Mrs A Shiels

Jesmund Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Jesmund Nursing Home is registered to provide accommodation and nursing care to up to 25 older people. At the time of our inspection 22 people were using the service, most of whom were living with dementia.

Our last comprehensive inspection of this service took place on 9 August 2016. At that time we found the provider was in breach of six regulations relating to person centred-care, dignity and respect, need for consent, safe care and treatment, premises and good governance.

We issued warning notices for the breaches relating to safe care and treatment, premises and good governance. The provider was given until 19 September 2016 to make the necessary improvements. We undertook a focused inspection on 7 December 2016 to follow up the warning notices and found the provider remained in breach of the three regulations. We wrote to the provider requesting a plan outlining what action they would take to meet these breaches. We received weekly updates until the 3 February 2017 on the progress made. At that point the provider assured us they had made sufficient progress towards meeting the regulations.

We did not follow up the other three breaches relating to person centred-care, dignity and respect and need for consent at our focused inspection. After our comprehensive inspection on 9 August 2016 the provider submitted an action plan which stated they would take sufficient action to address the breaches by December 2016.

We reviewed the action taken to address all six breaches at this inspection.

After our comprehensive inspection on 9 August 2016 we rated the service as 'requires improvement' overall and in four key questions. The service was rated 'inadequate' for the key question 'is the service safe?' These ratings remained unchanged after our focused inspection on 7 December 2016.

A registered manager continued to be in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found some of our previous concerns had not been sufficiently addressed and there was a risk of significant harm to the people using the service.

There were ineffective processes in place to assess the individual risks to people's safety and ensure adequate management plans were in place to mitigate those risks. Risk assessments were not updated in response to incidents that occurred and staff did not provide people with the level of support they required to remain safe.

Processes to review the quality of the service still remained in need of improvement. There were not sufficient checks in place to monitor all areas of service delivery and the processes in place were ineffective in identifying and addressing the concerns we raised.

Our observations showed staff continued to not treat people with the dignity and respect they deserved and did not always provide people with kind, caring and compassionate support. We observed staff ignoring people's requests for assistance, there were delays in providing people with the support they needed and often staff were focussed on the task they were performing rather than people's wellbeing.

The environment was still in need of improvement to meet the needs of people living with dementia and our recommendation remains that the provider should consult guidance on providing a 'dementia friendly' environment.

There were limited opportunities for social stimulation for people at the home and in the community. We recommend the provider consults guidance on the social inclusion, engagement and stimulation of people in a care setting.

At this inspection we saw some improvements had been made. The registered manager and nursing staff had reviewed and updated people's care records. This ensured additional information was provided to staff about how to meet people's care needs. The registered manager had liaised with other health and social care professionals to review people's mental capacity and organised for 'best interests' meetings to be held to ensure people received appropriate care. People had arrangements in place to deprive them of their liberty reviewed to ensure these arrangements remained in the person's best interests.

The provider had taken action to ensure a clean and safe environment was provided. They had improved their cleaning processes and there was closer checking and auditing of the cleanliness of the environment. The provider had also addressed the environmental risks and ensured a safe environment was provided.

Staff continued to provide people with the support they required with their health care needs, including their nutritional needs and ensuring people received their medicines as prescribed.

Staff received regular training and supervision, and there were regular staff meetings to obtain staff's views about the service. There were enough staff employed to meet people's needs and safe recruitment practices were followed.

Nevertheless, the provider remained in breach of regulations relating to safe care and treatment, dignity and respect and good governance. We have taken urgent action to restrict any new admissions to the service and requested weekly updates from the provider in regards to any incidents and accidents that occur and how these are managed. We are considering any further action that we may need to take to further protect people from harm and will report on this when it is complete. In addition, the provider was in breach of the CQC registration regulation relating to notification of other incidents. You can see what action we have asked the provider to take at the back of this report.

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

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

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

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. The registered persons did not have effective measures in place for assessing and mitigating risks to people's health and safety.

The provider had taken action to address previous concerns and now provided a safe and clean environment for people.

There were enough staff to meet people's needs and safe recruitment practices were followed. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The provider had taken action to ensure people were supported in line with the Mental Capacity Act (2005). However, staff continued to have a limited knowledge of the Deprivation of Liberty Safeguards (DoLS).

