Hendon Universal Property Company Limited

Seaton Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service
Seaton Court is a residential care home providing personal and nursing care for up to 68 people in two separate buildings. The service provides support to older people, some of whom were living with dementia and/or a physical or sensory disability. At the time of our inspection there were 31 people using the service.

People's experience of using this service and what we found
People's safety was not appropriately managed. Risks to people's safety were not always managed as staff were not following peoples risk assessments and care plans. Medicines were not always managed appropriately. People had not received their medicines in line with their prescriber's instructions and medicines were not stored safely.

There were insufficient staff to meet people's needs. Staff were not able to give people the care they needed at the time they needed it. Staff were not always recruited safely. There was limited information held about agency staff working with people at the home. Staff were not consistently following guidance for preventing the spread of infection at the home. Incidents were not always investigated appropriately, and actions taken to prevent future occurrence.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People did not receive effective support with eating and drinking.

Staff were unaware of risks to people and their dietary needs. People's needs and care plans were not understood by staff. People were not always supported to make decisions about their care. Staff were rushed and peoples care was delivered in a task-based way which was not person-centred. People received care which did not consider their dignity and their communication needs were not consistently met.

Systems had failed to identify where improvements were needed to the care people received. Audits had not identified concerns about care not being delivered and medicines not being administered and stored safely. Where incidents had occurred, these had not been reported to other agencies and changes were not made to ensure these did not happen again.

Rating at last inspection
The last rating for this service was good (published 16 May 2022).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and how risks to people were mitigated. A decision was made for us to inspect and examine those risks.

The inspection was prompted in part by notification of an incident following which a person using the

service sustained a serious injury and died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to risk management, staffing levels and recruitment, dignity, person-centred care, consent to care and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Seaton Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was undertaken by 2 inspectors and an Expert by Experience who made calls to people's relatives following the initial site visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Seaton Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Seaton Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people about their experience of care and 16 relatives. We observed care to help us understand the experience of people who could not talk with us. We spoke with 12 staff which included the registered manager, deputy manager, operations manager, team leaders, health care assistants and kitchen staff. We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including medicine audits and the training matrix were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Risks to people's skin integrity were not managed safely. Several people were assessed as being at very high risk of pressure injury, care plans were in place to reduce the risk through repositioning people to relieve pressure, but these were not being followed by staff. This meant people were left at increased risk of their skin deteriorating.
- Risks to people from aspiration were not being managed safely. One person was assessed as requiring a modified diet by a speech and language therapy team (SALT). Guidance had been given for this person to be always monitored to eat safely however this was not being followed by staff. Which meant the person was at risk of aspiration.
- Risk assessments and care plans were not reviewed and updated following incidents. For example, one person had eaten food which was not in line with their SALT advice which exposed them to the risk of harm. No actions had been taken to ensure the person always received the support they required which could result in a risk of choking.
- Systems to monitor equipment used to keep people safe were not effective. Air pressure mattresses checks to ensure they were inflated to the correct setting had not been carried out as staff were unaware of the correct setting and were not acting when they were incorrect. This meant people were left at risk of their skin breaking down.
- Medicines were not administered as prescribed. We found incidents where people had not received their medicines as prescribed. For example, one person had been given the wrong dose of prescribed medicines.
- Medicines were not stored safely. We found prescribed topical medicines were left in people's bedrooms which were unlocked and accessible to people who may suffer from confusion. This meant people were at risk of being able to access or ingest medicines not prescribed for them.
- Where incidents had occurred, there was no evidence these had been investigated and plans put in place to reduce the risk of recurrence. One relative told us, "Person's name] had a fall and a visiting health professional asked for a sensor mat to be fitted, despite another fall recently this has not been put in place."

The failure to ensure risks to people were mitigated and medicines were managed safely was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were not supported by enough suitably skilled staff to meet their needs. We saw people requiring supervision with meals, eating alone. People were not being repositioned in line with their skin integrity care plan and people were not being supported to get up and have personal care needs met as there was insufficient staff to support people.

