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Summerlands

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

Summary of findings

Overall summary

This inspection took place on 26 and 29 June 2017 and was unannounced. The home provides accommodation for up to 23 people with a learning disability requiring personal care. There were 21 people living at the home when we visited. Summerlands is a privately owned care home close to the centre of Southsea. It comprises of a large Victorian Villa situated in its own grounds. Accommodation is spread over four floors, with stair lifts between some of the floors.

The Care Quality Commission has reviewed the way it registers services for people with a learning disability. Our website includes this information about 'registering the right support'. This was discussed with the manager who was aware of this guidance and understood how this should be considered with any future service developments.

The home did not have a registered manager. 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.

At the last inspection in January 2017, we identified breaches of Regulations relating to safeguarding, the management of risk, the manner in which people were treated and the governance systems. We made four requirements. The provider sent us an action plan stating the action they were taking to meet the requirements of the regulations. At this inspection we found the previous concerns had not been addressed and also identified additional breaches of regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Monitoring systems were not effective in identifying areas for improvement and as a result, people's safety and the service they received was compromised. We found continuing concerns with the management of medicines and health care needs, risk and care planning, quality of records, people were not treated with dignity and respect, their personal finances were not managed for their best interests and their legal rights were not protected. The home's environment and facilities were not well maintained and robust recruitment procedures had not been undertaken.

Care files and individual risk assessments contained conflicting and out of date information which and did not reflect the care and support people needed. Action to meet health needs had not always been taken. Systems to manage medicines were inadequate and did not ensure people received all prescribed medicines safely.

There were insufficient staff employed. Staff had not received an induction, all necessary training and were not supported in their roles. Recruitment procedures had not ensured all necessary pre-employment checks had been completed before staff commenced working at the home.

Emergency procedures were inadequate to ensure people's safety. Staff had not received fire awareness or other training to provide them with the knowledge as to what action they should take in the event of a fire placing them and people at risk. People were not supported to eat a balance healthy diet. People were not receiving adequate mental and physical stimulation.

Staff did not follow legislation designed to protect people's legal rights. Although adults, people were not always treated as such or with dignity and respect.

People were happy with the food they received although healthy alternatives were not always offered or encouraged. People were not receiving adequate mental and physical stimulation and activities were limited.

People felt able to raise concerns with the acting manager who took time to listen to people and seek resolution for their concerns.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to the provider and will report on this when it is completed.

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

The service was not safe.

Risks to people had not been fully assessed. Action had not been taken to mitigate against known individual risks and risks from the environment including those related to the control of infection. Staff did not know what the risks to people were.

People were not protected from the risk of abuse. Medicines were not stored or managed safely.

Recruitment processes had not ensured all essential pre-employment checks were undertaken. There were insufficient staff to provide people with the care they required.

Is the service effective?

Inadequate

The service was not effective.

Staff had not completed essential training and there was no system in place to identify their training and development needs. Staff had not received an appraisal and there was no system in place for these to occur.

The requirements of the Mental Capacity Act were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with the legislation. Care staff did not have an understanding of Deprivation of Liberty Safeguards and action had not been taken to reapply for these when they had expired.

People were at risk as systems were not in place to ensure people's health care needs were known and met.

People were positive about their meals which they said they enjoyed however there were occasions when staff failed to ensure people received food and drinks in a prompt manner.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity, respect or involved in day to day or other decisions about the way the home was organised.

Information was not provided in a format suitable for many people living at the home which excluded them from some decision making.

Where people had individual cultural or religious needs there was limited information as to how these should be supported and basic actions to meet these needs were not occurring.

Is the service responsive?

Inadequate

The service was not responsive.

Care records contained inaccurate, inconsistent and out of date information which did not reflect or inform the care people were receiving. People did not always receive the care they needed.

People were not receiving adequate mental and physical stimulation.

People felt able to approach the acting manager and raise concerns with systems in place to act on these.

Is the service well-led?

Inadequate

The service was not well led.

Management systems had not ensured that the breaches of regulations we identified in January 2017 were acted on. The provider's quality monitoring systems had not identified that people were not receiving safe, effective, responsive care or led to improvements in the service provided.

The home did not have a registered manager and information about previous inspections was not made fully available to people or visitors.

Staff and people were positive about the homes management which we found were wanting to address the areas of concern we identified to them.

Summerlands

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 29 June 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports, action plans and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law. We also spoke with staff from the local authority safeguarding team and reviewed minutes of safeguarding meetings.

We spoke with nine people living at the home, one relative and four health or social care professionals. We also spoke with the acting manager, five care staff, housekeeping staff and the cook. We observed care and support being delivered in communal areas.

We looked at care plans and associated records for eight people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2017 we found medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to ensure medicines was managed safely. However at this inspection we found improvements had not been made and the management of medicines remained unsafe and placed people at risk.

Medicines were not managed safely. A lockable medicines cupboard was secured to the office wall. However, on the first day of our inspection the office was left unlocked and the keys were left in the medicines cupboard with no staff present. On the windowsill of the office were multiple tubs and bottles of prescribed fluid thickening powder and liquid medicines. On the desk was a cream prescribed for one person. People were walking around independently in the area outside the office and therefore these medicines were potentially accessible to them as they had not been stored securely. Staff told us that the temperature of the medicines cupboard was not checked and recorded. A medicines fridge was also in the office. This was unlocked. The temperature of the fridge was checked on most days although we did find this had not been checked on five days since 1 May 2017. The instructions for the storage of insulin stated that when in use this should not be refrigerated. Staff were unaware of this and we found it was stored in the fridge. Therefore we could not be assured that medicines were stored at temperatures which ensured their effectiveness and that they were safe to use.