The environment had not been adapted to meet the needs of people living with dementia.

Staff supported people with their nutritional and health needs. Staff received regular training and supervision.

Is the service caring?

Inadequate

The service was not caring. Staff did not provide people with support in a respectful and dignified manner. Staff were task focussed and did not interact with people in a kind and caring manner. They did not always involve people in decisions or ask for people's permission before providing them with support.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. There were limited activities provided on a daily basis to ensure people were adequately engaged and stimulated.

The provider had made improvements to ensure people's care and support needs were met. Care records had been reviewed

and updated.

Is the service well-led?

Inadequate

The service was not well-led. The provider continued to not have effective systems in place to review and monitor the quality the service delivery and take action were required.

The registered persons did not adhere to all of the requirements of their CQC registration and did not always submit statutory notifications about key events that occurred.

The registered manager held regular meetings with people and staff to obtain their views about service delivery.

Jesmund Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 February 2017 and was unannounced. Two inspectors undertook this inspection.

Before the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four people and seven staff, including the registered manager and the provider. We reviewed three people's care records, four staff records and records relating to the management of the service including medicines management. We undertook general observations and used the Short Observation 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.

Requires Improvement

Is the service safe?

Our findings

We identified at our comprehensive inspection in August 2016 the provider did not provide a safe environment and had not adequately assessed the risks to people's safety. This included in regards to uncovered radiators and inadequate windows restrictors. Environmental risks including those of people falling due to uneven surfaces had not been assessed or mitigated, and some electrical controls were held together with electrical tape. This unsafe practice was still in place at our focused inspection in December 2016.

At this inspection we saw a safe environment was provided. The provider had addressed the previous concerns including covering all radiators to reduce the risk of people burning themselves and installing restrictors on all windows to reduce the risk of people falling from height. Broken equipment, including electrical controls, had been removed.

The provider had arranged for a health and safety consultant to assess the service and identify the risks to people's safety. In response to this review the registered manager had started to implement the recommendations issued including updating their health and safety policy and completing risk assessments and management plans. This included risk assessments in regards to uneven surfaces and the risk of people tripping.

Staff assessed the individual risks to people's safety. This included the risk of people falling, developing pressure ulcers and becoming malnourished. We saw these risks were reviewed monthly. However, we found that risks to people's safety were not always reassessed in response to incidents and adequate information was not maintained about how risks were managed and people were protected from harm. For example, one person had recently had a fall. There was no reference to this fall in their care plans and the risk of them falling again had not been reassessed. Their care plans did not include any reference to the injury they had sustained, how it was sustained or how the risk was being managed. Staff told us the risk of the person falling was being managed through staff observations and ensuring staff were near them at all times. However, we observed at times that staff were not carrying out these observations and there were not always staff in the room with them.

We saw in another person's care records there was limited information about how to support the person safely with their personal care, transferring and their mobility when they were expressing behaviour that challenged staff. For example, the person's care records stated they needed support from one member of staff. Their care records also stated two staff should support this person when they were displaying aggressive behaviour as they could be reluctant to receive support. There were no further details about why a second staff member was required, what the risk was or how they were to support the person to ensure their safety. There was a risk that the person may not be safely and appropriately supported whilst receiving assistance with their personal care.

This person's care records also stated staff were to undertake hourly checks at nights because they were at risk of falls and due to their continence needs. However, there was no documented evidence of these checks

being undertaken. The person's pressure ulcer risk assessment categorised them as at high risk of developing pressure ulcers. The registered manager confirmed the person was not supplied with any pressure relieving equipment to reduce the risk. Their care records stated staff were to reposition them every two to three hours during the night. However, the registered manager told us this was no longer required because the person's risk level had reduced but this was not reflected in their risk assessment. There was a lack of information about how this risk was being managed.

Staff were aware of the incident and accident reporting process. We viewed the incident records which captured details of the incident. However, there was little information recorded about what ongoing support was provided and how this linked with the person's care and support plans. On the day of our inspection two people had facial bruising. Three of the staff on duty were unable to explain to us how these injuries occurred and there was no reference to these injuries in the individual's care records. There was a risk that information about incidents and how to keep people safe was not being effectively disseminated amongst the staff team.

