SHC Clemsfold Group Limited

Orchard Lodge

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: Orchard Lodge is a residential care home that also provides nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Orchard Lodge provides accommodation in two units called Boldings and Orchard, which are all on one site. Orchard Lodge provides nursing and personal care for up to 33 people who may have a learning disability, physical disabilities and complex health needs. Most people had complex mobility and communication needs. At the time of our inspection there were 17 people living at Orchard Lodge.

Orchard Lodge is owned and operated by the provider Sussex Healthcare. Services operated by the provider have been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is ongoing and no conclusions have yet been reached.

At the previous inspection in November 2018 we found six breaches of regulation in relation to safe care and treatment, safeguarding service users from abuse, dignity and respect, person-centred care, receiving and acting on complaints and governance. At this inspection we found two breaches had been met in relation to acting on complaints and safeguarding people from abuse, while four regulations continued to be breached.

At this inspection, some improvements were identified and acknowledged although these were not sufficient or wide-spread enough to improve the overall final rating. We found that a number of risks remained. Issues we had identified at the previous inspection in November 2018, had still not improved or been actioned by the provider. Concerns about risks associated with application of NEWS, PEG management, choking, eating and aspiration, repositioning and skin integrity and medicines had all been highlighted to the provider on many occasions at other of their services. This information had not been properly shared or used to improve safety and care at Orchard Lodge.

Orchard Lodge has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. These values were not always seen consistently in practice at the service. For example, some people were not receiving the assistance with communication they needed to be as independent as possible. Orchard Lodge was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Orchard Lodge in response to changes in best practice guidance.

People's experience of using this service:

The service met the characteristics of Inadequate in the Safe and Well-Led domains and Requires Improvement in the Effective, Caring and Responsive domains. This meant the provider needed to make improvements to people's support. These are detailed below.

Some aspects of the service remained unsafe. Some people were at risk from harm as risk assessments were not effective in reducing the likelihood of harm and staff had not taken steps to keep people safe.

Learning from incidents had not been consistently implemented.

People's needs and choices were not always assessed so staff knew and understood how to deliver support for them to achieve effective outcomes.

Quality assurance and governance systems were not operating effectively and were not supporting staff and management to understand their responsibilities and ensure that quality performance and risks were properly managed.

Some health needs were not being met safely or effectively.

People were supported in a kind and caring way by staff who knew them well.

People's relatives told us that the new manager had improved communication with family members about their loved ones' care and developments at the service.

This inspection identified continued breaches of Regulations 9, 10, 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rating at last inspection:
At our last inspection in November 2018, the service was rated "Inadequate". Our last report was published in February 2019.

Why we inspected: All services rated as Inadequate are re-inspected within six months of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement:
We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

We imposed conditions on the provider's registration for this location.

Follow up:
The overall rating for this registered provider is 'Inadequate'. The service will remain in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This was the sixth inspection since July 2017

where the provider remained in breach of Health and Social Care Regulations.

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.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Orchard Lodge

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The first day our inspection team consisted of two inspectors, a specialist nurse advisor 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. Their area of expertise included learning disabilities and people with complex health needs. The second and third days, our inspection team consisted of two inspectors and a specialist nurse advisor.

Service and service type:
Orchard Lodge is a residential care home that also provides nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Orchard Lodge has not had a registered manager since April 2017. The acting manager has been in post since January 2019 and is currently in the process of registration with the Care Quality Commission. 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.

Notice of inspection:
This inspection was unannounced.

What we did:
We reviewed the information we had received about the service since the last inspection in November 2018.

This included details about incidents the provider had notified us about, such as allegations of abuse. We assessed the information we require providers to send us at least once annually 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.

We spoke with two people who lived at the service to obtain their views of the care they received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received.

On the first two days of the inspection, we spoke to the peripatetic manager and on the third day we spoke to the acting manager. We also spoke to the clinical lead registered nurse, two agency registered nurses, a team leader, four care assistants, a senior physiotherapist, the activities and engagement manager, an activities coordinator and the chef. We also spoke to seven relatives of people living at the service. During the inspection, we observed medicines being administered to people. We reviewed records about people's care which included care plans of each person at the service. We looked at a range of clinical records as well as care and nursing notes. We also looked at recruitment records and profiles, accident and incident reports, quality assurance documents and medicines records. After the inspection, we also contacted six health and social care professionals to gain their feedback on their experiences of working with people and staff at the service.

Inadequate

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

When we last inspected the service in November 2018 we found breaches of Regulation 12, as not all had been reasonably done to mitigate risks to people and Regulation 13 as the provider had failed to operate effective systems to protect people. At this inspection we found that the provider continued to be in breach of Regulation 12. The provider was no longer in breach of Regulation 13 although improvements in this area were still needed.