Medicines were not always administered in line with prescriptions and errors had not been identified and acted upon. For five people we found medicines which had been signed as being administered remained in the blister packs, meaning they had not been given to the person in line with the prescription. No explanation could be provided and this had not been identified by staff in the home. For a sixth person we found in the medicines cupboard an envelope that said "Found outside [person's name] room 21/6/17 [person name] PM meds". The Medication Administration Records (MAR) recorded this had been administered and there was no further recording to say that this tablet had been found on the floor and had therefore not been taken.

Some people were prescribed medicines to take as and when they were required (PRN). PRN protocols were in place where needed. However, these contained no information about when staff should escalate the use of these medicines to health professionals for review. MARs lacked information about the dose that had been administered when this varied. For example, one person's MAR said the person could be given one or two tablets however, the actual number of tablets given was not recorded. For another person the use of their PRN medicines was recorded inconsistently. Some staff had signed the MAR while others had recorded this on a separate sheet and the dose was not recorded on either record. This meant people were at risk of not receiving as required medicines in a consistent manner and health professionals may be unable to establish the effectiveness of the medicines when these were being reviewed.

Records relating to medicines were not accurate. Medicines received from the pharmacy were recorded on the (MAR) sheets however the date was not included. Medicines carried forward were recorded on the MARs

although this was not always carried forward accurately. We found that one person medicines had not been signed to show they had been administered but they were not present in the blister pack. The member of staff told us they had administered these and had forgotten to sign for them. The failure to ensure full and accurate records of medicine administration were maintained meant we could not be assured that people had received medicines as prescribed by their medical practitioner.

The acting manager confirmed that they had not been able to find any evidence that competency assessments with staff had been undertaken to ensure they could carry out medicines procedures safely. The acting manager also told us no medicines audits had taken place.

The failure to ensure medicines are stored, administered, recorded and managed safely was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person medicines records contained a photo and information about any allergies they may have. Care staff told us the local pharmacy had visited the home and provided some basic medicines administration training.

At the last inspection in January 2017 we found improvements were needed to ensure the safety of the property and equipment used including safety of upper floor windows and excessive temperature of hot water taps. We also identified concerns with the cleaning and flooring of bathrooms and cleaning of commodes. This was a breach of Regulation 12 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to address these concerns. At this inspection some action had been taken to address concerns however this was not sufficient to ensure people were not placed at risk.

People remained at risk as infection control procedures were not always followed and adequate cleaning were not being completed. At the previous inspection we identified that flooring in some bathrooms and toilets was badly stained and loose at the edges meaning it could not be cleaned effectively. At this inspection we found no action had been taken to rectify these concerns and flooring in bathrooms and toilets still posed an infection risk as it could not be cleaned correctly. Areas of the home were dirty and unhygienic including a toilet located off the lounge which had dried faeces on surfaces and walls of the toilet. In bathrooms and toilets we saw fabric bath mats and fabric towels. Unless washed between people these posed an infection risk. We also found that not all bathrooms or toilets had soap for people to wash their hands with after using the facilities. We observed items waiting to be laundered were left on the laundry room floor which is an infection control risk and poor practice. On one occasion two staff left a person room (whom they had been supporting with personal care) to get a wheelchair. They did not remove either their gloves or aprons before doing this. Two cleaners were provided weekday mornings and they were responsible for cleaning all areas of the home. At weekends no cleaners were provided. The acting manager was unsure about cleaning routines and told us they had not completed an infection control annual statement as is required by legislation. We were unable to view infection control audits as the acting manager told us these had been taken to their home and were therefore unavailable.

In addition to the risks previously identified we also found that risks relating to the safety of people in the event of an emergency were not safely managed. The acting manager told us that staff had not received fire training during the 18 months prior to the inspection. Staff had not received a formal induction and there was no induction process for when agency staff were used. At the previous inspection we noted that emergency information was not provided for people in a suitable format. This was discussed in January 2017 with the then acting manager however, at this inspection no action had been taken to ensure people were provided with emergency information in a suitable format. During the inspection we saw some people

leaving the home independently via a lounge door. No staff were in the area and they would have been unaware that the person was leaving. This meant that in an emergency staff would not know how many people were in the building and may place themselves, other people or emergency service professionals at risk due to time wasted searching for people who were not in the home. We were unable to confirm that weekly checks of the fire detection systems were occurring as we were told the records for these were unavailable as they were in a file at the acting manager's home. Following the inspection we contacted the local fire officer to inform them of our concerns.

Other concerns for people's safety were also identified. On several occasions during the inspection we saw cleaning chemicals which could pose a risk to people left unattended in areas where people were moving around unsupervised. We saw that in 2011 an asbestos survey had been completed of the home. This identified some remedial work which was required however, the acting manager was unable to demonstrate that this work had been completed meaning people may be living at risk of asbestos disease. The poor state of the home's environment and garden also presented trip risks to people. Staff were unaware of any systems in place which would support them to contact other staff in the building in the event of an emergency. The home occupied four floors of an extended older building and staff said that if a person required emergency support they would have to leave the person to locate another staff member.

The failure to ensure all necessary action is taken to reduce as far as possible risk posed by the homes environment including those related to the control of infections was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found restrictors had been fitted to all upper floor windows and thermostatic controls had been fitted to hot water outlets meaning people were now protected from these risks. Records viewed confirmed electrical and gas supplies had been checked by an external contractor and were safe for use. The home had been inspected by the local authority food hygiene officers and been awarded five stars (the maximum possible) for food hygiene.

Individual risks to people were not always managed safely and guidance of external health professionals to manage health related risks were not followed. Risk assessments did not cover all risks to people. Where risks had been identified these had not been reviewed or amended when needs changed. Staff were not always aware of the risks to people or how these should be managed.

For example, one person was at risk of choking. A speech and language therapist had undertaken an assessment and provided guidance that the person should only have food that was fork mashable. Staff were unaware of this and told us they gave the person food that was cut up small. This placed the person at higher risk of choking. We asked the acting manager to address this immediately. On the second day of our visit we saw staff, including kitchen staff had been made aware of the need for a soft fork mashable diet. One member of staff told us that was the first they knew that this person needed this type of diet but said they didn't know why it was needed. When asked if this person was at risk of choking they said "apparently". We rechecked the records on the second day of our inspection and found no risk assessment had been undertaken and no changes had been made to the person's plan of care. As the service used agency staff at times, the lack of accurate records could place this person at risk of harm.

