Castle Meadows (Dudley) Limited

Castle Meadows Care Home

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: Castle Meadows Care Home provides personal and nursing care to older people and younger people who may live with dementia or physical disabilities. Castle Meadows is registered to accommodate 51 people. There were 36 people living at the home at the time of the inspection.

People's experience of using this service:
• The quality of people's care continued to raise serious concerns and areas of the service had deteriorated further.
• There continued to be increased risk to people because medications were not always managed safely.
• Not all events regarding people's safety and well-being had been communicated to other agencies with responsibilities for keeping people safe.
• People dependent on staff to pre-empt and meet their needs were not consistently provided with the support they needed. This was linked to insufficient staff, the way staff were deployed and staff's access to training.
• Processes were not in place to ensure people's right to privacy was maintained and their health needs consistently met.
• Systems had not been put in place to ensure people benefited from living in a home where the quality and safety of their care was effectively monitored and concerns identified and addressed.
• The service is now judged to be inadequate in keeping people safe, as well as continuing to be inadequately well-led.

Rating at last inspection: The rating at the last inspection was Requires improvement overall. The report was published on the 26 July 2018.

Why we inspected: CQC had been advised of concerns in relation to people's care and the management of the home, which indicated increased risk to the people living at the service. Prior to this inspection, the service was placed into whole home safeguarding by the local authority due to concerns in respect of people's care.

At our last inspection we required the provider to improve the management of medicines. On this inspection, we found some improvements had been made to the safety of medicines for people who were supported by one staff team, but medicines were not managed safely by other staff teams. There had not been sustained improvements to the way people' medicines were managed. We also identified deterioration in other areas of people's care.

Enforcement: We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

Follow up: We will continue to monitor the service and will undertake another comprehensive inspection within six months.

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

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.

Castle Meadows Care 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.

The inspection was prompted in part by concerns about the management of risks in relation to people's safety and the management of the home. This inspection examined those risks and looked at the quality of care provided.

Inspection team:
The inspection was completed by one inspector and an assistant inspector.

Service and service type:
Castle Meadows Care Home is a residential care home, with nursing. 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.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager deregistered with us on 27 February 2019 and was not present at the inspection. A new manager had been employed the week of our inspection, and we met them during the inspection.

Notice of inspection:
The inspection was unannounced.

What we did:
Before the inspection, we reviewed:
• Information we had received about the service since the last inspection. This included details about

incidents the provider must notify us about, such as abuse.
• Feedback from the local authority and professionals who work with the service.
• 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.
During the inspection:
• We spent time with people in the communal areas of the home and in their rooms and we saw how staff supported the people they cared for.
• 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 spoke with seven people who lived at the home and three relatives, to gain their views about the care provided.
• We also spoke with the provider's representative, the manager, three nursing staff, eight care staff and an administrator, two members of catering staff and a cleaner. In addition, we spoke with a staff member with responsibilities for activities and an apprentice, who also assisted people with their care.
• We reviewed a range of records. This included sampling seven people's care documents and multiple medication records, plus records about safeguarding people's liberty and freedoms.
• We also looked at records relating to the management of the home. These included systems for managing any complaints, accidents and incidents, checks on medicines administered, infection control processes and the equipment and environment. In addition, we reviewed four staff recruitment files and staff training records and saw the systems in place to manage Deprivation of Liberty Safeguards.
•In addition, we contacted the Clinical Commissioning Group and Local Authority commissioners and safeguarding team during and after the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