Assessing risk, safety monitoring and management:
• People living at Orchard Lodge had complex health conditions, physical disabilities and communication needs. People were fully reliant on staff to support them with all aspects of their care. At this inspection we found that not all had been done to reduce specific risks to people and that management of some of these risks were inadequate.
• The provider had introduced the National Early Warning Score (NEWS) system, across different locations including Orchard Lodge, from November 2017. The NEWS is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. The NEWS will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be, and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further.
● At this inspection, we found that staff were failing to implement NEWS consistently or effectively, increasing the risk that people would not receive the required medical support.
● Records highlighted a recent incident whereby a person's health condition deteriorated. Observations had been completed correctly and demonstrated that an urgent need for a referral to emergency medical services was required, but the agency nurse had not escalated this appropriately. On another occasion where a deterioration in a person's condition was noted, their NEWS was scored at a level that required staff to complete repeat observations, call 999 for emergency support and refer to the person's step-by-step guidance on monitoring and managing potential signs of sepsis. None of those actions were taken in response. Clinical notes detailed the deterioration in the person's condition throughout the day and GP support was gained by staff. Staff had also failed to seek emergency support when a subsequent reading, four hours later, confirmed a score that would have triggered these actions.
• We brought this to the attention of the peripatetic manager who agreed that staff should have called emergency medical support immediately and undertaken regular observations. The peripatetic manager informed us that they would escalate these concerns with the provider to ensure ongoing learning. They told us, "The records will be used in the next NEWS training to highlight a poor example of the use of NEWS and how the wrong action was taken."
•□Concerns had been identified at some of the provider's other services regarding the failure of staff to identify and escalate health support for people when their condition deteriorated.

● Risks to people from aspirating were not always fully mitigated. Aspiration happens when food or fluids are inhaled into the lungs. Some people at the service received their nutrition by percutaneous endoscopic gastrostomy (PEG). A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. Care plans identified that some people were at risk of inhaling food and drink into their lungs, which could lead to aspiration pneumonia. When people slept, their beds needed to be raised at a specific angle in order to mitigate aspiration risks while their PEG feed continued throughout the night. One person's notes, and their positioning charts, failed to demonstrate and record that the person's head was elevated throughout the night. This regime of elevation of the person's head was started, under a trial period, in December 2018. The guidance stated that this procedure needed to be reviewed and signed off by a dietician. We found that this had not been addressed by staff. The clinical lead had recorded that the sleeping regime had been confirmed as satisfactory by the service's own staff without checking with the dietician.

● We raised these concerns with the peripatetic manager who took immediate action to get the sleep system guidelines signed off as being safe to continue. They also told us that the service did not have the correct positioning charts in place and confirmed that the appropriate charts would be implemented that day.

● We checked the sleep positioning guidance of another person who used a bespoke sleeping system and required positioning in a specific way. Their sleeping care plan required head tilt at a specific angle; although there were no guidelines available for staff in their room apart from a position photograph that showed the person in an incorrect and unsafe flat position.

● There were visual indicators on some people's beds to demonstrate the correct angle that the head of the bed needed to be moved to at night. However, we asked one staff member how they would know what angle to position the bed when indicators were not present, and they told us that they would judge the angle with their arm and that they, "Know what 30% angle is." This reliance on individual judgement increased the risk that people's head positions could be undertaken at incorrect angles and could put the person at risk from choking or aspiration.

● People's records contained multiple guidelines for staff about PEG feed and positioning needs, but some care records contained inconsistent information about how to manage this risk safely. Two people's feeding regimes detailed the time period for their feed, their elevation needs when receiving their feed, and for the period after when feed and fluids had finished. Their turning charts did not clearly demonstrate or record that they were in a safe position when receiving their feed or whether the feed had been paused when repositioned, as per their PEG guidelines. Staff we spoke to confirmed that they knew how to support people safely but could not explain why this was not being recorded. The evidence above shows that not all had been done to mitigate and manage the risks to people of aspiration.

● We raised these specific concerns with the Regional Operations Director on the first day of the inspection. They assured us that immediate steps would be taken, in conjunction with the clinical staff, to address these concerns. The provider ensured that actions around people's positioning when being PEG fed would be completed and that duplication of guidance and documentation would be removed from the relevant care plans. We then received written confirmation of these assurances. The provider confirmed that instructions around PEG feed and positioning were clearer and more concise for staff, and that greater accuracy would be reflected in staff recording when feeds were paused and restarted. They also confirmed that staff would now be recording people's correct position and angle whilst in bed and that they were being correctly repositioned in accordance to their care plans. We received assurances that this would be assessed by the Regional Operations Director the following morning handed over to the acting manager on their return to the service.

• On the third day of the inspection, we checked the three people who had been identified as being at most risk and found each person was in their correct, assessed positions. We reviewed the new charts on the third day of the inspection but found that both night and day staff had not used the correct repositioning codes.

The clinical lead informed us that they had also picked up on this and would be addressing the issue with staff to ensure that the new instructions would be fully embedded with staff.

