveys were sent to people and relatives to measure the quality of the

service and to identify if there were areas that needed improving. Relatives told us that they had completed these but had not done so recently.

Staff told us that the registered manager was "Good" and that they were supportive to them. One member of staff told us that they had recently had training on nutrition which they had found useful. There were regular team meetings held and minutes of these were kept, areas discussed included how the team worked together and how work was allocated.

There had been several incidents, including safeguarding concerns, that had occurred which had not been reported to us appropriately. The registered manager told "I recognise its my omission". As a result CQC would not have information available to monitor the service effectively.

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

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Significant events had not been notified to CQC appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans did not detail people's most up to date care needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Identified risks to people were not always managed well or acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	Complaints were not always responded to in line with the providers own policy

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Staff recruitment processes were not followed and appropriate checks on new staff had not been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough trained staff to safely meet people's 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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance processes had not been effective in identifying shortfalls in the service provided to people

The enforcement action we took:

Warning Notice issued