Staff did not always protect people from the risk of scalding presented by hot drinks and meals. We observed two people mention at different times of the day that their drinks were too hot. One said, "I bet it's too hot as usual" then sipped it and confirmed it was too hot. The other asked staff for some cold water to top up their drink as it was too hot. We observed at lunchtime that staff informed people their dessert was hot. However, we heard one person express shock at how hot the food was when they put it in their mouth. These individuals were able to understand that certain drinks and food may be hot. However, there was a risk that other people may not understand and potentially sustain internal burns or scalding.

The provider remained in breach of regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection in August 2016 we found areas of the environment were dirty and there were stains on the carpets and walls. Some people's furniture in their rooms was ripped and covered in food debris. Some of the bathrooms could not be adequately cleaned because of damage to the bath panels and flooring. The provider did not have effective arrangements to ensure the premises were cleaned and maintained to a suitable standard. These concerns remained in place at our focused inspection in December 2016.

At this inspection the majority of the environment was clean and free from stains. All of the bedrooms, apart from one person's, had been cleaned. They were free from odour, the furniture and carpets had been cleaned and the bed sheets were in the process of being changed. We observed that one person's bedroom had fresh stains and liquid spills on their carpet. Shortly after identification of this staff began to clean the room. The bathrooms that were regularly used had been redecorated and the broken bath panels and flooring had been replaced. The communal hallways had also been redecorated. Some of the furniture in people's rooms remained ripped. The provider informed us they had plans to replace this furniture.

Since our last inspection a dedicated cleaner had been employed. There were cleaning schedules in place and when we spoke with the cleaner they were clear about their duties. They informed us they cleaned each room daily and in addition identified which rooms would benefit from a deeper clean. They were able to explain to us whose bedrooms required more frequent cleaning.

The provider was now meeting the previous breach we identified at our last inspection in regards to the cleanliness and suitability of the premises.

The registered manager continued to organise for health and safety checks to be undertaken. This included

gas safety, testing of electrical equipment, servicing of hoists and lifting equipment, testing the call bell system and testing fire safety equipment.

Staff were knowledgeable in recognising signs of abuse. They told us any concerns they had in regards to a person's safety and possible abuse were reported to the registered manager. We heard from the registered manager they were aware of their responsibilities to safeguard people from harm and reported allegations of possible abuse to the local authority safeguarding team so they could be investigated. The registered manager had recently raised a safeguarding concern and was waiting for further instruction from the local authority before undertaking an investigation into the concerns raised.

Staff continued to support people with their medicines and ensured people received their medicines as prescribed. We saw that accurate records were maintained of the medicines administered and stocks of medicines were as expected. Information was provided to staff about when to give people their 'when required' medicines and what actions the staff should take before relying on medicines, for example in response to behaviour that challenged. Staff used the Abbey pain scale to assess whether people who were unable to communicate verbally were in pain before providing people with their 'when required' pain relief. Information was also provided to staff on those who required covert medicines with instruction from the person's GP stating it was in the person's best interests to have their medicines covertly and how to give the medicines to ensure their effectiveness. We saw that medicines were stored securely and at the correct temperature.

There continued to be safe recruitment practices in place. Adequate checks were undertaken to ensure staff were suitable to work at the service. This included obtaining references from previous employers, checking staff's eligibility to work in the UK and undertaking criminal reference checks. From reviewing the staff rotas we saw that each shift was staffed by the number of staff the provider had assessed as being required to meet people's needs. Staff sickness and vacancies were covered to ensure the numbers of staff on duty were as required. On the day of our inspection a staff member had called in sick and the management team had arranged for this shift to be covered.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection in August 2016 we found people were not always supported by staff in line with the Mental Capacity Act (MCA) 2005. Staff had not arranged for mental capacity assessments to be undertaken to establish what decisions people were able to make, nor did we see evidence of best interests decisions. We were also concerned that people were being deprived of their liberty without the legal authorisation to do so.