● Risks to people with complex needs were not always managed well, or shared between staff effectively, in relation to their eating needs.
● Many people required specific support, which included that of speech and language therapists (SALT), to ensure that their food was prepared in ways that reduced the risks of choking. People's care plans contained information relating to their dietary needs, although some information that the chef and kitchen staff held about people's needs was incorrect or inconsistent. The chef told us that they received updates and changes in people's dietary needs verbally from staff.
● Information was available in the kitchen which guided staff on some people's consistency requirements (in line with their SALT assessment), however, information on three people's nutritional needs were not available. Other people's information was not up to date and contained contradictory information about their needs compared to the placemats in use on dining room tables. The chef also used a quick glance sheet that contained incorrect information. For example, information for one person stated that food should be finely chopped, but SALT guidelines stated that it should be well fork mashed.
● Incorrect and inconsistent information available to the chef and staff increased the risk that people may not receive their food in the correct form, increasing their risk of choking. For example, another person's SALT guidelines stated that they should not be given sandwiches or breadcrumbs and advised that meals should be fortified to make them more calorific. However, the chef's reference sheet recorded that breadcrumbs should be given as an alternative to sandwiches and made no reference to fortifying food. We raised these concerns with the chef, clinical lead and staff during the inspection.
● The chef prepared pureed food to the required consistency. However, where people required a soft diet or fork-mashable diet, the chef would cook food soft enough to be cut up or mashed but relied on staff to make sure this was done correctly before people received their meals. This increased the risk that people would not receive their food in the consistency that would be safe for them to eat. Our observations demonstrated that people were served food that corresponded with their eating and drinking guidelines. However, the evidence detailed above showed that risks to people choking or aspirating were not always properly mitigated. The service used agency staff who may not always be fully aware of people's requirements.
● We addressed these concerns with the chef and kitchen staff who provided assurances that issues we raised would be addressed immediately.
● Seven of the ten people living in Orchard wing had been identified as being at risk of choking or aspiration. Although people had choking risk assessments in place and had eating and drinking guidelines that identified preventative measures to reduce the risk, none of these people had risk assessments that identified control measures or actions to take to keep people safe in the event of a choking incident occurring. Staff had received training to use a de-choking device in the event of a person choking. However, feedback to Inspectors from staff was inconsistent and unclear on what initial interventions they would take before making the decision to use the de-choking device. One registered nurse told us that they were unsure whether people had choking assessments in place. Another staff member told us they would attempt abdominal thrusts but did not mention back slaps or encouraging a person to cough before doing this. One staff member was asked at what stage they would use the de-choking device and stated that they would use this "When the person's colour changed." Staff were asked what actions they would take to support people who were in their wheelchair in the event of a choking incident. Some people's physical status meant that it would be difficult to provide abdominal thrusts. One staff member said, "I don't know about that. I will write that down and find out. I have never thought about it". Another staff member said, "That's a good point. I would use the de-choker then if they are in the wheelchair." The impact of the lack of staff's understanding around actions to take, should an incident of choking occur, placed people at risk.

● We raised these specific concerns around lack of guidance for staff when a choking incident might occur, and the lack of specific choking care plans for people, on the third day of the inspection. We received further assurances from the management team that these risks would be updated and that choking care plans would be put in place to ensure that risks were mitigated.

Risks associated with choking or aspiration have been highlighted in inspections of a number of the provider's other services. This had not led to improved safety at Orchard Lodge.

● Although there was no one at the service receiving support with pressure area care, risks were not always mitigated and monitored to maintain people's skin integrity. Some people had air mattresses on their beds to reduce the friction between themselves and their bed to safeguard them from pressure ulcers or bedsores. We found that the settings on two people's mattresses did not match their recorded weight; reducing their effectiveness in maintaining skin integrity. Correct settings were also required to ensure that some people's specific sleeping positions were maintained. A staff member told us that the mattress settings were not checked and that only maintenance issues were reported to the clinical staff. However, the clinical lead confirmed that mattress settings should be checked and recorded but was unaware that staff were not completing the charts. They informed us that they would address the discrepancies in settings and recording immediately.

Using medicines safely:

● We identified a number of issues in the risk management, guidance and recording of medicines.
● Some people were unable to eat, drink or take medicines by mouth for safety reasons and required their medicines to be administered only through their PEG. We found that not all medicines on two people's medicines administration records (MAR charts) included the instruction that medicines should be given by PEG, and still indicated that these should be given orally. This was an issue that was highlighted at the last inspection in November 2018 where the manager at the time provided assurances that people's care plans had been thoroughly reviewed. This concern had also been identified on a recent provider audit but had still not been actioned. The absence of accurate and safe information about people's medicine placed them at risk of unsafe care and treatment. Although staff we spoke to were knowledgeable about this need, the service used agency staff regularly who may not be as familiar with people's needs. We raised these concerns at the inspection with the clinical lead and acting manager.
● There were significant gaps in recording of medicine administration on people's MAR charts. We identified 25 gaps in recording from February 2019 until the current inspection. We spoke to the registered nurse on duty about a gap in recording for a liquid medicine and how staff could check in retrospect that this had been given. The nurse stated they did not measure the amount of liquid medicine remaining after each administration, so the only way to know if it had been given would be the verbal confirmation of the nurse who had completed that specific medicine round. Therefore, it was not possible to confirm whether this medicine had been administered if the MAR was not signed off to say so. This error had also not been identified on that week's medicines audit and, as a result, had not been addressed with the nurse. This showed that there were insufficient systems and checks in place to ensure that medicines errors were identified and rectified. We have detailed more on the service's quality assurance systems in the Well-Led section of this report.
● We found that opening dates on boxed medicines had not always been recorded. Nine medicines were found not to have dates recorded. This issue had also been highlighted in a recent medicine's audit carried out by the peripatetic manager. It is good practice for services to ensure that this task is completed so that staff are able to monitor how long medicines are lasting, and so that manufacturer's guidelines can be followed to ensure that medicines are safe and remain effective.

● Some protocols for medicines that people received 'as and when needed' (PRN) were found to be out of date. We found that protocols for four medicines for two people had expired. This issue had also been highlighted on an internal audit carried out two months prior to the inspection but had not been actioned. It is essential for protocols to be reviewed regularly to ensure that ongoing clinical needs are met safely. We highlighted this issue with a registered nurse on the first day of the inspection. Staff arranged for a GP to review these and these had been updated by the end of the second day of the inspection.
● One person's emergency medicine protocol had been identified within an internal audit in March 2019 as requiring an immediate review by the GP. This had been actioned but information from the review had not been received, or chased, for ten days after it happened. At the time of the inspection the new protocol was missing from the person's file, which meant that some staff would have been unable to determine what actions should be taken. This information had still not been obtained by the third day of the inspection.