People were placed at increased risk as staff had not received essential training to use equipment correctly or meet their needs safely. Two people were unable to stand and required the use of hoists to enable them to move between their bed and chairs. On the morning of the inspection two staff who had not received moving and handling training had either used the hoist to get these people out of bed or lifted them into their chairs. An occupational therapist had undertaken an assessment for one person and stated the type of

sling that should be used. We saw a different size and make of sling was in the person's bedroom ready for use.

These two people were at high risk of developing pressure injuries. Pressure relieving equipment was available however, this was not being used correctly in accordance with the manufacture's guidance for the people's individual weights. Correct bedlinen was also not being used for one person which would reduce the effectiveness of the equipment increasing the risk that the person may develop pressure injuries. The weighing scales were not working and in order to ensure the mattresses were set appropriately staff would need to know people's weight. One person had no weight recorded and it was therefore not possible to determine if their pressure relieving mattress was set correctly however our observation of the person indicated that it was set for a much lower weight. The second person's weight had not been checked since February 2016 and based on this recording the mattress was also set incorrectly. Staff were not able to tell us how to check these mattresses were set correctly. We asked the acting manager to take action to address this.

On the second day of our visit they told us this had been addressed with staff who were now required to check these mattresses twice a day. They said they would be introducing a recording tool to show this had been done but had not yet developed this. However, when we spoke with a member of care staff they told us that the setting of mattresses was checked once a week. The scales remained broken so accurate use according to the person's weight would not be possible. When in bed both these people would require staff to assist them to reposition. To ensure their safety and that of staff equipment called a slide sheet should be used. We were unable to find slide sheets for these people. We asked the acting manager and they showed us one slide sheet which would be inappropriate to use for both people without full laundering between people. They were unable to locate a second slide sheet in the home.

Where risk assessments identified actions to reduce the risk staff did not always ensure these were followed. For example, one person was at a high risk of falling and had been provided with a pendant call bell with which to summon assistance if required. On the first day of the inspection we saw they were not wearing this and it was seen in their bedroom whilst they were elsewhere in the home. We saw they were wearing this on the second day of the inspection.

The failure to assess the risks to health and safety of service users and do all that is reasonably practicable to mitigate any such risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2017 we found system and processes in place did not always ensure people were protected against the risks of financial abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to address these concerns. At this inspection insufficient action had been taken to address this concern and people remained at risk of financial abuse.

The provider had approached the local authority with a request for them to take over responsibility for people's personal finances. However, the provider remained the financial appointee (legal representative) for some people's finances and was a signatory on their bank accounts.However, there were no systems in place to ensure external oversight of how people's personal finances were managed. We found some people had purchased expensive items. The acting manager confirmed that these people would not have been able to understand the nature of the transaction which may not have been in their best interest. For example, one person had purchased their own pressure relieving mattress. This had cost in excess of two hundred pounds. In care homes such equipment is usually supplied free of charge via the district nurses who would

undertake an assessment of the person's needs and identify the most appropriate type of equipment. Equipment supplied by statutory agencies would also be serviced and maintained at no cost to the person. The acting manager was unable to provide information as to why this had occurred and we found no documentation to demonstrate this was agreed by the person or in their best interests. Therefore the person had made an unnecessary purchase and would be incurring ongoing servicing costs. There were no inventories for any people. Some people owned expensive items such as televisions and music systems. The failure to accurately record these meant people may not be able to demonstrate ownership and items may become lost or mixed up especially as there were people sharing bedrooms.

Care staff had not received safeguarding training. Although all those we spoke with said they would report concerns to the acting manager and were confident these concerns would be acted upon. One care staff member told us they had reported a serious safeguarding concern to the previous manager (in about April 2017) however, when no action had been taken they had not acted to report this to the provider or agencies responsible for safeguarding outside of the organisation such as the local safeguarding team. This meant no action had been taken to safeguard the person and prevent future safeguarding concerns. The acting manager told us about a couple of incidents when one person had physically assaulted another person with their handbag. The lack of staff training or reporting of safeguarding concerns meant people continued to be at risk of abuse.

The failure to ensure people are protected from abuse was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Of the people we spoke with, four said that they felt safe. One person said, "I like it here". A family member said that they felt their loved one was safe. Other people appeared happy and relaxed. However, one person said that they did not feel safe and told us that they had requested to move because they were afraid of another person who was aggressive. We discussed this with the acting manager who was aware of the situation and went to speak with the person to identify their specific concerns.

Recruitment and selection processes did not ensure that all essential pre-employment checks were completed before new staff commenced working with vulnerable people. The acting manager described the recruitment procedure in use and we viewed four recruitment records. Candidates completed an application form and if suitable, were invited to interview with the acting manager and another senior staff member. The application form directed staff to list previous employment. Applicants had not fully completed this and this had not been followed up during their interviews therefore a full employment history was not available for all staff. Recruitment files did not contain two references including that from previous employers for all staff. Staff suitability to work in the care sector was therefore not established as these necessary pre-employment checks could not be evidenced for all staff. For two of the four files viewed there was no evidence to confirm that the staff members were legally able to work within the UK. The acting manager stated they would obtain this information from the staff members.

The failure to have robust recruitment procedures and ensure that all information about candidates set out in schedule 3 of the regulations has been confirmed before they are employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Criminal record checks with the Disclosure and Barring Service (DBS) had been completed for all new staff. New staff confirmed they had completed application forms and had an interview. They also confirmed they had not commenced working at Summerlands until their DBS check had been completed.