● Rotas showed staffing levels had not been provided in line with the providers assessment of staffing needs based on people's dependency for a period of 4 weeks. This meant people had been at risk of not having their needs met for an extended period.
● Staff were not deployed safely. The service was relying on agency staff throughout the inspection period, there was limited direction given to staff on how to meet people's needs. Agency staff could not tell us about people's needs. For example, they were unaware of how to meet dietary needs safely. This meant people may not receive the care and support they needed.
● People told us there were not enough staff to care for them safely. One person told us they had been waiting for 2 hours to get up. Another person told us they were thirsty, and they had not been given a drink having been up for a few hours.
● Relatives told us staff were not always available to support people in communal areas. One relative told us, "When [person's name] is in the lounge along with four or five other people there is no staff member present. This concerns me because [person's name] is inclined to try to stand and mobilise and they are at risk of falls." Another relative told us, "My original feeling about the care provided was that it was very poor, including there being insufficient staff. There are more staff now, but weekends are thinly staffed. [Person's name] hated it when first resident at the home but we are both now resigned to there being low staffing levels."

Systems were not in place to ensure enough suitably qualified, competent, skilled and experienced staff were deployed This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not supported by safely recruited staff. The provider had not ensured checks on the past employment and checks through the Disclosure and Barring Service (DBS) were completed by the agency before deploying the staff to work with people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Checks to ensure agency staff working with vulnerable people were suitably qualified and experienced, had the right skills had not been conducted by the provider.
● The provider had not assured themselves of the suitability of the agency staff in terms of their experience, training and safety before deploying them to work with vulnerable people.

Systems were not in place to ensure suitably qualified, competent, skilled and experienced staff were deployed This placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not consistently safeguarded from potential abuse and neglect. Systems had failed to identify where incidents of potential abuse had occurred. The provider had not investigated incidents where people were placed at risk of harm and referred such incidents to the local safeguarding team for investigation.
● A person had a scald from a hot drink given to them by staff, this was not investigated, and no actions had been taken to prevent recurrence.
● We found 3 incidents which had not been identified as possible abuse or neglect and had not been raised externally relating to medicines administration, dietary needs not being met safely, and an injury. We raised these incidents with the local safeguarding team for investigation retrospectively

Systems and processes to monitor, record and safeguard people from abuse were not effective. This placed

people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured the provider was using PPE effectively and safely. We saw several staff not using PPE in line with current guidelines. For example, some staff were not changing aprons when giving personal care.

● We were not assured the provider was responding effectively to risks and signs of infection. We saw one person was being barrier nursed due to an infection, however not all staff were aware of this, and this meant there was a risk of cross infection.

● We were assured the provider was preventing visitors from catching and spreading infections.

● We were assured the provider was supporting people living at the service to minimise the spread of infection.

● We were assured the provider was admitting people safely to the service.

● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

There were no restrictions to people having visitors at the home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not following the principles of the MCA. The provider had undertaken MCA assessments and identified where people lacked the capacity to make all their own decisions. However, there were not always documented decisions in place for people where decisions had been taken. For example, one person had a decision taken about not following SALT advice regarding their dietary and fluid intake. There was no best interest decision and no SALT involvement in the decision. This meant the decision taken may have left the person at risk of choking.
- Staff were not always aware of people's capacity to consent to care. We saw records were confusing about people's capacity to consent and some staff were unaware of people's capacity when they were supporting them. This meant people may not have given consent to their care.

Systems were not effective in ensuring people's rights were maintained under the Mental Capacity Act. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
- The provider had not ensured all staff working at the home had received an induction and training for

their role. Agency staff were working at the home and there was no evidence of any checks on the skills of the staff training, and experience. This meant the provider could not be assured staff were able to support people effectively.

● The provider had not ensured all staff were inducted and received training in their role. Records showed staff training was not up to date and several staff had not received training in areas such as basic emergency aid, diabetes, dementia awareness, fire safety and infection prevention control. Staff were unclear about supporting people with diabetes and were not following up to date guidance on infection prevention control.