● Environmental risks were assessed through completed health and safety and fire assessments, although actions to address issues raised had not always been completed within designated and safe timescales. We identified significant delays in the completion of health and safety risks identified in fire audits. The manager told us they were not sure why these had taken so long to action and that responsibility for implementing these actions remained with the provider's utilities manager. They confirmed that these actions had not been followed up with the service's management since coming into post. We have detailed more on this within the Well-Led domain.
● At the last inspection in November 2018 we found that care plans about PEG management lacked detail on how to clean the PEG site effectively and no records were available to evidence that staff were completing this. At this inspection, concerns remained. Documentation was still not in place to demonstrate when staff had cleaned the PEG site. One registered nurse informed us that care staff undertook the cleaning of the PEG site area when completing people's personal care. However, a team leader told us, and the nurse, that staff did not clean the PEG site but cleaned around it when supporting people with showers.

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

Learning lessons when things go wrong:

● Lessons had not been learned effectively.
● At this inspection we found inconsistencies in the quality of completion of untoward event forms (UTE's), in the response to incidents and actions taken to address and prevent reoccurrence. We saw UTE's which recorded actions that were necessary to prevent further incidents occurring. However, these actions had not always been responded to or followed up to ensure learning and improvement. For example, a UTE had been completed in January 2019 to record medication errors by an agency nurse. One of the actions was for the training of agency nurses with medicines to be checked. At this inspection, we identified that this action had not been addressed.
● The safe management of risk was raised as a concern in our previous inspection in November 2018. However, we have found that the breach of regulation relating to risk remains at this inspection.
•□ Systems and processes to safeguard people from the risk of abuse;

● At the last inspection in November 2018, we found that systems and processes to protect people from abuse had not always worked effectively. This was because two incidents at the service had not been referred to the local authority safeguarding team.
● At this inspection, we found that safeguarding concerns had been appropriately referred to the local

authority. The manager told us that they had sought clarification in the reporting of safeguarding from the local authority.
● Care and clinical staff demonstrated good levels of understanding of what might constitute a safeguarding concern, while the management and clinical leads showed a good level if understanding of their responsibilities to keep people safe from abuse.

● At the last inspection in November 2018, care plans about bowel management continued to lack sufficient personalised information to help staff know when people may be constipated. At this inspection, improvements had been made to ensure staff had the right guidance and information to support people. Constipation risk assessments and elimination care plans were comprehensive and personalised. They included information on what actions staff should take in the event that person was constipated, including referring to guidance on what 'as and when' medication should be administered. Bowel charts were completed correctly, and actions were taken where applicable.
● People were supported to drink sufficient fluids in order to maintain hydration. We reviewed people's fluid charts and recordings showed that people were receiving their recommended daily intake.
● Checks had been carried out on the safety of fire doors, while emergency lighting and emergency equipment were regularly tested. External professionals had carried out checks and monitoring on electrical and gas supplies while water systems had been assessed to ensure they were safe for people to use.

Preventing and controlling infection:

● We observed good standards of cleanliness in communal bathrooms and living spaces throughout the inspection. There were cleaning schedules in place that ensured that the service remained clean and free from malodours.
●Staff had access to personal protective equipment such as gloves, aprons and anti-bacterial hand gel and we observed these being used throughout the inspection.

Staffing and recruitment:

● Throughout the inspection we observed that there were sufficient staff to meet people's needs. Staff rotas confirmed that enough staff were scheduled and deployed appropriately on shifts. People told us that staff were patient with their support. One person told us, "Yes, they take their time with me." Relatives we spoke to said that the staffing levels had improved after a period where they felt there wasn't enough staff. One family member said, "It's got a little bit better, there was a stage when they weren't safe and not looked after and not enough during the evening and weekend." Another relative told us, "The ratio at the moment is ok." The peripatetic manager confirmed that the service was using a dependency tool to ensure that staffing ratios were maintained to meet the needs of people at the service. One registered nurse told us, "There's usually enough staff. We have been short once, but they solved the problem. They sent someone straight away."
● Recruitment of staff had been undertaken using robust safety checks to ensure suitable staff worked at the service. Pre-employment checks had been completed that included references, identity checks and referrals to the Disclosure and Barring Service (DBS).

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At the last inspection we found breaches of regulation as the provider had not consistently met people's assessed needs. At this inspection we found that there was a continued breach of this regulation.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- At the last inspection in November 2018 we found that people did not always receive effective care and treatment in response to their health care needs. This was because people had not received hydrotherapy sessions as detailed in their care plans in order to support them with mobility and health conditions. Replacement physiotherapy sessions had not been provided consistently to people. The service's hydro pool was available for use at the time of the last inspection in November 2018.
- At this inspection, people were still not receiving their assessed levels of hydrotherapy sessions. Care plans for thirteen people we reviewed documented that they should receive weekly hydrotherapy sessions. People required this therapy for different reasons including 'to provide dynamic movements and for free and active movements and exercise'. People's mobility was impaired, and some had physical conditions which caused painful joints, so activity in water could be beneficial in enabling limbs to be supported while exercise programmes were carried out.
- Records about hydrotherapy from January 2019 until the current inspection showed that all people had received less than 35% of their assessed hydro sessions. Three people had only received one session during this period. While there were two isolated occasions where issues with equipment and infection control had prevented its use, the hydro pool had been available for staff to support people. One relative we spoke to was unclear on the status of their family member's hydrotherapy sessions. They told us, "I don't know when they are going to restart." We raised this issue with the peripatetic manager who was unable to identify why these sessions had not been provided.
- As detailed in the Safe section, care plans and medicine protocols had not always been reviewed and updated to ensure that people's current needs were being met.