There were not enough care staff to meet people's needs on a daily basis. A relative told us that the home

was working on supporting their loved one to have a bath every day but at present they did not have enough staff. The person told us they were able to have a bath on Saturday, Monday and Wednesday. During the morning we noted that people were sitting in the lounge. For in excess of half an hour no staff entered the lounge and when a staff member did enter they just looked then walked away. One person needed support to mobilise and apart from lunch they sat in the same chair for the whole of the time we were at Summerlands. Staff were not readily available during dinner. A member of staff would walk through the dining room and check everything looked alright then left. During the two days of the inspection we did not see any care staff supporting people with activities. People were also not receiving essential personal care.

In addition to the care staff there was a cook who prepared the main lunch time meal. However, care staff had to prepare and clear away the evening meal which removed them from providing care or support for people. During the week cleaners and laundry staff were employed however they did not work at weekends. This meant care staff had to undertake essential cleaning and laundry tasks meaning they had less time for care duties when more people were at home as there were no day services at the weekend. There were three care staff on duty throughout the day and two overnight. The acting manager told us that no dependency or needs assessment tool had been completed. They were therefore unable to evidence how the decision to provide these staff numbers had been determined. The acting manager told us they were aware there was a need for additional care staff during the day and identified they would like to provide dedicated activities staff. They also told us they felt an additional staff member was required at night to provide a sleep in shift which would mean more staff were available during the evening and to respond to any emergencies overnight. They explained that this had not occurred as they were waiting for additional money to be provided from the local authority who paid for people to live at the home.

The acting manager told us they had previously supported the manager in a deputy role. For the seven weeks the manager had been unavailable there had been no additional administration or management support for the acting manager. They identified that this meant they were unable to support care staff or complete all essential management roles. Staff told us they did not feel there was enough of them. One member of staff told us that at times when people were supported in their rooms this meant other people were left with no support or supervision in communal areas.

The failure to provide sufficient numbers of staff to ensure people's need can be met or to have systems to determine the number of staff required in order to meet the needs of people using the service and keep them safe at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in January 2017 we identified that there was no system to identify trends or patterns for accidents or incidents. At that time the manager stated they would be reviewing the processes used to enable a trend analysis to occur. This would help them to identify key areas of the home or times of the day when accidents occurred and take action to reduce the risks. The acting manager told us that the system in place in January 2017 remained in place. There had been few accidents or incidents and therefore a trend analysis had not been completed.

Inadequate

Is the service effective?

Our findings

Two people said care staff provided support in the way they like to be supported and that they would say if this was not the case. One person said, "I would soon tell them if they didn't". A relative said "My [relative] has staff supporting her as she would like".

People were at risk as staff had not received essential induction or ongoing training to ensure they had the necessary skills and knowledge to meet people's needs safely and effectively. A relative said "When the staff were settled, they appeared to know what they were doing, but there have been a lot of changes recently". We spoke with two new care staff members. One had been employed for two months and one for two weeks. Both told us they had not received a formal induction and had received no training other than being shown how to administer medicines by the local pharmacy.

We asked the acting manager about how training was provided and for evidence that staff had completed essential training. They said they did not have a training matrix and were unable to demonstrate what training each staff member had completed. The acting manager told us that they were in the process of reviewing how training was provided. They told us they would now be using an on line training system but staff had not commenced this yet. They added that all staff would start by doing the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support.

We spoke with staff and they did not have some essential knowledge such as in respect of safeguarding, mental capacity or epilepsy and diabetes training. Staff were using equipment to move people and reduce risks of skin breakdown without training, placing them and people at very high risk. We saw that paramedics had been called when a person had an epileptic seizure. The acting manager told us that this probably had not been necessary as the person often had seizures but staff had not been sure what they should do.

The failure to provide staff with the necessary training, including induction and ongoing training, to give them the necessary knowledge and skills to meet people's needs safely and keep them safe at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in January 2017 we recommended that the provider established a robust system for undertaking and recording staff appraisals. At this inspection the acting manager told us they had been undertaking supervisions, which we saw copies of in staff files, however they had not completed any appraisals.

The failure to ensure staff receive an appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not always met appropriately. For some people whose care records identified health conditions, risk assessments and care plans were ineffective in guiding staff to these

conditions. For example, three people had a diagnosis of epilepsy. All three people's risk assessments were exactly the same and contained no information about how their epilepsy presented, any possible triggers, early warning signs and the length of their usual seizures. They included basic first aid guidance about what to do but this was not always safe as it instructed staff to move the person. Most staff told us they would not move a person having a seizure however, one member of staff was only aware of one person living at the home who had epilepsy. For people who had a diagnosis of diabetes, risk assessment did not identified risks associated with this condition such as hypo/hyperglycaemic attacks, eye damage, foot and kidney damage. Staff were unable to tell us about the risks associated with this condition and what they would monitor for.

We saw in the records for one person's medical appointments it stated they had become aggressive, although it did not provide any detail about what the term aggressive meant. Staff told us this person could shout and swear and the acting manager told us they had threatened to physically hurt them. No risk assessment had been undertaken and no plan of care had been implemented to mitigate the risks which may mean they would not receive essential medical treatment. For another person we saw that a hospital appointment had been cancelled in March 2017 and not rearranged. The acting manager said attempts had been made to contact the department but they were unable to get through and had lodged a complaint with the hospitals complaints department. However, no other action had been taken to ensure the person received a new appointment such as speaking with the GP or following up the complaint.

Care records did not consistently contain health action plans. These are documents which record information about people's previous medical history and action that is being taken or is required to ensure people with a learning disability receive all necessary support to have their health needs met in a planned and proactive manner. The acting manager was unable to tell us when some people had previously seen dentists and when next appointments were due. For one person their records showed their last dentist appointment was in 2013. The acting manager told us they did not think this was correct and said they would be making appointments for everyone who lived at the home. The failure to plan people's routine medical needs means these may be missed and people do not receive prompt treatment at an early stage.

