Loven Spinney Limited

The Spinney Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Spinney Nursing Home (The Spinney) is a care home registered to provide accommodation for people who require assistance with personal or nursing care needs. It is registered for up to 35 people. At the time of the inspection 22 people were living in the service.

People's experience of using this service and what we found
We found the provider had not implemented systems to ensure people were adequately safeguarded and serious risks to people's health and safety were not promoted. The management of medicines was unsafe and infection control practices did not support good hygiene or reduce the risk of cross infection. There was no evidence of lessons being learnt by the staff team when things went wrong. However, people we spoke with said they or their relative felt safe living at The Spinney. One family member told us, "[Relative] loves it here; they are safe." Another person told us: "I'm quite content."

People were not always supported to have maximum control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The service was not working within the principles of the Mental Capacity Act (MCA) in relation to Deprivation of Liberty Safeguard (DoLS) applications and consent was not always obtained from people before care and treatment was delivered.

People's needs had not been thoroughly assessed and care plans did not reflect people's assessed needs or identified risks. The planning of people's care was poor and people were not always provided with good nutritional support. At our last inspection we recommended the provider offered people a wider variety of meal choices.

Routine appointments and visits by community professionals had been arranged. However, people were not always supported to access emergency health care services in accordance with their needs, particularly in relation to accidents resulting in potential head injuries.

The governance of the service was not effective, as the internal auditing systems had not recognised issues identified by the inspection team. Therefore, the assessing and monitoring of the service was not robust.

People were not always supported to be involved in the care planning process or to make decisions about their care and treatment. At our last inspection we recommended the provider involved people in planning their own care and support. At this inspection we have made a repeat recommendation about supporting people to make decisions about how their care and support is delivered.

We noted on one occasion a person's privacy and dignity was compromised, as care staff did not recognise when assistance with personal care needs were required. At our last inspection we recommended the provider improved practices around promoting privacy and dignity. At this inspection we have made a

repeat recommendation about respecting people's privacy and dignity.

Feedback from people was not regularly sought and meetings were not being held. We made a recommendation about this.

Parts of the environment were in need of updating and modernising, so the home is brought up to an acceptable standard for people to live in. We made a recommendation about this.

There were some gaps in training schedules and formal supervision was not consistent. A high percentage of agency workers were utilised and induction programmes for new employees and agency staff were not thorough. We made recommendations in these areas.

The management of complaints could have been better. We made a recommendation about this.

Recruitment practices adopted by the home were robust. This helped to ensure new employees were suitable to work with vulnerable people.

People told us they felt safe living at The Spinney. They were well-presented and looked relaxed in the company of staff. Staff members approached people in a pleasant manner and were supportive when assisting them with daily activities. We saw some lovely interactions and staff members were chatting with people in a friendly way.

Staff communicated with people in a way in which they preferred and relevant information was accessible. People were supported to maintain their interests whilst living at the home and activities within the home and within the wider community were provided to avoid isolation.

Rating at last inspection and update
The last rating for this service was requires improvement (published 7 December 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations. The service has deteriorated to inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Spinney Nursing Home on our website at www.cqc.org.uk.

Why we inspected: This was a scheduled inspection based on the previous ratings.

Enforcement: We have identified breaches in relation to person-centred care, safe care and treatment, safeguarding people, nutrition and hydration and good governance.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

The Spinney Nursing Home

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 inspection team consisted of two inspectors on day one and three inspectors on day two; a medicines inspector on both days and medicines support on day two. Day one was also supported by an Expert by Experience. An Expert by Experience is someone who has experience of the type of service being inspected.

Service and service type
The Spinney is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on leave at the time of our inspection.

Notice of inspection
Day one of the inspection was unannounced. Day two was announced.

What we did before the inspection
Prior to our inspection we checked all the information we held about the service. This included any notifications the service is required to send to us by law, any allegations of abuse or feedback about the service.

The provider sent us a provider information return. A provider information return is information providers are required to send us with key information about their service, what they do well, and improvements they

plan to make. We used all this information to plan our inspection.