- People had received their assessed physiotherapy sessions by specialist physiotherapists. Records showed that people were receiving their assessed amount of physiotherapy sessions which included stretches, chest percussions, and physical therapy using equipment such as adapted tricycles. We observed people having some of these sessions during the inspection. Staff were also required to provide additional support to encourage and promote people's mobility needs. However, when we spoke to a staff member about one person's mobility support, they confirmed that this was not happening regularly. This person required support to have three to four walks on a daily basis. The staff member said that the person was supported sometimes in the morning when having physiotherapy but that these walks were not taking

place. The staff member said this was because during walks the person would, "Drop their leg. He gets lazy." When asked if the walks would continue, they responded, "We can try." The person's care notes did not evidence that the person was receiving these mobility sessions.

Staff support: induction, training, skills and experience:

● Staff continued to receive training relevant to the needs of people living at the service, but we found areas where nursing competencies in NEWS application and medicines management were sometimes lacking. This is an area requiring improvement. We have detailed within the Safe domain the shortfalls in NEWS as well as the recording of medicine administration and monitoring of medicine protocols. The peripatetic manager told us that they were introducing competency checks for all agency employed nurses, that included NEWS, as they had done for another of the provider's services; although this was still work in progress. The peripatetic manager told us of plans for clinical staff, then care staff, to attend patient deterioration training through NHS providers although this had not yet been completed.
● We highlighted to the management during the inspection that there was also a need for the service to ensure that agency nurses had competency assessments with medicines. The providers own quality assurance checks had identified this action although it had not yet been completed. We did not see evidence that this was been completed regularly and with every agency nurse.
● All staff had completed core training such as fire safety, safeguarding and moving and handling. One staff member told us that they had recently finished their moving and handling 'train the trainer' course and had approached the clinical lead to improve their knowledge through reviewing mobility care plans. Staff received training in critical areas such as learning disability support. One care assistant told us that the training they received made them, "Feel more confident, secure and safe."

The failure to consistently meet people's assessed needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We have detailed the risks associated with the preparation and delivery of people's specific eating requirements within the Safe domain of this report.
● People were offered two set choices of meals every day, although they could have an alternative set choice if they wished. Menus were created after monthly consultation with people at menu meetings. One person told us they liked the food. They said, "Sometimes I have soup for lunch" and that they could choose as there was a, "Menu that they have on the table."
● People's care records demonstrated that their nutritional needs were regularly reviewed. Malnutrition assessments (Malnutrition Universal Screening Tool) had taken place for all people and where required, some people were weighed monthly. Any concerns regarding unplanned weight loss had resulted in appropriate referrals to dieticians. Records showed that these systems were effective in monitoring weight and identifying concerns when weight loss was identified. Dietician referrals had been arranged and advice to alter diets, such as increasing calorie intake through fortifying meals and changing rate and concentration of PEG feed, had been put in place by staff.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:

● People were generally supported to live healthier lives and were supported with referrals to specialist healthcare services such as moving and handling and speech and language therapists. However, we have

detailed within this domain the failure to ensure that people's hydrotherapy was being undertaken. Also, within the Safe domain, we highlighted the inconsistent application of the National Early Warning Score which meant that appropriate medical support was not always sought in line with some people's assessed status. We read records highlighting that emergency support was sometimes required in order to assess people's condition, but staff failed to do seek it.

● Relatives were happy with staff's support of their loved one's healthcare arrangements. One relative said, "He is supported well with health needs." People were supported to maintain good oral care and care plans detailed what equipment they required and how staff should support them. One relative told us that their family member was supported to attend regular dentist appointments to ensure that good oral care was maintained.

● People had care passports that would help hospital staff understand their current health status in order to provide safe care and treatment when admitted. This detailed people's communication needs and signs when they might be in pain or distressed, in order for them to take timely and appropriate actions.

Ensuring consent to care and treatment in line with law and guidance:

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 and DoLS and whether any conditions on authorisations to deprive a person of their liberty were being met.

● At the last inspection in November 2018 we found that there were no recorded best interest decisions made on one person's behalf. At this inspection, we found best interest decisions had taken place and were recorded. We found that decision specific mental capacity assessments had been undertaken and that professionals and relatives had been involved in making decisions in the person's best interest. Some people had conditions attached to their DoLS authorisations. Staff had ensured that these conditions had been met. Staff were knowledgeable about ensuring that they obtained people's consent.

Adapting service, design, decoration to meet people's needs:

● People's needs were mostly met by the design and decoration of the service. Adaptions had been made to the environment and layout to ensure the needs of people had been met.

● Communal corridors and doorways had been widened to allow suitable and safe access for people's wheelchairs and equipment.

● People's bedrooms contained ceiling tracking hoists to support them to be transferred and moved safely.

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.

People did not always feel well-supported, cared for or treated with dignity and respect.

At the last inspection in November 2018 there was a continued breach of Regulation 10 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not always use respectful and dignified language with some people and not all people received the same level and quality of interaction from staff. At this inspection we found that while some improvements had been made in respect to the way staff spoke with people, work was still needed to ensure that people received the same level of interaction from staff.