The failure to ensure service users health care needs are known and met was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person told us that they had diabetes. We saw them going out to local shops independently and returning with a bag which appeared to contain food items which they took to their bedroom. No staff appeared to note their return. Their care plan contained information about how staff should monitor food the person purchased when out and the actions staff should take if inappropriate foods were purchased. We saw that on a previous day staff had noted that the person had purchased sugar free chewing gum therefore this had been left with the person.

One person had a Percutaneous Endoscopic Gastrostomy (PEG) tube in place. This is used when people are unable to eat or drink sufficiently or safely orally. Although the person was now managing their nutritional needs through eating the PEG remained in place. Discussions with staff showed that this was being managed correctly ensuring it would be safe to use if required and the person was protected from any potential complications this may present. However, records of the care of this tube were not being maintained.

Staff had not received training in the Mental Capacity Act, 2005 (MCA) and were unclear about how this should be applied for the people they were caring for. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. 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 make

particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. When people are assessed as not having the capacity to make a decision, a best interest decision meeting should be convened involving people who know the person well and other professionals, where relevant. When asked about the MCA one staff member said "Think it relates to their abilities" but was not able to expand on this.

Care plans contained no evidence to show that people who had capacity, had consented to the care and treatment that had been planned for them. Assessments of the ability of people to make specific decisions had not been made and the principles of the MCA were not followed. For example, bed rails were being used to prevent some people falling out of bed. Staff told us one person did not have capacity to give consent but there was no record to show how this had been assessed or that the decision to use bed rails had been taken in their best interests as no recent assessment had occurred. Decisions had been made on behalf of other people, but there was no evidence to show that people who knew the person well had been involved. Some people had purchase items for their bedroom including where people were sharing rooms and these items would be shared. For example, two people had shared the cost of purchasing two sets of curtains for the windows in their rooms. The curtains purchased were the same design and it was not clear how the decisions to purchase that design had been made. We were told one of these people lacked capacity to make decisions about their finances. This meant decisions may not have been taken in accordance with people's wishes.

The failure to ensure consent was sought and the principles of the Mental Capacity Act 2005 were applied was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty when receiving 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 Deprivation of Liberty Safeguards (DoLS). We found the service was not working within the principles of the MCA and DoLS. Not all staff had an understanding of DoLS and how they should be applied to people's care. For example, one staff member did not know what DoLS meant but thought one person had one. The acting manager told us one person had a DoLS authorisation in place however when we viewed the records of this we saw that it had expired in May 2017. The acting manager told us they had not realised this and had not submitted a new application as is required. The care records for the person who had been subject to DoLS contained no information about this or how staff should support the person in relation to the DoLS and MCA. Care staff were unaware that the DoLS had expired. One member of care staff told us they felt they needed clearer guidance. They said "If a person really wanted to leave and they were under a DoLS, how do we stop them?"

We recommend the provider introduces systems to ensure where DoLS have expired that this is noted and acted upon appropriately.

Everyone told us the food was good. We saw the cook going around asking people if they wanted the planned menu, which was written on a blackboard in the dining room, and offered alternatives when required. We observed two alternatives being given when dinner was served. The same process happened with dessert. However, information about the planned menu and alternatives was not provided in an accessible, picture, format which would have helped some people whom we were told could not read, to make an informed choice about their meal.

It did not appear that drinks or snacks were readily available for some people. One person said that they had a break, (meaning a drink) at 10am and 3pm, apart from with meals. We saw a jug of squash in the dining

room however there were no drinking glasses available. For people who were more independent we saw they were able to make their own drinks. We observed several occasions when people did not receive offered food and drinks promptly but were left waiting at tables. For example, on the first day of the inspection as lunch was concluding a care staff member offered a person seated in the lounge a drink. The person said "yes please" and the staff member left the room. A while later the person had not received their drink and another member of care staff came into the room to take the person out. The person left the room to get ready to go out without having the drink they had been offered and were therefore at risk of not receiving adequate fluids on what was a hot day. On the second day of the inspection a staff member brought a person into the dining room for their breakfast. They consulted with the person who was clear what they wanted to eat and drink. The staff member left the room. Another staff member came to ask the person what they wanted to drink and eat, they told the second staff member what they would like and the staff member left. Almost half an hour later the person was still sitting at the table having not received anything to eat or drink, no care staff were present or in the kitchen. We told the cook what had transpired and they stated they would organise the person's breakfast. We could not be assured that staff would have returned to provide the person with their food or a drink.

We spoke with the cook who told us they knew people well and knew their likes and dislikes. We saw that a range of different meals were provided and these were plated and refrigerated if people did not come for these at the time of serving. Where people attended day services a packed lunch was provided and they were given the reheated hot meal in the evening. Other than those people living with diabetes, the cook was unaware of people who may need to avoid some foods due to their medicines. Where one person required their meal to be liquidised the cook was using moulds to ensure the meal was presented in a pleasing format which imitated the food which had been liquidised. Once prompted by another member of staff we saw a staff member supporting a person to eat their pudding in a positive way. The staff member was seated beside the person and was verbally encouraging them to eat. The person had been provided with adapted cutlery and drinks in a lidded beaker with a straw.

Records of care people had received did not specify what meals, drinks or snacks people had received other than to state if they had eaten and drunk well. People were provided with biscuits and Jaffa cakes with hot drinks however there did not appear to be a choice and healthy alternatives such as fresh fruit were not offered or encouraged. A number of people at the service were either diabetic or obviously overweight and therefore required healthy options to be offered.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in January 2017 we found people were not treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to address this concern. However at this inspection we found improvements had not been made and people continued to be treated with a lack of respect.

Our observations suggested that people were relaxed and comfortable in staff presence and were comfortable and confident to talk with us. Requests people made were mostly met however, people were not always listened to or treated with dignity and respect.