At the last inspection on 22 May 2018 and 23 May 2018, we rated Safe as Requires Improvement. We asked the provider to take action to protect people who use the service through the proper and safe management of medicines. We found the provider had not taken the action necessary to manage medicines safely and reduce risks to people.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely
•Records of medicines administered by nursing staff showed us people did not consistently receive their medicines as prescribed. For example, one person, who had been prescribed a medicine pain patch to be administered every three days, had a gap of seven days before their medicine pain patch was re-administered.
•One person, who relied on staff to support them to have the medicines they needed to remain well, had a delay of four hours in the administration of their medicines. For another person, we saw there was a gap of three days in in the administration of creams they required to support good skin health. The person should have been supported by staff to have their skin cream applied each day.
•The medicine records we looked at were not accurately completed. For example, body maps were not accurately completed to confirm where people's medication pain patched had been administered. Risks to people living at the home were therefore increased.
•The stock of medicines held did not consistently match the amount of medicines stored at location. This also included controlled drugs. Where discrepancies had been noted, systems were not in place to investigate and resolve the discrepancies.
•Effective systems were not in place to manage the disposal of medicines. This increased the risk people may be administered the wrong medicines, including medicines that were out of date, and where the recipient's details had been removed.
•People's medicines were not securely stored. We observed people's medicines were left unattended in a communal area of the home, for over twenty minutes, upon receipt from the pharmacist.
•Staff members told us they had not consistently been annually assessed as competent to support people with their medicines.

Staffing levels
•People told us the staffing levels at the home did not support them to have the care they needed at the time of their choice. One person said, "You feel deserted. (You) have to wait a long time, as staff are dealing with (other people's) hoists. (It is a) recent and regular occurrence." Another person living at the home told us there were less staff available to help at night, which led to delays in going to bed and being supported to go to the toilet.
•One staff member told us, "Those (people) nursed in bed do not really get one-to-one time except when you are going in to do something with them, (such as a) pad change or lunch. This means the lounge is

sometimes left unmanned. The problem is downstairs is busy, too." Another staff member told us the time constraints meant the administration of medication, "Felt rushed." The staff member said because of this, they did not always have time to check people had taken the medicine they administered them.
• The manager at the home told us they did not use a dependency tool to ensure staffing levels met people's needs. They advised us they planned to introduce one, so they could be assured people's safety needs and preferences were met.

Learning lessons when things go wrong
•We saw an incident had been reviewed after a person experienced a fall. The incident report considered if there were any actions required to reduce risk to the person further. However, the person's care plan had not been updated to provide staff with the clear guidance they need to follow to reduce risks to the person.
•The provider told us they had not been advised of concerns affecting people's safety and any measures taken to address these in 2018. In January 2019 the provider introduced new systems so they would be alerted to these types of concerns. The provider confirmed the newly introduced systems had not alerted them to a serious concern affecting one person's safety which happened in January 2019.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Following this inspection, we passed our concerns to patient safety at the clinical commissioning group and Local Authority commissioners for their awareness.

Assessing risk, safety monitoring and management, systems and processes
•Processes in place did not ensure safeguarding concerns were escalated to external organisations with responsibilities for keeping people safe. During this inspection, we made a safeguarding referral to the Local Authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

•Systems in place to monitor and manage risks to people were inadequate. For example, people's care plans and staff handover information were not consistent. One person's care plan did not provide staff with enough information to support the person when they moved around the home in their wheelchair. We found this was recorded on the handover sheet. We also found people's care plans did not provide staff with enough information to manage risks to all the people living at the home. People were therefore at increased risk of injury and accidents.
•People were at risk of experiencing prolonged pain as people's needs were not consistently reviewed.
•People were at risk of experiencing poor diabetes management as the equipment for monitoring their diabetes was faulty and 'rescue' medicines in place were out of date.

Preventing and controlling infection
• Staff had access to equipment they needed to reduce the likelihood of the spread of infections, and we saw staff used this.
•The home was clean. Domestic staff we spoke with told us there was enough time for them to take the action they needed to keep the home clean.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection on 22 May 2018 and 23 May 2018, we rated Effective as Good. We found at this inspection the care provided had deteriorated.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
•Some people and relatives told us staff knew how to look after people living at the home, but we found staff had not consistently been supported to develop the skills they needed to care for people, in a timely way.
•One staff member advised us they had not received training to support people to manage their anxieties. Another staff member told us there had been a delay in them being provided with training to assist people to move safely.
•The systems in use to record and manage staff training lacked clarity, and there was no effective oversight by the provider. The new manager explained they were in the process of addressing this.
•Staff had not consistently been supported at the start of their employment, through an induction period. One staff member said, "[I had] no training, [I was] just thrown in the deep end." Another member of staff advised they were given induction by a colleague who had only completed two shifts at home.
•Some staff had worked at the location for many years, but many of the staff had been employed for under 12 months. One staff member said, "Most of the nurses are new. Seniors going did affect residents." Another staff member told us about the changes to the management team and said, "I see people confused because of changes of manager."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they came to live at the home, but we found their assessments and care needs were not always regularly reviewed. There was a risk people's preferences and needs would not be met because of this.
•People, and their relatives told us their views were considered before they moved to the home, but they were not consulted as part of subsequent assessments of their needs.
•Staff told us there was no system in place for consulting with people and their relatives when assessments were reviewed, or care plans updated.