Systems were not in place to ensure enough suitably qualified, competent, skilled and experienced staff were deployed This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● There were mixed views about meals and drinks people received. One person told us the food was nice and they had a choice of meals, whilst another told us there was limited choice. One relative told us, "Food and drink are good. The chef made a great cake for [person's name] on their birthday. "Another relative told us, "Food and drink are OK. Requests for alternative foods go unheeded and [person's name] is still offered meals that they do not like. They used to have supplementary drinks but does not appear to be receiving them now. [Person's name] has lost a lot of weight and a dietician is now involved."

● Staff were unaware of peoples SALT assessed needs. Staff could not tell us where people required a modified diet and relied on the catering staff to ensure people had the right meals, they were not aware of the individual risk assessments and guidance. This meant people may be at risk of not having their nutritional needs met in line with their care plan.

● People were not consistently supported to eat and drink in line with their care plan. One person was left alone with their breakfast, despite the care plan stating they needed to be supported due to a risk of choking.

Staff working with other agencies to provide consistent, effective, timely care

● Staff were not consistently following up on concerns about people's health and wellbeing in a timely way. One person had been reported to be feeling unwell in the morning handover from night staff. The day staff did not follow up on this until mid-afternoon, despite being asked to by inspectors, The person was distressed and continually complaining of feeling sick and unwell. This meant the person was left at risk of their health needs not being met.

● Where health professionals were involved in people's care the advice was not consistently followed for example, where one person had diabetes and blood glucose testing advice had been given this was not being followed. This placed people at risk of receiving unsafe and ineffective care.

Supporting people to live healthier lives, access healthcare services and support

● People were not consistently supported to manage their health needs. One person told us they were very concerned about their health as staff were not supporting them to monitor things in line with their health practitioner's advice.

● Where advice had been given by a visiting health professional this was not consistently followed by staff. This meant people were not effectively supported to maintain their health and wellbeing. One person's care records directed staff to ensure the person was repositioned to aid the healing of pressure sores, this was not being completed in line with professional advice.

The failure to ensure people had risks relating to nutrition and their health mitigated was a breach of

Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance, and the law
● People's needs were assessed and planned for. However, these were not consistently reviewed when things changed, or incidents occurred. For example, skin integrity risk assessments were not consistently updated following advice from health professionals.
● Staff were not familiar with peoples care needs assessments and care plans and could not describe how they used this information to ensure people had their needs met.
● Assessments and care plans held conflicting information. One person's care plan had conflicting information about their dietary needs. This meant we could not be assured people were having their needs assessed and plans put in place to meet them.

Adapting service, design, decoration to meet people's needs
● The environment of the home was well presented. Communal areas were equipped with sufficient suitable furniture and bedrooms had been personalised.
● Adaptations were available for people as required. For example, toilets and bathrooms were adapted and equipment was in place to support people with mobility needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity, and independence; Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported, respecting equality and diversity

- People were not supported to maintain their independence and make their own choices. One person told us they had been concerned about their health and diet and raised concerns with the staff, however no actions had been taken to follow the persons wishes.
- People told us they were distressed when their concerns had been raised with staff but not acted upon. One person told us they had raised concerns about insects in their room which was distressing them however no action had been taken to address these concerns.
- People's dignity was not maintained, and their independence not promoted. People were left in bed without having their personal care needs met all day. One person was observed having a large stain on their nightwear where they told us they had spilled a drink the day before and they had not been able to change their clothing.
- People were not consistently supported by staff who understood their needs. For example, staff we spoke with could not tell us about peoples assessed needs and how support should be provided. One relative told us, "[Person's name] is type 1 diabetic and this was apparently not identified and adjusted for in their diet, which resulted in consumption of some inappropriate items."
- People and their relatives were not consistently involved in decisions about their care. One person told us they were not able to choose when to have a shower as there were no staff available to support them. A relative told us, "Communications are appalling. Feedback forms are not available. I have had no communication in respect of changes to [person's name] care."