During the inspection
Some people had communication difficulties or were living with dementia and were not able to give us their opinions. However, to understand the experiences of those who used the service we were able to speak with six people who lived at the home and a relative. We observed interactions between staff and people. We spoke with four members of staff and seven company representatives. We looked at several records. These included six care files, medication administration records, four staff files, training records and associated documentation relating to the operation and management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and some additional quality assurance records. We spoke with the local authority and requested feedback from two community professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider failed to ensure suitable arrangements were in place to identify and mitigate potential risks, to ensure medicines were managed safely and to ensure infection control practices were robust. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

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

- The provider did not have systems to ensure people were protected from harm, as there was lack of oversight from senior management and lessons were not learnt when things went wrong.
- People at risk of falling had been identified and accidents had been recorded. However, people had not been adequately monitored following falls and falls resulting in head injuries had not been appropriately managed.
- Not all clinical risks had been recognised or adequately monitored and the systems for analysing incidents were not robust. Care records did not always reflect identified risks and clinical guidance was not always followed.
- Environmental risks assessments were not always effective and although service certificates were current, equipment needed was not always available or in working order. The Control of Substances Hazardous to Health (COSHH) guidance was not adequately followed. This placed people at risk of harm.
- People who lived at the home were at risk of harm because fire safety had not been sufficiently considered or monitored.

Using medicines safely

- The provider did not have systems to ensure medicines were managed safely and records showed people had been exposed to serious risks of harm.
- Medicines ordering had not taken place in a timely manner to ensure people had enough stocks of prescribed medicines.
- The Medication Administration Records indicated people did not always receive their medicines as prescribed.
- Storage and disposal of medicines and controlled drugs was unsafe and was a risk to the health and wellbeing of those who lived at the home.

Preventing and controlling infection

● The provider did not have systems to ensure good infection control practices had been adopted by the service.
● There were unpleasant odours present in some areas of the service. The environment needed a thorough clean. This created a potential risk of cross infection. One person told us, "I want to get out of this smelly place."
● The infection control audit in October 2019 recognised significant shortfalls, which were identified as being unacceptable and yet action had not been taken to address these failings. Therefore, the policies of the home were not being followed in day to day practice.

The provider had failed to ensure suitable arrangements were in place to identify and mitigate potential risks, to ensure medicines were managed safely and to ensure infection control practices were robust. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider failed to ensure people were adequately safeguarded. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.
● The provider did not have robust systems to safeguard those who lived at the home.
● The provider had failed to ensure all safeguarding incidents had been reported to the relevant authorities. Therefore, the policies and procedures of the home were not being followed.

The provider had failed to safeguard people. This placed people at the risk of avoidable harm. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

● Systems were in place for recording any allegations of abuse and staff had received safeguarding training. Those we spoke with said they would report any concerns about people's safety to the management team without delay.
● People who lived at The Spinney and their relatives told us they felt people were safe. However, our findings found people were at significant risk of harm.

Staffing and recruitment

At our last inspection the provider failed to ensure safe recruitment practices had been implemented. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection in relation to recruitment practices. The provider was no longer in breach of regulation 19.

● The provider had ensured an adequate number of staff were deployed and safe recruitment practices were adopted by the service.
● Recruitment processes were in place and checks had been undertaken before staff started working at the

home.

● Records showed a high percentage of agency staff were being used. The management team told us the service was operating on 50% agency staff, which did not provide continuity of care and support for those who lived at the home. However, on the days of our inspection there were enough staff on duty.

● Most people felt there were enough staff on duty, but others gave examples of times when they had to wait lengthy periods for assistance. One person told us they had to tell agency staff at night how to support them.

We recommend the provider considers recruiting more permanent staff to provide a more stable workforce and support people to receive better continuity of care.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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 whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met..
- The provider had failed to introduce robust systems to ensure the service was working within the principals of the MCA.
- Some mental capacity assessments had been conducted after DoLS applications had been made to the local authority. Therefore, people's capacity to make decisions had not always been assessed before the home applied to deprive them of their liberty.
- Consent had not always been obtained from those who had the capacity to make decisions about how their care and treatment was delivered.

The provider had failed to ensure the service was working within the principles of the MCA. This placed people at risk of avoidable harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- The provider did not have systems to ensure people's nutritional needs were always fully met.
- People had mixed views about the food served. Comments ranged from, "Very good" and "It's OK; not fine dining though" to "It's terrible" and "I wouldn't give it to my dog". One member of the inspection team ate lunch with people in the dining room and found although the portion size was small the food served was hot

and edible. One person said, "They [the staff] make sure I get my meals."
● People were at risk of malnutrition because the service did not always monitor and manage high level nutritional risks appropriately. For example, one person was assessed at high risk of malnutrition, but this was not recorded in their care plan and specialist advice had not been sought.
● People were not protected from potential harm because specialist dietetic advice had not been sought when needed.