The 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Since our last inspection the registered persons had applied for authorisation to deprive people of their liberty through the Deprivation of Liberty Safeguards (DoLS). They kept records of the DoLS authorisations in place and when they expired. The registered manager arranged for the restrictions in place to be renewed to ensure people were only being deprived of their liberty when lawfully authorised to do so.

The registered manager had undertaken mental capacity assessments to identify whether people had the capacity to consent to their care decisions. We saw that when people did not have the capacity to consent that staff liaised with other health and social care professionals involved in their care to make 'best interests' decisions. Staff also involved people's relatives in care decisions. When people did not have any relatives, the registered manager arranged for independent mental capacity advocates (IMCA) to support and represent people during decision making processes.

The provider was now meeting the previous breach we identified at our last inspection in regards to the need for consent. However, when speaking with care staff we identified that some staff had limited knowledge of DoLS and what this meant for people using the service. The registered manager informed us they would organise for further training and supervision to be delivered to staff to increase their knowledge in this area.

At our comprehensive inspection in August 2016 we issued a recommendation that the provider consult national guidance on providing a dementia friendly environment due to the environment being poorly lit and there being a lack of visual stimulation and cues to help people with dementia navigate around the service. Since our inspection the provider had made some minor adjustments to support those living with dementia including making hand rails a different colour and using bold coloured mugs to make them easier for people to see. The registered manager told us they had made initial contact with the Alzheimer's Society to obtain advice and support about how to alter the environment. However this was not in place at the time

of our inspection and therefore our recommendation still stands.

We recommend that the provider continues to consult national guidance on providing a dementia friendly environment.

At our comprehensive inspection in August 2016 we found staff had not received recent training on communicating with people with dementia and working with people who displayed behaviour that challenged. The registered manager informed us they would organise for staff to receive refresher courses in these topics.

At this inspection we saw staff had continued to receive regular training. This included training in relation to person centred care, health, continence care, safeguarding, dementia and communicating with people, MCA, DoLS, infection control, food hygiene, moving and handling, wound care, health and safety, COSHH, medicines management, nutrition and first aid. The majority of staff were positive about the training they received and the opportunities they had to update their knowledge and skills. Staff received regular supervision from the registered manager. These sessions gave staff the opportunity to discuss their roles and responsibilities and to reflect on their knowledge and skills.

Staff continued to work with other healthcare professionals in order to meet people's health needs. People's GP visited the service weekly and in between when required to assess people's primary care needs. In addition, staff were able to organise for domiciliary dentists, opticians and chiropodists to visit the service. Staff liaised with specialist healthcare providers when people required additional care, including podiatrists and community mental health professionals.

Staff continued to support people with their nutritional needs. We saw people's care records provided information about people's nutritional needs including any special dietary requirements they had. Our observations showed staff adhered to the information in people's care records and provided them with diets appropriate to their individual needs. Staff regularly weighed people and monitored their food intake to establish any signs of their health declining. The records we saw showed people's weights remained stable and the provider told us how they had supported some people to put weight on when there were concerns that their weight was low. Some people had been seen by dieticians and speech and language therapists. Staff implemented the advice given to ensure people's individual nutritional needs were met.

Inadequate

Is the service caring?

Our findings

At our comprehensive inspection in August 2016 we saw staff did not consistently treat people with dignity and respect. We heard people's requests for drinks were not acknowledged. At times the language used by staff when speaking with people and the language used in people's care records was disrespectful. Some interactions were task focused and staff did not always inform people before providing support. Some people also fed back that staff focused on the task rather than offering people choices about how they spent their day.

During the course of this inspection, we observed numerous instances where staff continued to not treat people with the dignity and respect they deserved.

Staff failed to respond appropriately when people needed their help and assistance. We observed when we arrived, although people had finished their breakfast some time before, some people were still sat in dirty protective garments used to protect their clothes when eating which was not dignified. We saw one person showed clear signs of pain and discomfort but staff walked past them several times without acknowledging them. Another person told staff repeatedly they needed their inhaler, which was in another room, but staff ignored them. We heard the person say, "I'd go and have a look myself but you'd push me back in the chair as usual." When the person was finally told, after numerous requests, why they couldn't have their inhaler immediately, they responded "oh, is that why you were ignoring me?" We found some people were not immediately supported with their continence needs which resulted in lingering malodours in the communal lounge. This was likely to have been uncomfortable and unpleasant for people. The provider and registered manager's explanation for this was that staff had been reluctant to move people in the presence of an inspector. This demonstrated that people's needs were not always put first by staff.