Supporting people to eat and drink enough to maintain a balanced diet
•Some people required clinical support to have the nutrients they needed to ensure their health. We found the support they received was inconsistent. For example, one person who was supported by one staff team

had the assistance they required in a timely way. Another person, however, experienced delay in receiving the support they needed.
•People told us they enjoyed their meal time experiences. We saw these were not rushed and people were given choices regarding what they would like to eat.
•People were not always supported to have access to healthy snacks at the time they wanted. We saw one person ask for something to eat. They were advised their evening meal would be served later. There was no offer to provide food to meet the person's immediate requirement.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•Equipment for monitoring people's health needs, such as diabetes, was not working correctly. As a result, the emergency services had been called in error to support one person, when they did not need this.
•People and their relatives told us people were supported to see external healthcare professionals, such as GPs, speech and language therapists and chiropodists when needed. However, the recommendations from other health professionals were not consistently followed. For example, in respect of the timeliness of staff supporting people to have the nutrients they needed.

Adapting service, design, decoration to meet people's needs
•Rooms where people were nursed in bed contained very limited sensory items to engage people. There was a risk this would adversely impact on people's well-being.
•People told us they could choose how their rooms were decorated, or which room they wanted to reside in.
•We saw some people had adapted communal areas of the home they liked to spend their time in, and enjoyed having mementos which were important to them close to hand.

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 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The manager told us they had identified 11 people required a DoLS to be applied for and gave us assurances these would be applied for without delay.
•The manager was not able to confirm they had notified CQC of the DoLs applications authorised.

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 on 22 May 2018 and 23 May 2018, we rated Caring as Good. We found at this inspection the care provided had deteriorated.

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
•The overall valuing of people as individuals was compromised as the provider had failed to identify and act to address shortages of staffing, and the resources needed to maintain people's privacy.
•People told us there were insufficient staff to meet their well-being needs. For example, people told us staff did not have the time to talk with them. One person told us the best thing about living at the home was the other people living there, as they provided the support the person needed so they did not feel isolated.
•One relative told us the number of management changes meant requests for communication about their family member were not always followed through.
•Staff confirmed the current staffing arrangements meant they had to concentrate on undertaking tasks to care for people, rather than providing holistic support to meet people's wider needs. This included the support provided to people who remained in their rooms, owing to ill-health. One staff member said, "Staff truthfully don't have time to sit and talk to people. Staff would like to give people a lot more time and attention."
•Some people told us they had developed bonds with some staff who supported them. We saw there were instances where staff, although very busy, did engage with people living at the home, and these interactions were positive.
•Staff spoke warmly about the people they cared for, and we found staff who had supported people for extended periods of time did know what was important to people. This included people's interests, beliefs and relationships with others which were they valued.

Respecting and promoting people's privacy, dignity and independence
•People's right to privacy was not consistently considered when staff communicated information about their needs. In one instance, sensitive information about people's well-being and health was communicated between staff on shifts in a communal area of the home, with other people living at the home present.
•The provider had not put resources in place to ensure people's privacy was promoted. For example, people's sensitive care records were left on a table in a communal area on the first floor of the home. We saw one person raised a concern with staff regarding the location of the files. Staff advised the person they did not have a separate, secure area to securely store them.
•There were other examples of people's sensitive information being stored inappropriately. This included people's medicines, which showed their name and the nature of the medicines to be administered, located in communal areas.