Following lunch one member of staff presented a person with ice-cream, the person was clearly pleased, the member of staff said "That is because you have been good". We also heard staff using phrases such as "good girl". Everyone living at Summerlands were adult with the youngest person being over the age of 50 years. To use terms usually used to reference children or to inform people that they have received ice cream because they have been good is inappropriate and undignified. Language such as this does not treat people as adults and as equals to the care and other staff working at the home.

We asked a staff member about a medical condition. They pointed across the lounge and speaking loudly said "that's [name of person], over there with [name medical condition]." This did not respect the person's confidentiality and was not dignified.

Another person was being supported to go to day services. Their transport arrived and a staff member was taking the person outside. We pointed out the person was still wearing their slippers which staff had not noted. The staff member apologised to the transport driver but not to the person who they took back into the home without explanation.

An external professional told us that people were not always well presented when they left the home and clothing was not always clean and tidy or suited to the planned activity.

On the first day of the inspection we saw two people in their bedrooms with a drink and each had a Jaffa cake on the table in front of them. Neither had been provided with a plate and the Jaffa cakes had been left directly on the tables. We raised this with the acting manager who agreed that plates should be offered and that these would be more dignified and protect people from any food hygiene risks. However, on the second day of the inspection we again saw both these people with Jaffa cakes laid directly onto their tables. We also observed a staff member taking a hot drink to a person who was in their bedroom. The staff member also carried, in their hands, i.e. not on a plate, a Jaffa cake. The person was not offered a choice of afternoon snack and it was not served in a pleasant or dignified way. These examples show that people were still not treated in a dignified adult manner.

We did not witness members of care staff seeking consent before care or support was given. For example, on

the second day of the inspection we saw staff wipe two people's faces at the dining table following lunch. On neither occasion did they ask or inform the person about what they were about to do. One person would have been able to wipe their own face if prompted and provided with a napkin however staff just wiped their face. For the other person staff approached them from behind and without saying anything wiped the person's face. The person was visibly upset and made noises indicating this whilst waving their head and arm around. These interactions were undignified, inappropriate and negative for the people concerned.

Throughout the inspection we observed very limited interaction between staff and people. Interactions we observed were invariably initiated by people, were of limited duration and task orientated. On occasions people were ignored. For example, during lunch a person called three times to a member of staff walking past. They did not get a response until the third time of calling. Also at lunch time we saw two staff walked into the dining room on a couple of occasions, they did not engage in conversation, stood watching people, before leaving the room again. A person had finished their meal, a care staff member gave them their walking frame and then moved a chair under a table another person was sitting at to enable them to walk past. The other person shouted "ow" twice as the chair had knocked their leg. The first person shouted that they hadn't done anything and things in the room became tense as other people also responded. The care staff member did not acknowledge the person who had said "ow" and did not acknowledge the situation in the room. They said nothing.

We observed staff walking into people's bedrooms without knocking on bedroom doors and without acknowledging people within the bedroom. Staff always appeared rushed and going somewhere. These examples demonstrate that staff failed to treat people with respect.

The failure to ensure people are treated in a dignified way at all times was an ongoing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about dignity and respect with the acting manager. They said they "completely agree" and added that they felt they were "fighting a losing battle". We noted that some ancillary staff including the cook and a cleaner were more interactive with people and when people approached the acting manager they took time to listen to the person and informed them of actions they were planning to take to resolve the problem for the person.

People were not involved in key decisions about the service. Many of the people living at Summerlands had done so for a number of years and were capable of being involved in decisions about the service. For example, people were not included in the recruitment of new staff. They were not involved in decisions about what sort of staff they would like, key skills staff may need, involved in shortlisting, interviewing applicants or in deciding who should be offered jobs at the home.

Systems did not support people to be involved in some day to day decisions. Information was not provided in a suitable accessible format which would help keep people informed and enable them to make choices and decisions. For example, menu choices were written on a blackboard and no pictures of the options were provided. Care plans and care records were not in a format suitable for people, information about how to complain was not in an accessible format and the minutes of service user meetings were in a typed inaccessible format kept within a folder in the, usually, locked office. There was no information for people about planned activities or suggestions of things they may like to do each day. The failure to ensure people could access information in a suitable and accessible format meant people were excluded from involvement in decisions affecting their individual care and the service generally.

People had limited opportunities to develop skills and continue to use skills they may have had. People

were not encouraged to do their own laundry or cleaning of their bedrooms. The home employed cleaners and laundry staff. We saw they did not include people when cleaning their bedrooms or when personal laundry was being undertaken. At tea time when staff were preparing the evening meal we saw they had not encouraged people to assist them, people were not involved in laying tables or preparing the meal.

Care records contained limited information about people's life histories and any individual or cultural needs they may have. For example, one person's care file contained conflicting information about the country the person had been born in and their first language. There was no information as to how their cultural heritage should be acknowledged or how this may affect the provision of care. The acting manager told us the person had previously enjoyed going out shopping and purchasing food items associated with their country of birth which they had cooked with support. However, following a decline in their health they were no longer able to go out on their own and were no longer able to do this. No action had been taken to provide the person with the type and taste of food they had previously been known to enjoy. The person had previously enjoyed attending a heritage centre weekly to meet with people from the county of their birth. However they no longer did this. Their bedroom did not reflect their cultural heritage and the only decoration to reflect this was an out of date calendar from 2016 which was positioned on a wall behind the person's bed and chair which they would be unable to see.

Some people attended a local church where they were able to do this independently. However, for other people there was limited information or access to have their religious needs met. For example, one person's care file simply stated the person was a particular religion. There was no further information about this such as if the person had regularly attended church or if they wished to see a priest if this was organised. No information was present as to actions staff should take if the person became unwell or was nearing the end of their life to ensure the necessary prayers would be said and their body dealt with in a way appropriate for their religion.

Staff supported people to express their sexual identity and provided an environment where people could discuss these issues should they wish to do so.