At the last inspection, the provider had not taken all reasonable measures to protect people from risk of harm. At this inspection, although some actions had been taken to address those specific areas, other concerns remained; where not all had been done to ensure people were protected from risk and harm. Therefore, a culture of caring values was not always evident across the service. We elaborated on these concerns in more detail in other sections of this report.

Ensuring people are well treated and supported; respecting equality and diversity:

- Whilst we observed many occasions where people were supported in a caring manner, there were some instances when staff did not respond appropriately or to ensure that that each person received the same level of interaction.
- During the lunchtime meal, one person was waiting to be supported to eat in their wheelchair when they started to kick the footplate of their wheelchair. Whilst there were staff nearby, the person was not attended to in order to support them to manage their frustrations. The person was not attended to quickly. However, as the table was crowded, the staff member moved another person away from the table without asking them, in order to make room for the person who was kicking their wheelchair.
- We observed the registered nurse advising staff to tell one person to sit upright as they felt that they would slip down in their chair if they did not tell them. However, we did not observe the supporting staff asking the person to do so. The impact of this was that the person remained in a position where they could have slipped down from the chair.
- On another occasion, one staff member stopped an activity with one person to take a phone call. The person was left by themselves with no explanation provided to the person. The staff member then went to the computer to pursue the query. There were no other staff members available, so the person was left sitting by themselves.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's cultural and spiritual needs and preferences had been obtained and considered in their care planning. Staff had supported people to attend religious services in order to meet those needs. When people experienced difficulty in attending services, religious representatives were approached to provide readings at the service.
● People were well supported during group activities. They were supported with undertaking hand-over-hand drawing and we observed the activities assistant showing patience and engagement throughout the activity.
● Although we have detailed above, incidents were staff did not always provide the attention and support people needed, we observed occasions where they were compassionate and reassuring when people required it. For example, we observed staff ensuring people were occupied and engaged when people were waiting for transport to take them on a community activity. Staff were calm and showed an understanding of what people needed to be reassured.
● Feedback we received from relatives was positive about staff and their approach to their family members. One relative told us, "The carers are fantastic. The support at the moment is very good." There is a different attitude now altogether." Another relative said, "It feels a lot more personal and a lot of the time I am satisfied with the care."

Respecting and promoting people's privacy, dignity and independence:

● Most staff were aware of the need to ensure people's privacy and personal information, and information had been securely stored within the service. However, we saw an email sent by a staff member through their own personal email which attached photographs of a person's wound that had been taken using their personal phone. Providers will regularly take photographs of people's wounds (with their permission) in order to monitor the progress of their wound care support. However, the staff member had not followed the provider's security policy and had risked the security of a person's personal information, by using personal communication methods. We brought this to the attention of the provider who informed us that an untoward event (UTE) form would be completed and investigated with the staff member.
● People were supported by staff who were careful not to discuss people's care and treatment openly in front of others. When people required support with their PEG for food and medicines, staff took people to quieter areas such as the sensory room or their own rooms to complete this.
● Relatives told us that their family members were always well presented. One family member told us, "In terms of personal care she is always clean and tidy. Her hair is washed, and staff make every attempt to look after her hair."
● During the mealtime period, people were encouraged to be as independent as possible. Staff supported people to eat with specialist cutlery, offering support when they needed it. People were given time to be as independent as possible when eating and drinking, with staff giving them appropriate space and not rushing them. Staff were respectful in giving praise to people.
● One care assistant showed patience when supporting a person during their meal, taking time to tell them what was on their spoon and asking whether they were enjoying the food. Staff asked people's permission before clothes protectors were put on them before eating.
● We observed people being supported in the grounds of the service to be independent in promoting their own mobility needs. Staff were encouraging, and gave praise, to people using their mobility tricycles.
● We observed staff members respecting people's privacy and knocking on people's doors before entering

Supporting people to express their views and be involved in making decisions about their care:

● We detailed within the Responsive domain of this report about how people's communication needs had not always been acted upon to ensure that they received information in a way they could understand. There

was a system in place for regular reviews of people's support involving service users. However, people were not enabled to be fully involved in these as there was a lack of effective communication tools and a lack of provision of accessible information. This meant that people could not be fully engaged in their support.

● The manager had been proactive in improving the lines of communication between the service and people's relatives and carers since starting at Orchard Lodge. Communication books had been set up for relatives to communicate with staff or raise questions and issues, and for staff to inform relatives about of different elements of their family members care. Relatives told us that this was a positive step which they felt had been successful since it was put into place.

● Relatives confirmed that they were invited to reviews, were able to 'have their say', and received copies of review notes. Recent relative surveys had been taken to gain their views on the quality of the service.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

When we last inspected the service in November 2018, we found a breach of Regulation 9 as the provider had failed to ensure that people's assessed needs were met, while we also found a breach in Regulation 16 as there had been a failure to act on complaints. At this inspection we found that the provider had met the breach of Regulation 16 although we continued to find evidence that people's needs were not always being met, so the breach of Regulation 9 continued.