Effective systems were not in place to ensure people's autonomy; dignity and respect were maintained. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not having their assessed needs met. People were not having their personal care needs met in line with their preferences. One person told us they really would love to have a shower in a morning, but this was not being done. A relative told us, "When visiting, I find [person's name] has a wet incontinence pad which clearly needs changing and which emits strong smells. I feel they are not changing [person's name] frequently enough."
- People were receiving care which was task based and not person centred. People told us they could not have a drink if they got up early as night staff did not make drinks for people. Everyone we spoke with told us they had to have their breakfast in bed, some told us they would prefer to eat at the table and then wait for support to get up. One relative told us, "[Person's name] needs some assistance with drinking which is not always provided."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People did not have their communication needs met. Communication needs were assessed and planned for; however, staff were not aware of people's specific communication needs when supporting people. This meant the person may not have been able to communicate effectively.
- One person required adaptations to support them with communication. Staff were not aware of this and were not supporting the person to be able to communicate their needs.

Systems were not in place to ensure people's needs were assessed and planned for in a person-centered way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to have regular contact with their family and friends.
- There was a program of activities on offer for people at the home and some people told us they enjoyed taking part. One relative told us, "[Person's name] takes part in activities. They are very active and love dancing." Another relative told us, "The activities co-ordinator is very good. They try to include [person's

name] in activities but often ends up assisting them with eating their pureed diet."

Improving care quality in response to complaints or concerns

● People and their relatives were able to make a complaint and responses were given in line with the providers policy. However, one relative told us about a complaint they had made to the home about how risks were managed for one person, and they were unhappy with the response as they did not feel the management response was adequate.

● People and their relatives understood how to make a complaint.

● Where complaints had been made there was an investigation in line with the complaint's procedures at the home and a response sent.

End of life care and support

● Where people were coming to the end of their life assessments had been completed and plans put in place this included details about where and how the person wished to be supported.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider failed to have systems and procedures in place to ensure people were supported safely. The lack of adequate assurance systems meant there were not enough suitably trained and competent staff to support people safely. This meant people were left at risk or harm.
- The system in place to ensure suitability of staff had failed. Records of staff appointed, both regular and agency staff did not offer assurance they were of good character and were safe to work with vulnerable people. This meant people were at risk of being supported by staff who were not suitable to work with vulnerable adults.
- Governance procedures had failed to identify unsafe practice. Daily records checks were carried out but were not effective in identifying where people had not received their care in line with their care plan. Medicines audits had not identified unsafe storage and administration. This meant people were left at risk of continued harm.
- Systems failed to ensure people received care and support which was person-centred. Where people had not had their needs met or their preferences considered this had not been identified or actioned as part of adequate quality assurance processes. This meant people were at risk of not receiving person-centred care.
- The provider had failed to ensure checks were effectively carried out on air pressure mattresses, these were detailed in care plans to be completed, however this was not done and there was no oversight of this. This meant people may not receive the care they need and be left at risk of damage to their skin.
- There were no audits of care plans to ensure where needs changed, or professional advice had been given care plans were updated.
- The failings identified at this inspection meant the provider was in breach of multiple regulations which led to people being at risk of not receiving safe, effective and person-centred care.

The registered provider had failed to assess and monitor the service for quality and safety and mitigate risks to people. This was a breach of regulation 17 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We met with the provider to discuss the inspection and they have taken actions to begin to address the concerns we identified in the inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● The provider was aware of their responsibilities under duty of candour however the lack of oversight of incidents meant we could not be assured this had been met in all instances. Improvements were needed to how incidents were reviewed and documented to include considering duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● People told us they were not engaged in decisions about their care and how this was delivered.

● We received mixed views about how relatives were engaged in the home. One relative told us, "Last week I received a survey by email but the survey attachment would not open and I could not complete it. I reported this and requested a hard copy, but it has not arrived." Another relative told us, "I have recently received more communications from the home through telephone calls."

● Where advice had been given by health professionals relating to peoples care this was not consistently recorded in care plans and staff were not consistently aware of this or following it.

● Where incidents had occurred learning from these had not always been put into place.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people received dignified care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure staff followed the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The providers systems had failed to ensure incidents of potential abuse and neglect had been reported to the appropriate body.