Action had been taken since the previous inspection in January 2017 to provide screens within shared bedrooms so that where personal care was provided people's privacy would be maintained. The acting manager told us that when shared rooms had a vacancy these would be converted to single bedrooms so that over time shared bedrooms would no longer occur. Some bedrooms were large and people had personalised these. One person was very proud of their room and showed us their new storage unit which they had been supported to purchase via the internet.

Inadequate

Is the service responsive?

Our findings

At the last inspection in January 2017 we found records did not reflect that care was planned or delivered in a manner which reflected people's preferences and needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008. The provider was required to take action to address this. They sent us an action plan telling us what they would do to address this concern. However at this inspection we found improvements had not been made in the care records and people's needs were not being met.

People could not be guaranteed to receive care and support that was personalised and responsive to their individual needs. Care and support files did not provide clear information about what people's needs were or how they should be supported. Most care plans lacked the level of detail required to ensure staff had all the information necessary, were not up to date or contained conflicting information about people's current needs and how these should be met. For example, one person had diabetes which was controlled by medicines and diet. In different parts of their care file there was differing information as to when and how often their blood sugar levels should be checked ranging from when needed (no detail when this may be) to monthly. We identified that the person was having their blood sugar levels checked twice a week at around 7am. Nowhere in the care plan was this specified. The person's blood sugar recordings were very stable and it is unlikely that they were required to be done with this level of frequency. The person was therefore being subjected to a painful procedure twice a week without any information as to why this was required.

The acting manager told us one person was at high risk of falls. Their care file contained a falls risk assessment tool which had last been completed in January 2017 with a score of 11 meaning they were assessed as at high risk. However, there was no falls prevention or management care plan in their file. One care plan contained some good information about how they were to be supported to use the stairs but nothing else about their mobility. This stated they should be supported by two staff, however one member of staff told us they were supported by one member of staff. A second care plan referred to physiotherapy input and the instructions for these were in a different file. There was nothing recorded in the daily notes which would suggest these exercises to improve the persons mobility took place.

One person was at high risk of weight loss and records detailed they had a fluctuating appetite. They had been prescribed food supplements by their GP which records showed they were receiving. The home's weight book stated they should be weighed weekly on a Monday and Thursday however, the last recorded weight was on 16 April 2017. We saw that nobody else had been weighed since mid-April 2017. We asked about this and were told by the acting manager that the home's weighing scales were broken and no action had been taken to source replacements. This meant where there were concerns about people's weight regular monitoring that would be needed was not occurring and staff would be unable to take action should people gain or lose weight. One person was on medicine which thinned their blood meaning that this may not clot. Whilst a risk assessment was in place to identify that this could happen, it did not contain any information about what this medicines was and did not include signs for staff to be aware of that may indicate internal bleeding. When we asked a member of care staff if there were any risks associated with this person's medicine, they were not able to tell us about this.

One person had been prescribed a cream that had not been applied since it had been prescribed as staff did not feel confident to apply. However, no action had been taken to ensure this need was met. No discussion with health professionals or request for district nurse involvement had taken place.

Many of the care staff at Summerlands had not worked there long term. On the first day of the inspection one staff member had worked at the home for eight months, the second staff member two months and the third for two weeks. Where care staff did not know people well, and care plans were not adequate, people were at risk of receiving care and treatment that was not personalised to their individual needs. For example, one person's care plan related to meeting their personal care needs stated 'staff to support me with all personal care'. This contained no detail as to how staff should do this or information about preferences the person may have. Some care staff and the acting manager demonstrated a good understanding of certain people, their health status and current care needs. Other staff, for example those who were new to Summerlands were less informed about people's needs. In these cases, where people were unable to communicate their needs well, staff had to rely on people's care plans to guide them. When we asked staff about care plans they were unsure about the information within them and it was evident these were not working documents which staff had read or referred to on a regular basis.

There was a lack of activity provision to meet people's individual needs. We asked people what activities they did. Their responses included from "watching TV", "we do bingo occasionally", and "I do nothing". One person said that they liked to do their knitting. At no point in the morning of the first day of the inspection did any member of staff offer to support a person with an activity. At 11:05 we sat and chatted with one person who was in the dining room. We asked them what they were doing this morning. They replied "I am waiting for lunch". Lunch was not until 12:00. No staff suggested any activities to the person or provided them with books or craft activities they could work on for the hour until lunch was served. In the afternoon of the first day of the inspection a staff member took two people out to the local shops and a café for a drink. One person was seen spending time in their room knitting and another person was in their room listening to music. In the lounge the television was on throughout the day. When one person asked for a film this was put on however, there was no discussion with other people in the lounge to see if they were all happy to watch the (Christmas) film. One member of staff told us they felt there was not enough staff to support people with activities.

The failure to ensure that care is planned to meet people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had not completed first aid training but were able to describe basic procedures they should follow should people require emergency care during a seizure or diabetic low blood sugars. Whilst some of this information differed from that within the care plans the information staff provided would ensure action was correctly taken in these situations. However, not all staff were aware of who may have epilepsy or diabetes or other health information about people meaning staff may not check for these conditions if the person is presenting in a different way.

Care files and daily logs contained no reference as to how people had spent their time or what activities they had been engaged in. The acting manager told us some people had decided they no longer wanted to attend day services so more people were at home during the day. They said they would like to employ an activities staff member however funding for this was not available. The minutes of the two resident meetings which had occurred in 2017 included discussion about activities. One person had identified in the first meeting that they would like to go and watch a particular sport. They raised this again in the second meeting as it had not occurred. The acting manager confirmed that the person had not yet been supported to do this.

Four people said that they knew how to raise a concern three of whom said that they were listened to. One person said that if they had any issues they would tell their sister. Another person felt they were not listened to. We discussed this with the acting manager who was able to explain why this may be how the person was feeling. A relative said they knew how to raise a concern, and added that every time they had raised a concern, it had been dealt with appropriately. Throughout the inspection we saw people approached the acting manager who took time to listen to them and where necessary took action to resolve their concern. This showed people and relatives felt able to approach the acting manager as and when required although information about how to complain in an accessible format was not readily available for people.