The provider had failed to ensure people's nutritional needs were being met. This placed people at risk of avoidable harm. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

● People were supported with their meals in a gentle and supportive manner. A choice of menu was available and beverages were regularly offered. Tables were laid nicely including crockery, cutlery and condiments for people to use.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider had not ensured people were always supported to access health care services in accordance with their needs.
● The plans of care showed inconsistencies in relation to specialist referrals and specialist advice had not always been sought in accordance with people's needs. For example, one person had swallowing difficulties and had lost weight, but advice from the speech and language therapy team and dietician had not been requested. This placed them at risk of harm.

The provider had failed to ensure people were always supported to access health care services. This placed people at risk of avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

● The service had built some positive relationships with external health and social care professionals. Staff supported people to attend hospital appointments and there was some evidence of the service working with other agencies. One person told us the optician had visited the home and had made a hospital referral, which the staff supported them to attend.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider failed to ensure people's needs were adequately and continually assessed in line with standards and best practice guidance.
● People's risk assessments and care plans did not always include accurate or clear information. Therefore, care and treatment were not always delivered in line with people's assessed needs.
● The care records for one person showed they were at risk of malnutrition. However, staff had not sufficiently assessed the level of this risk and had not adequately monitored the person's nutritional needs. This placed the person at risk of harm.

The provider had failed to ensure people's needs were appropriately assessed. This placed people at risk of avoidable harm. This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had failed to implement robust systems to support staff in developing their knowledge and

skills.
● Induction programmes were not robust and were not consistently completed for permanent staff or agency workers.
● Training had been provided for the staff team. However, this was not consistent and some gaps in training were evident. For example, none of the permanent staff had received specific training to provide support for one person who lived at the home.
● Staff were not formally supervised on a regular basis and therefore the provider's supervision policy was not being followed.

We recommend the provider introduces more robust systems to support staff in developing their knowledge and skills.

Adapting service, design, decoration to meet people's needs
● The provider had not developed the environment to meet people's needs.
● In some areas the premises needed to be updated and modernised. The main communal lounge was not a homely area for people to spend their time. The adjacent storage area was overflowing with items and the nurses' station in the communal lounge was cluttered with staff belongings, such as coats and bags.
● There was wheelchair access directly into the main lounge area.

We recommend the provider conducts a full audit of the premises and makes improvements as needed to bring the environment up to an acceptable standard for people to live in.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- The staff team did not always ensure people's privacy and dignity was respected.
- The inspectors noted one person needed assistance with personal care and had to bring this to the attention of care staff. This had not been recognised and addressed in a timely manner by staff who were near the individual. Therefore, this did not promote the person's privacy and dignity.

At the last inspection we recommended the provider introduces systems to better promote peoples' privacy and dignity. At this inspection we recommend the provider organises training for the staff team in relation to privacy and dignity.

- During our inspection we saw some lovely interactions by staff members towards those who lived at the home. For example, one staff member was sitting helping someone with their lunch in a polite and courteous manner, whilst chatting with them about everyday things. We saw another staff member helping one person in a supportive manner to maintain their independence whilst mobilising with a walking aid.
- We saw staff members knocking on people's bedroom doors and waiting to be invited in before entering. People told us staff were respectful and their privacy was promoted.

Supporting people to express their views and be involved in making decisions about their care
- The provider did not always ensure people were supported to make decisions about their care and treatment.
- People had not always been involved in the care planning process. However, we observed staff members verbally asking people if they agreed with the care and support being provided.

At the last inspection we recommended the provider involved people in planning their own care and support. At this inspection we recommend the provider introduces more formal systems to ensure people are supported to express their views and be involved in the decision-making process.

- Notices displayed demonstrated a restriction on visiting during meal time and late evening. However, it was clear visiting during these times could be arranged with prior agreement.
- Relatives said they could bring their family pets with them. One person we spoke with told us their Labrador was a regular visitor to the home.
- People were asked to provide feedback about the service through the completion of surveys.