•Staff did, however, consider and act to support people with the dignity and independence needs. This included staff assisting people to ensure their clothing suitably covered them, and to encourage people to maintain as much independence as possible during personal care.

Supporting people to express their views and be involved in making decisions about their care
•Where people had been involved in discussions about their care their wishes were not always carried out, because of the staffing levels. Two people told us they had discussed with staff how often they would like a bath or a shower. People told us the lack of staffing meant they did not have the support they wanted as regularly as discussed.
•People told us they were involved in some day to day decisions about their care, such as what they would like to eat, and what they would like to wear. Other people told us they were not always given a choice about where within the home they would like to spend their time.

The above is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

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 on 22 May 2018 and 23 May 2018, we rated Responsive as Good. We found at this inspection the care provided had deteriorated.

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People's needs were not consistently met. This included their pain management and clinical support required to ensure they remained safe, healthy and well.
•People's care had not consistently been planned, so their needs would be met. For example, staff could not advise us when one person's catheter required changing. We found records relating to this did not provide staff with enough information to determine when this needed to be changed. Catheters need to be changed regularly as they can be a source of infection, which can lead to pain and discomfort for the person.
•Staffing levels and deployment meant people nursed in their rooms lacked sufficient, regular social interaction. For example, we saw one person was brushing the wall with their hairbrush and chewing on it, as they had no other form of stimulation.
•People's personal care preferences were not always observed, owing to staffing levels at the home and the way staff teams were deployed. One staff member told us about people's access to personal care and said, "[Staff] can only do showers one a fortnight." The staff member said the amount of people who required two staff to assist them meant "Getting up in the morning, people experience delays."
•This was also highlighted by another member of staff, who advised us, "Staffing levels mean people's choice as to what time they get up is not respected." A further staff member said this was the case and advised us people's choices around the time to get up and go to bed at weekends was more limited, because of the number of staff available to assist them.
•People's communication needs were not consistently understood and acted on by staff. For example, we had to draw to the manager's attention guidance in one person's file to help staff to communicate with them, which was not being used.
•There were inconsistencies in the information provided to staff to support people. For example, care plans did not always provide the guidance staff needed to support people with diabetes dietary needs. One staff member told us it was difficult to find the information they needed to support people with health needs within their care documentation.
•There were systems in place for staff to communicate people's health needs at the start of each shift. The information provided to staff did not always comprehensively confirm how staff were expected to care for people. We found information in people's care plans was not consistent with the information provided to staff during shift handover. This increased risks to people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

•A member of staff with specific responsibilities to support people to do things they enjoyed had recently been appointed. We saw during the time they were available people enjoyed being supported by the staff member and experienced an enhanced sense of well-being.
•We were also given examples of actions taken individually by staff to support people to continue to do things they enjoyed doing. For example, one care staff member had brought in wool for one person to use, as they took pleasure in knitting.

Improving care quality in response to complaints or concerns
•People told us they had not raised any complaints about the care provided.
•There were very limited records of complaints made since our last inspection. One relative advised us they had raised a concern recently. The manager who was then leading the service failed to recognise this was a safeguarding concern, not a compliant. The manager leading the service did not escalate the concern to either the Local Authority or CQC.
•Processes were not embedded for escalating complaints or concerns to the provider, who advised us they had not been made aware of this concern.

End of life care and support
•People's wishes for their care at the end of their lives had been recorded, where people and their relatives wished this to be done.
•Staff told us no one was in receipt of end of life care at the time of the inspection. One staff member gave us an example of the support provided to people at the end of their lives, so their preferences would be met, where these had been expressed.

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 on 22 May 2018 and 23 May 2018, we rated Well-Led as Requires Improvement. We found at this inspection the way the home was managed had deteriorated.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This is so we can check that appropriate action had been taken. The provider had failed to ensure robust systems were in place to achieve this. This had resulted in important information relating to one person's safety not being notified to CQC, or escalated to other organisations with responsibilities for keeping people safe. The manager was also not able to confirm all Depravation of Liberty Safeguarding notifications had been sent to us.