Staff were indiscreet when talking about or to people. When an inspector was offered a towel to place on a chair in the communal lounge they were told by a staff member, "some people are incontinent." This response could be overheard by people in the lounge which may have been embarrassing or hurtful to them. On another occasion, a staff member interrupted a conversation one person was having with another, telling them they were going to get up and visit a family member. This was untrue and the staff member had said this in order to get the person to go to the toilet. This may have given the person a false expectation, caused them confusion and possible distress.

During mealtimes we observed people were not supported in a dignified or respectful way. For example, a staff member supporting one person to eat, continued to put spoonfuls of food in their mouth despite the fact the person was engaged in a heated exchange with another person. The staff member stood between the two people and told the person they were supporting to "finish your lunch". They did not listen to what the person was trying to say or give them time to say it. Another staff member did not listen to one person who said they did not want any more food and gave them another two spoonfuls before acknowledging the person's request and stopping. A staff member woke another person up and told them repeatedly that they needed to finish their drink.

A staff member supporting another person with their meal told them it was "dinner time" but then did not explain what they would be eating and that they would be supporting them with this. Whilst being supported we observed the person's facial expression and body language suggested they did not like the food but the staff member did not recognise this and continued to provide them with their meal. When the person spat some of their food out the staff member wiped their mouth and continued with the task. After lunch we observed again that people waited for up to half an hour to have soiled protective garments removed.

Staff did not always ask for people's permission or provide a helpful explanation before supporting them. For example, we saw one person eating independently and eating in their own time. Staff interrupted this person, took the spoon from them and started giving them the food with no explanation why. In another instance a staff member came into the lounge with a hairbrush and started brushing a person's hair without letting the person know what they were about to do. The staff member then took the same hairbrush without cleaning it and brushed two other people's hair.

Staff did not support people to make decisions and choices about their care. Staff communicated with people verbally. They did not use pictures, visual cues or objects of reference to help people understand what was being said and be able to make a choice. We observed one person was standing up in the lounge but staff repeatedly and insistently asked the person to sit down. They did not ask the person where they wanted to sit or what they wanted to do. We later observed the person speaking to staff in an agitated tone. Staff continued to encourage this person to stay in their seat rather than find out what the person wanted to do. Staff we spoke with had limited understanding of how to support people who did not verbalise to make choices. For individuals that were able to verbalise we found that their choices were not always respected by staff. We observed one person asked for a particular drink. After three times of asking, staff bought them a drink but it was not the drink that they were asking for.

The provider remained in breach of regulation 10 of the HSCA (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection in August 2016 care planning was not sufficiently robust to provide staff with the information they required to undertake their roles and ensure people received the support they required. We found care plans described the behaviour people exhibited but did not sufficiently inform staff about the triggers to the behaviour or how to support the person when displaying this behaviour. Sufficient detail was not included in people's records about their support needs and some records contained conflicting information.

At this inspection we saw that care records had been reviewed. People's support plans had been re-written to provide further detail to staff about the person's needs and how they were to be supported. This included detail about the behaviour people exhibited which may challenge staff, what may trigger the behaviour and how staff were to support the person to reduce the chance of the behaviour escalating. Information was included in people's care records about what aspects of their personal care they required support with and how this was to be delivered. This included how many staff they needed to provide them with support safely and what they were able to do independently. We saw that people had support plans in relation to continence care, mobility, nutrition, psychological needs and other individual care needs. For the majority, people's care records had been updated and were regularly reviewed.

At our comprehensive inspection in August 2016 we found that when performers and the activities coordinator were not at the service there were little opportunities for activity and stimulation. Since our previous inspection the provider had increased the frequency of visits from musicians to once a week as this was an activity which people enjoyed. The provider still had an activities coordinator in place. However, they only provided one hour of activity three times a week. There continued to be limited opportunities for activity and stimulation when these individuals were not at the service and people were left without activities for several hours a day. During our inspection there were no activities being delivered and no stimulation for the people at the service apart from the television. There was no activities programme in place and limited opportunities to access the community.