Planning personalised care to meet people's needs:

- The service was not always acting to ensure people's communication needs were being met. People living at Orchard Lodge have complex needs and it is essential to develop and use effective ways to support people to communicate.
- Care plans about people's communication needs were detailed and demonstrated an understanding of people's physical and emotional behaviour, although lacked detail to support staff to communicate as effectively as possible. We did not observe staff using any assistive communication techniques with most of the people at the service. Some staff were trained to use a type of sign language called Makaton, but we did not see staff utilising this throughout the inspection. One person was using an electronic tablet with communication apps to support them to make choices and communicate with staff. Staff told us that they were still developing methods to support the person with this device.
- Care plans were completed in a written format although these were not accessible for people. We found that the provider had not fully considered or implemented the guidance within the Accessible Information Standards (AIS). All providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard in full from August 2016 onwards. This means they must, identify, record, flag, share and meet the information and communication needs relating to people with a disability, impairment or sensory loss.
- The provider had identified people's different communication needs, in line with these standards, but had not always assessed how information should be recorded or shared with the person in an accessible way that met their communication needs. Many people's communication care plans recorded that people would require information presented to them in easy read formats, although we did not observe any information, apart from the complaints policy, that was provided in this way for people.
- The peripatetic manager told us that work was being undertaken to make visual records of food to allow people fuller access to make their choices and to put these on dining tables. However, during the inspection, menus were not displayed on the tables but on the wall in words, while the pictures bore no relevance to what people were going to have on that day.The manager told us following the inspection that the board was changed on a daily basis and would include pictures of additional meal options for people to select.
- The peripatetic manager also told us that a software system was being explored that allowed staff to download easy read and adaptive leaflets. However, this work had yet to be introduced. The peripatetic

manager told us that existing referrals to speech and language therapists had focused on people's nutritional needs and had not addressed communication issues.
● Concerns with providing effective communication support has been raised with the provider in the last two inspection reports.

The failure to ensure that people's assessed needs are met was continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preferences, interests and giving choice and control:

● At the last inspection in November 2018 we found that the provider still had work to do to engage people who wished to be involved when activities were taking place. The provider had also told us about planned improvements to develop a more meaningful activity programme with an external company.
● At this inspection, the provider had engaged a wellbeing organisation called Oomph, which supports care services to enhance the mental, physical and emotional wellbeing of people in care through social and physical activities. We were told that the company was providing transport to help staff support people with outside activities and trips. We saw evidence that people were being supported to participate in more outside trips into the community.
● However, we were told that the external company was undertaking training in supporting people with learning disabilities and developing a wellbeing plan to use in homes for people with learning disabilities. At the time of the inspection, this had not been introduced, but the activities and engagement manager indicated that the service would be using the companies' programme when fully developed.
● Staff noted that there had been positive changes to the activities and engagement that people were supported with. One staff member told us, "The activities are better now, it's changed. People are supported to become more involved. We are going out with people now, almost every day." Staff also told us that the promotion of the key worker role which was also allowing care staff to become more active in the support of people in meaningful activities.
● Relatives' feedback was positive about the level of engagement that staff provided. One family member said, "There are lots of activities. They have painting and reading and baking, all sorts of things when the weather is good. They do a lot and go on shopping trips round and about." Another relative told us, "In terms of activities I only see him during the weekend. They sit them around the table doing different things. I know they do activities every day."
● We observed group activities being undertaken during the inspection including drawing and writing, while people looked actively engaged in various creative craft sessions.

Improving care quality in response to complaints or concerns:

● At the last inspection in November 2018 we found that action had not always been taken in response to complaints. We looked at how complaints and concerns had been managed since the inspection.
● The provider had a complaints policy in use. This was being followed when dealing with complaints which had been responded to appropriately. Records of complaints were kept and reviewed quarterly by management to look at how service could improve.
● The registered manager told us that they were open to receiving complaints and spoke about encouraging this feedback.
● Relatives told us that they would know how to make a complaint should they need to.

End of life care and support:

● There was no one receiving end of life support at the time of the inspection. Staff had ensured that plans were in place with people's GP's, where necessary, to ensure that they would have access to medicines to keep them comfortable if necessary.

●The peripatetic manager told us that advanced care plans had been sent to people's relatives to complete, while discussions had also taken place in conjunction with the NHS's 'Dignity on dying' campaign. We were told that discussions had prompted positive actions by relatives in making preparations for some people.

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. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the previous inspection we identified six breaches of regulation. At this inspection we found there were continued breaches of Regulations 9, 10, 12 and, as detailed below, Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

● Themes have been identified across the provider's services which have been highlighted to them as of significant concern. Many of these themes have been identified at Orchard Lodge, for example the management of medicines, positioning, nutrition and choking. Despite these themes having been repeatedly raised with the provider, learning from them had not been successfully or effectively shared or used to drive forward improvements at Orchard Lodge.

● At the last inspection evidence showed that the systems and processes of quality monitoring and governance in place were not consistently effective. At this inspection, we found that these systems and processes remained ineffective in identifying issues and ensuring that the necessary actions and changes were carried out.
● Quality assurance and governance systems were in use and there were internal and external quality managers working with staff and management on-site. However, these systems were not being used effectively to support staff and management at the service to manage safety risks and deliver a good standard of person-centred care at the service.
● Systems and processes for the management of medicines were found to be ineffective. For example, expired PRN protocols had been identified in an internal audit dated February 2019, but this had not been actioned at the time of our inspection. A further provider quality visit in March 2019 stated that there were no concerns with protocols being out of date even though the previous audit had identified they had been. This showed that actions from audits were not always being completed by staff once they had been identified and also demonstrated that audits were not effective in identifying existing issues.
● Internal audits were not always effective at identifying quality issues or risks. We identified a gap in a MAR chart that had failed to be picked up at the most recent weekly medicines audit. On some occasions when gaps had been picked up through internal audits, actions had not always been fully addressed by staff. One missing entry had a note attached for the staff member to sign but the MAR chart had been archived and therefore the gap had remained.
● A monthly audit completed in January 2019 had identified a number of areas requiring action, however no dates of completion had been recorded and there was no manager sign off.
● Medicine audits were not always signed off by the manager and actions had not been evidenced or

followed through. The provider's internal quality support visit report in March 2019 had identified this issue but we saw three subsequent medicines audits following that report that had not been reviewed or signed off by the manager. We spoke to the manager regarding the high level of gaps in medicines recording that had been identified since February 2019, and they confirmed that they had been unaware of these.
● The provider had also arranged for an external pharmacy to undertake a medicines audit in March 2019. This audit stated that staff should ensure that all MAR sheets were signed and that boxed medicines should have opening dates recorded on them. As detailed in the safe section of this report, these actions were not being completed.