This is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009, Notifications of other incidents. We are deciding our regulatory response to this and will publish our regulatory response if action is taken.

•There was no registered manager in place at the home. The service has had multiple managers employed to manage the service and this was impacting on people's, their relatives' and staffs' confidence in leadership at the home and the care provided.

•We identified significant shortfalls in the quality of leadership and management which affected people using the service. The quality checks completed by the management team and the provider were ineffective in identifying improvements needed in the service that people received.

•The provider and those needing to make decisions on people's care, were not aware of many of the concerns we raised during our inspection, relating to the oversight of medicines and risk management. The provider told us they had not regularly received information required to check the effectiveness and safety of the care provided in 2018. They had begun to address this and had introduced new checks and reporting systems in January 2019.

•The new systems had not, however, identified and driven improvements required in relation to medication administration, staffing levels and deployment and notifications required to be submitted to CQC.

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 way the home was managed meant people did not consistently receive the care they needed, based on their preferences. We saw evidence of this in people's care planning, the extent to which their preferences

and needs were met, and the training staff received to fulfil their roles effectively.
•The new systems introduced by the provider had not highlighted concerns we found in relation to people's right to privacy and the management of people's individual risks.
•Areas which had not been a concern on the last inspection, were now being shown to be problematic and/or a breach of regulation.

Working in partnership with others
•Staff told us they had developed effective relationships with people's GPs and other health and social care professionals such as speech and language specialists. However, we found checks and systems in place had not highlighted advice from health and social care professionals was consistently acted on. This placed people living at the home at risk of ill-health and discomfort.
•There had been a lot of involvement by external agencies owing to the concerns from the last inspection and recent care practice and leadership. Despite this, the service has continued to deteriorate.

Continuous learning and improving care
•The provider did not have effective systems in place to address improvements required. For example, the provider told us they had taken learning from other recent CQC inspections, such as introducing new ways to check to quality of the care provided. We found these systems were not effective or embedded.
•Action plans had been put in place to improve care, but these were not consistently followed through. For example, to ensure care records and plans reflected people's current needs and preferences.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•The provider did not have effective systems for gathering people's views of the service they received. Although the provider had completed some visits these were not effective in identifying the issues we found at this inspection.
•There was no embedded system to ensure feedback was given to people and relatives regarding any concerns they had raised, or changes the provider planned to make.
•Staff did not feel their views were considered when changes were made to the way the home was managed. For example, staff members told us they had raised issues regarding staffing levels, after these had initially been cut by the provider, but told us they were not listened to.
•Staff told us they did not have regularly opportunities to meet with managers to reflect on the care provided.

The above issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People told us they had opportunities to discuss with staff what interesting things they may like to do, and what menus they would like.

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 People's health, and social needs were not consistently met. People's preferences were not always responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not supported to maintain their privacy and people's records were not securely stored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's care preferences. Staff were not consistently trained in order to provide good care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not supported to have the medicines they needed, safely. Systems in place for managing risks to people's risks were not working effectively.

The enforcement action we took:

We took action to impose a condition on the provider's registration which requires them to ensure all medicines prescribed or required in an emergency are available within the service and all equipment required for the management of diabetes is urgently reviewed to ensure it is within date, calibrated and fit for purpose, and staff have the skills and ability to use them.

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 Safeguarding processes did not ensure concerns were escalated to other agencies with responsibilities for keeping people safe.

The enforcement action we took:

We took action to impose a condition on the provider's registration which requires them to ensure any staff member subject to an allegation or investigation of abuse is prevented from being on duty with the provider until conclusion of any investigation, and it is deemed safe and agreed by CQC for their return to work.

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 There were wide spread and significant shortfalls in leadership. Systems and processes to check the safety and quality of the care provided did not consistently identify and address improvements required.

The enforcement action we took:

We took action to impose a condition on the provider's registration which requires them to implement quality assurance systems and processes to ensure the accuracy and effectiveness of the care provided

and to submit a report on the first Monday of each month to summarise the action taken to address the issues identified.