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

- The provider ensured people were treated in a kind and caring manner by the staff team.
- People we spoke with were happy with the approach of the carers at The Spinney. When asked about the staff team, one person said, "No complaints at all; [staff name] is fantastic; she will even make me a sandwich in the night."
- People were well-presented and some ladies wore jewellery and make up. We saw staff members interacting with people in a pleasant manner and together they shared a laugh and a joke.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The provider failed to ensure people's needs, preferences and wishes were planned in a person-centred way.
- Care plans were in place. However, the quality of these was poor; particularly in relation to falls risks, safety, medical history and nutrition. For example, the care plan for one person failed to reflect a high risk of malnutrition and for another a potential choking risk had not been adequately recorded or managed. This placed people at risk of harm.
- The care records were not always accurate or up to date and they contained significant conflicting information. People we spoke with were not aware of their care plans although one person said, "I may have signed something when I first came in."
- End of life care plans were not consistently completed to show how people's end of life choices and wishes had been sought and considered.

The provider had failed to ensure people's needs, preferences and wishes were planned in a person-centred way. This placed people at risk of avoidable harm. This was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider had systems to enable people to make a complaint.
- There was a complaints policy, which provided people with information about how to make a complaint, should they wish to do so.
- Records showed complaints had been recorded and investigated by the service. However, there was no evidence of actions taken or lessons learned by the staff team.

We recommend the provider introduces a more robust system to ensure complaints are well managed and lessons learned by the staff team.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had systems to ensure information was provided to people in an accessible format.
- People were supplied with information about the services and facilities available before they moved into

the home.

● The staff team communicated well with people in a way they preferred and digital technology was used in some areas, such as care planning, policies and procedures. One person told us they had an electronic hand held device and so could chat with their family outside of the service.

● Information and explanations were available to relatives and advocates regarding the care people received.

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

● The provider had introduced systems which supported people to avoid isolation and which helped to maintain their interests.

● An activity co-ordinator supported people to participate in a range of regular activities and encouraged them to maintain hobbies and interests whilst living at the home. She was lively and chatty throughout the day.

● Entertainers regularly visited the home and animal therapy sessions were often arranged. Outings to local places of interest were occasionally provided during the warmer weather and shopping trips were frequently organised. A variety of activities were seen taking place during our inspection.

● Seasonal and themed activities were arranged and people told us they were satisfied with the level of stimulation provided. We saw people enjoying getting the home ready for Christmas. One person said, "There is always something going on for me to watch."

● There was evidence of collaborative working with other agencies and the wider community to provide some stimulation for those who lived at the home. For example, there were strong links with the local church and primary school.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider failed to ensure suitable arrangements were in place to assess and monitor the quality of service provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had not ensured the service was well-led and therefore people who lived at the home did not receive good outcomes.
- There had been instability in the management arrangements at the home for a period of time, as the registered manager had been off work for several weeks, this had resulted in poor oversight of the service. However, our findings at this inspection demonstrated failings were long standing, as breaches were identified at the previous inspection and improvements had not been made. The lack of robust monitoring led to failures and further deterioration of the service. Some staff we spoke with felt management support was poor and the home was short of provisions, such as tea bags, larger size incontinence pads and specimen bottles for urine samples.
- The provider failed to ensure people received a good standard of care and systems were not in place to mitigate potential risks to those who lived at the home.
- Notifications had not always been submitted for certain notifiable events, which the provider is required to send us by law and the storage of confidential records was poor.
- Various audits had been undertaken in line with the organisational policy, although these were not effective.

Systems were either not in place or were not sufficiently robust to demonstrate the service was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider did not have robust systems to engage and involve people and the public.

● Surveys for those who lived at the home, their relatives and staff members had not been circulated for completion for eighteen months. Therefore, people's views about the service provided had not been recently sought. The views of community professionals had not been sought.
● We saw relatives' meetings had been advertised for June, August and October 2019, but evidence was not available to show these had been held. The December meeting was scheduled for the day of our inspection, which was organised by the activity co-ordinator. However, no relatives turned up, so the meeting did not take place.
● Meetings were being held each morning for staff, which were attended by a member of staff from each department. This enabled relevant information to be disseminated and any area of concern to be discussed.

● There was evidence of community links being maintained with local churches and schools.

We recommend the provider seeks feedback from people with an interest in the home about the quality of service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's needs, wishes and preferences were appropriately assessed or planned in a person-centred way. This placed people at risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure suitable arrangements were in place to identify and mitigate potential risks, to support people to access health care services, to ensure medicines were managed safely and to ensure infection control practices were robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to work within the principals of the MCA or adequately safeguard people. This placed people at the risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's

	nutritional needs were being met. This placed people at risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or were not sufficiently robust to demonstrate the service was effectively managed. This placed people at risk of harm.