The acting manager told us they had received one complaint since the previous inspection in January 2017. They explained the actions they were taking to investigate and resolve the situation. They told us this would include providing a written explanation and apology to the relative who had raised the complaint on behalf of a person who lived at the home.

Inadequate

Is the service well-led?

Our findings

Following the previous inspection in January 2017 we found improvements were needed to ensure there was a robust process to ensure the quality of the service provided at Summerlands. This was a breach of Regulation 17 of the Health and Social Care Act 2008. We made a requirement telling the provider they must make improvements. An action plan was received and at this inspection we found insufficient improvements had been made.

The service was not well led. Management systems had not ensured that the breaches of regulations we identified in January 2017 were acted on. These breaches continued and further breaches of regulations were found at this inspection. The provider's quality monitoring systems had not identified that people were not receiving safe, effective, responsive care or led to improvements in the service provided.

The home did not have a registered manager. 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. The previous registered manager left the home in January 2017. A new manager had been appointed at our last inspection and informed us then that they intended to apply to become the registered manager. However, no application was received. At this inspection this manager was not working and the previous deputy manager was now acting manager.

Following the inspection in January 2017 we received an action plan in April 2017. This stated that action was being taken to address the issues of concern we had found and would ensure a safe service was provided. However, we found that most of the actions identified in the action plan had not been completed meaning the necessary improvements had not been made. We found continuing concerns with the management of medicines and health care needs, risk and care planning, quality of records, people were not treated with dignity and respect, their personal finances were not managed for their best interests and their legal rights were not protected. The home's environment and facilities were not well maintained and robust recruitment procedures had not been undertaken.

The provider did not have an effective system in place to monitor and improve the quality of the service provided. There was no auditing of care records or files, infection control, no auditing to ensure staff were receiving all necessary training or supervisions, and no auditing of the care people were receiving. The acting manager told us no medicines audits had been completed and that the infection control and Health and safety audit were at their house as they had been working on these. We were also told that no recent unannounced spot checks had taken place and the acting manager confirmed it was "fair to say" that quality monitoring and assurance work had not been happening "as it should be".

There was inadequate forward planning to improve and develop the service or ensure a safe service was provided. For example, to ensure adequate numbers of staff with the necessary skills, knowledge and experience were employed. The home's environment and facilities required updating and some furniture such as sofas in the lounge were no longer suitable for use. The acting manager was aware of this and said

they had informed the provider of the need to replace some furniture.

The failure to have suitable systems to monitor the quality of the service provided was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to display at least one sign showing the most recent rating by the commission of the performance of the service. This must be displayed conspicuously in a place which is accessible to service user. In the homes entrance hall there were a number of signs and certificates however there was no information about the rating awarded to Summerlands following the inspection completed in January 2017. We asked the acting manager about this. They said a copy of the report was available. We were shown that this was partially under other papers on a notice board in the usually locked office. This was not displayed in a conspicuous place accessible to people living at the home or visitors. We identified this on the first day of the inspection; however no action was taken by the second day to display this information correctly.

The failure to display the most recent rating by the commission of the performance of the service was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed the home's policies and procedures. None of these were in an accessible format suitable for most of the people living at the home. The previous acting manager had reviewed and rewritten all policies since January 2017. We identified that some contained inaccurate or incomplete information and brought these to the attention of the acting manager.

Throughout the inspection the acting manager presented as open, honest and transparent. Whilst they had not been aware of all the concerns we identified, they were aware of the need to improve the service. We discussed our concerns with the acting manager who said they hoped to be able to resolve these issues when the long term management arrangements had been addressed. They told us they had "shared with staff our findings from day one [of the inspection]" and expressed their disappointment. The acting manager agreed that "across the board there are issues with medicines" and in respect of the assessment and management of risk that what we were saying was "fair and valid". The acting manager also agreed there had been a lack of involvement of people in their care plans and decisions about the home.

One relative said they had a good relationship with the acting manager. We saw they were able to raise an issue with them which the acting manager responded appropriately to. One care staff told us they "loved working at the home". They were unable to tell us what the values of the home were other than to suggest they were to look after the people living there. Another care staff member said they thought the management was "ok" and was confident if they reported concerns to the acting manager they would be listened to and they would be addressed.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider has failed to ensure people are included, as far as possible in making decisions about how their care needs will be met and failed to ensure care provided meets peoples individual needs. Regulation 9 (1)(a)b)c) (2)(a)(b)(c)(d)(i)

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person has failed to ensure people are treated with dignity and respect at all times. Regulation 10 (1)(2)(b

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person has failed to ensure people's legal rights in accordance witht he mental capacity act 2005 were upheld. Regulation 13 (1)(2)(3)(5)

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has failed to ensure medicines were managed safely and health care

needs were known and met. All necessary action to reduce the risks to individual service users and risks posed by the environment including those relating to infection control have not been taken.
Regulation 12 (1) (2)(a)(b)(c)(d)(d)(g)(h)

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person has failed to ensure people are protected from abuse. Regulation 13 (1)(2)(3)

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has also failed to operate effective systems and processes to assess and monitor the quality of service and ensure regulations are complied with. Regulation 17(1)(2)(a)(c)

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person has failed to ensure robust recruitment procedures and that all information within schedule 3 is held for all staff. Regulation 19 (1)(a)(2

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider has failed to ensure the

	ratings from the inspection in January 2017 were displayed in a conspicuous place within the home. Regulation 20A

The enforcement action we took:

We have cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person has failed to ensure sufficient numbers of suitably trained and supported staff are deployed to meet the needs of people and keep them safe. Regulation 18 (1)(2)(a)

The enforcement action we took:

We have cancelled the provider's registration.