● Actions from individual audits were not always added to development plans meaning it would not be possible to maintain effective oversight, manage quality and safety risks or drive on-going improvement. For example, all actions on successive 'Quality Development Audit Tool' reports between August 2018 and January 2019 had been delegated to the manager without any timeframes for completion. Actions had been identified from a fire risk assessment completed in July 2018 together with health and safety risk management audits in July 2018 and January 2019 but had not been delegated to individuals and timescales for completion were frequently not met. We have detailed these shortfalls within the safe domain.
● Audits or checks had failed to identify the issues we had highlighted in this report with regards to issues around repositioning and skin integrity and the incorrect application of NEWS. They had not identified, or actioned, that people were still not receiving their assessed hydrotherapy sessions.

● The above evidence demonstrated a lack of ownership and effective organisation that failed to ensure that quality assurance systems worked. Actions identified in individual audits had not been added to the service development plan between January and April 2019. The manager told us that the service was not really using this plan, delegating or carrying out and following up on actions from internal audits other than a daily walk around. The peripatetic manager told us, "The quality team can come in and identify issues but do not always support staff or manager to follow up on actions." The manager told us, "There is lots of paperwork involved when working with the quality team and they do not always realise where issues are related to each other or cross reference with other plans."
● At this inspection we found inconsistencies in the quality of completion of untoward event forms (UTE), in the response to incidents and actions taken to address and prevent reoccurrence.
●The provider had sought guidance from the local authority on the threshold for reporting accidents and potential safeguarding incidents to the local safeguarding team. From this guidance, the provider had taken the decision that if the incident did not meet the threshold for a safeguarding enquiry, then the incident would not be reported to the CQC. We identified inconsistencies in the submission of potentially reportable incidents to the CQC where bruising had been identified and potential harm may have occurred. Some incidents had been reported while others had not. The manager was not able to confirm their understanding of when notifications should be made to CQC.
● The manager and staff had differing expectations of who is responsible for completing UTEs and reporting to external bodies. The clinical lead and peripatetic manager stated that all staff completed UTEs and that they had responsibility to raise external safeguarding concerns as well as the manager.

The failure to assess, monitor and improve the quality and safety of the service and to mitigate risks to people is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● There had been no registered manager at Orchard Lodge since April 2017. It is a requirement of the provider's registration for a registered manager to be in post. There had been four managers in post since

April 2017; who had submitted but later withdrawn their applications to register with the CQC. The current manager had joined the service in January 2019 and was in the process of registering with the CQC. In the period prior to the inspection, the service had also been supported by a peripatetic manager.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;

● The manager was focused on maintaining the day to day culture and staff said that the manager had been an active presence at the service. Relatives and staff told us that there was always an open-door policy.
● The provider and manager told us of the new keyworker system that was being introduced to help establish a process for regular monthly reviews of people's care and to make people's support more personalised. Staff told us that they had been involved in a meeting where it was outlined how they wished for the system to be introduced. Staff said that this meeting had helped them to understand the importance of their responsibility to provide more person-centred care. One staff member told us, "We will help review care plans and look at people's preferences and what they enjoy instead of being task orientated. We need to involve people more in their day to day care." Although this system had not been fully embedded, family members spoke positively about this proposed change. With regards to their family member's support, one relative told us, "The key worker system is good as continuity is crucial for them." The manager told us that key working was one area that they had spent time supporting staff with and hoped this would help facilitate a move towards more person-centred care, including activity support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● There had been some improvements in engaging and communicating with people's relatives under the new manager. Relatives had told us of the concerns they had expressed with the turnover in management. One relative told us, "It's changed so much. It's too short term, management have changed so often."
● However, relatives were optimistic in the approach the current manager was taking. Communication books had been introduced and family members had been encouraged to communicate with staff through these. Relatives spoke positively about this move and confirmed that staff had responded to their recorded queries. One relative told us, "There has been a big focus on communication with relatives." Another family member said that the manager had been, "Very proactive and had got new ideas."
● Staff spoke positively about the manager's approach to engaging with staff and people. One staff member told us, "He has good ideas about us being more involved. I've had a lot of support."

Working in partnership with others;

● The manager had been working closely with the local safeguarding team. Staff had working relationships with local authority learning disability teams. There was good partnership working with healthcare professionals such as moving and handling assessors and speech and language therapists.
● There were different healthcare professionals involved with the service including, a chiropodist, psychiatrist, and advocate.

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 People's needs were not being met in line with their assessed requirements.

The enforcement action we took:

We imposed conditions on the provider's registration for this location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

We imposed conditions on the provider's registration for this location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not consistently provided as risks were not always mitigated on behalf of service users

The enforcement action we took:

We imposed conditions on the provider's registration for this location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to check the quality of care were not effective in assessing, monitoring and improving the care provided to service users.

The enforcement action we took:

We imposed conditions on the provider's registration for this location