We recommend that the provider reviews national guidance to support the social inclusion, engagement and stimulation of people who use the service at the home and in the community.

There continued to be processes in place for people and their relatives to raise concerns and complaints about the service. This included a complaints book which was available for people and relatives to document their concerns or they were able to speak with staff directly. The registered manager assured us they continued to listen to and respond to any complaints received. We viewed the complaints book which showed no complaints had been received since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our focused inspection in August 2016 the provider did not have effective quality assurance systems in place. The registered manager had introduced new systems to audit and review the cleanliness of the service. However, these audits did not cover infection prevention and control and did not specifically address the cleanliness of each room. The provider and registered manager had not arranged for a review of health and safety practice at the service. They did not have an improvement plan in place as to how they were going to address the concerns identified. These concerns remained at our focused inspection in December 2016.

Since our focused inspection the registered manager had improved their processes to review and monitor aspects of service delivery. We saw that a range of audits were undertaken on key service areas including cleanliness, kitchen safety, care planning and medicines management. The registered manager had also arranged for their pharmacist to undertake a full medicines management audit. This was undertaken in January 2017 and showed the staff were following good practice in this area.

However, the registered manager did not have a system in place to review and learn from key service information. They did not have any processes for reviewing incidents, complaints or data relating to people's needs such as infection rates or hospital admissions in order to identify themes, trends or learning from this data. The registered manager's care plan audits did not identify that people's records had not been updated in response to changes in their care outside of the regular monthly updates and ensure appropriate records were maintained to ensure people's safety. The registered manager also did not have any systems in place to review the quality of interactions between staff and people and to ensure people were treated with dignity and respect at all times.

The provider had not taken sufficient action to meet the breaches identified at our previous inspection. They did not have effective systems to monitor the concerns, identify the action required to address those concerns or a clear plan about how that was going to be achieved.

The provider remained in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The registered persons did not consistently adhere to the requirements of their registration. At the time of the inspection we saw that 14 people had been authorised as being able to be deprived of their liberty in order to keep them safe. We had received notification of five DOLS assessments and therefore we had not received statutory notifications for each person as required. The provider also told us about a safeguarding referral they had made to the local authority. We had not been notified of this allegation of possible abuse. The provider submitted four DoLS notifications two days after the inspection. However, at the time of writing this report we still had not received all the required statutory notifications.

The provider was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had introduced 'link nurses' to lead on different topic areas including infection control, dignity and respect and health and safety. These positions had only recently been introduced and therefore at the time of our inspection it was unclear what impact they were all having. Nevertheless, we saw that the infection control 'link nurse' had begun to observe practice and held meetings with staff when they identified poor practice. We saw that good practice guidance had been provided to all staff so they were aware of the importance of good infection control and what was expected from them.

The registered manager continued to hold meetings with people and with staff. Both of these meetings were held monthly. We viewed the minutes from the meetings. The meeting with people gave them the opportunity to express their views and raise any concerns they had. The registered manager also used this meeting to update people with changes to service delivery, including the recent environmental changes. The staff meeting was used to disseminate good practice and remind staff of their duties. At the recent meetings we saw topics discussed included care records, cleaning and infection control.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons did not notify the commission of allegations of possible abuse or the outcome of a deprivation of liberty safeguard application. Regulation (1) (2) (e) (4a) (4b)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not effectively assess and mitigate risks to people's health and safety. (Regulation 12 (1) (2) (a) (b)).

The enforcement action we took:

We took urgent action and imposed conditions to restrict new admissions to the service and requested weekly updates on any incidents and accidents that occurred and how these were being managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not ensure processes were in place to assess, monitor and improve the quality and safety of the service. They did not assess, monitor and mitigate risks to the health, safety and welfare of service users. (Regulation 17 (1) (2) (a) (b)).

The enforcement action we took:

We took urgent action and imposed conditions to restrict new admissions to the service and requested weekly updates on any incidents and accidents that occurred and how these were being managed.