TLC Group (Rockley Dene Homes Limited)

Candle Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

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

At our last inspection in December 2013 the service was meeting the regulations inspected. These inspections took place on 7 July 2014 and 8 July 2014 and were unannounced.

At the time of our inspection the registered manager was on leave and a manager covering in her absence. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Candle Court provides accommodation and nursing care for up to 93 people, some of whom have dementia,

Summary of findings

physical disabilities and mental health needs. The home consists of three units split over two floors. At the time of our inspection there were 75 people living at the home aged 55 upwards.

At this inspection we saw that the building was in poor condition, there were insufficient staffing numbers to meet people's needs, ineffective quality monitoring systems and records.

Most people using the service were unable to tell us whether they felt safe. However, one person who was able to give us their views, commented, "yes, not bad," when asked whether they felt safe. We saw that some people were free to come and go as they pleased. However, although we saw that DoLS applications had been submitted to the local authority, the remaining people who could not leave due to locked doors had not had their capacity formally assessed. Although staff received Deprivation of Liberty Safeguards (DoLs) training, five out of the eight staff we spoke with did not understand and how this impacted on the people they cared for.

We found the provider was in breach of standards relating to the safety and suitability of the premises, records, requirements relating to workers and staffing. The provider showed us an improvement plan developed to address some of the concerns raised on the day of our visit.

During our inspection we found several areas of disrepair around the building. This put people at risk of falls or trips. For example, in one shower room we found a broken handrail. In one of the communal bathrooms we found broken tiles and a ripped floor covering.

We reviewed risk assessments and care plans for people using the service. We found most risk assessments and care plans had been updated and reflected people's individual needs. However, we found several gaps in records, for example incomplete Do Not Resuscitation (DNAR) forms. Therefore people's end of life care needs were not always met.

We observed some good interactions between staff and people using the service. However, during our inspection we found that there was not enough staff on duty during the lunchtime. We saw that staff were rushed and hurried. Staff told us that there was not enough staff on duty during the busier times, such as mealtimes and where people required one to one assistance. Two relatives told us that staff turnover was, "high." and "they (staff) seem very short staffed all the time."

Relatives told us that they were able to visit their relative day or night and felt the service encouraged them to do this.

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

Summary of findings

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.

People were put at risk of unsafe premises which was not adequately maintained. We found several areas of disrepair around the building.

Staff we spoke with did not understand the Mental Capacity Act 2008 and the Deprivation of Liberty Safeguards (DoLS).

Staffing numbers were not sufficient to meet people's individual needs.

Inadequate

Is the service effective?
The service was not always effective.

Staff told us they felt supported by their manager. Although staff told us they had received supervision, records were not available to evidence this. Staff did not receive an appraisal.

People's nutritional needs were met by the service. We observed that staff appeared rushed when assisting people at mealtimes.

People were referred to other healthcare professionals to assist the service with meeting their individual needs.

Requires Improvement

Is the service caring?
The service was not always caring.

We spoke with seven relatives, most told us that their relative was treated with dignity and respect. However, poor maintenance of the building meant that people's dignity was not always respected.

People's likes and dislikes were recorded in their care records. However, records relating to people's end of life care were not always accurate.

People's relatives were involved in their care and attended reviews of their care.

Requires Improvement

Is the service responsive?
The service was not always responsive.

Although activities were provided at the home, we noted that some improvements were needed to ensure that people had opportunities to take part in social activities. We saw and relatives reported that people were isolated.

People were able to make complaints. Relatives told us that they were able to make a complaint and felt the service listened and acted on their concerns.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not well-led.

People were put at risk because systems for monitoring the quality of the service were not always effective.

People and relatives told us that they knew the registered manager and that they were able to approach her with their concerns.

Requires Improvement

Candle Court Care Home

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors, a specialist mental health advisor and an expert by experience, who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a 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. We reviewed the information included in the PIR along with information we held about the home. We contacted the commissioners of the service to obtain their views about the care provided in the home.

We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people using the service, seven relatives, the covering manager and three senior staff from the provider's head office. We observed care in the communal lounge areas and lunchtime in all the dining rooms. We looked at people's rooms and communal facilities, including bathrooms, toilets and kitchens. We reviewed care records for 13 people using the service and eight staff personnel files. This included staff training and induction records and recruitment details.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

People at the service were unable to tell us whether they were safe. However, one person who was able to tells us whether they felt safe, told us, "yes, not bad." A relative told us, "If I didn't feel [relative] was safe I would take them out."

The physical standards at the home were poor. We looked at 10 bedrooms, five bathrooms and toilets, all communal lounges, dining rooms and kitchens. We found bedrooms in poor decorative state. There were stains and cracks on walls and ceilings. We also saw that some curtains were missing and some were not closing properly. Leaking radiators had stained the carpets and walls. Carpets and floor coverings in people's en-suite toilets were stained and had an unpleasant smell. We also noted an overpowering smell of urine and body odour when we entered the ground floor unit. The provider had not ensured that people were protected from risks associated with unsafe or unsuitable premises due to inadequate maintenance.

In the communal bathrooms and toilets we saw lights above mirrors were not working, and in some bathrooms not all of the lights worked, making it very difficult for people to see. Therefore people were at risk of falls due to inadequate lighting. In one shower room we found a broken handrail, this put people at risk of falling when using the handrail for support. We informed the provider about this and this was repaired by a maintenance person during our inspection. We saw that toilet seats were loose, incorrectly fitted and toilet roll holders were missing. In another bathroom there were broken tiles and the floor covering was ripped. This was a trip hazard, therefore putting people at risk of falls. We saw ceiling panels missing in one bathroom and staff told us that a leak had occurred some time ago and the panel had not been replaced. Wash hand basin taps were not colour coded to indicate hot and cold water. This put people at risk of scalding. There were no plugs in some of the sinks and shower heads were broken or missing.

In communal hallways and bathrooms ceiling panels were missing and electrical wires were visible. We were told by the maintenance person that there had been electrical problems with the lighting and the provider was currently replacing light fittings. However, we found a number of lights around the building were not working and corridors were often dark. This made it difficult for people using the corridors to see clearly and put people at risk of falling. We saw that the provider had started to carry out some repairs during our visit. We were shown records of electrical work that had been completed to replace lighting in the communal areas. However, we noted that there were several electrical repairs still outstanding.

We spoke with the covering manager about the condition of the environment. He told us that the provider was aware of the outstanding repairs and the unpleasant odours. We discussed the poor condition of the home with the covering manager, operations director and chief operations officer. We were informed that the provider had considered selling the home, however this was no longer happening and the decision to refurbish the home was made instead. We were shown a copy of a home improvement action plan dated May 2014. This included appointing a maintenance person and a programme of works to improve the environment.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that there was insufficient staff to meet people's needs during the lunch period. We observed staff interactions with people at meal times and in the communal lounge using SOFI. We saw that sometimes staff supported people who challenged the service and spoke with people in a calm and reassuring manner. However, we also saw that although staff interacted with people, they did not always have the time to listen to people's responses. For example, one staff member said "how are you?" and then walked away without waiting for the person's response, as they were required to assist another person. In another example a staff member told us of a person who asked for help, "if I go and hold their hand and stay with them for a good while they will be happy and stop asking for someone. However I just don't have the time to sit with them for long. As other things need to be done."

We saw that staff assisting people with eating did not tell them what they were about to eat or drink and there was little conversation between staff and people. We saw people who needed assistance with eating were left until after everyone else had eaten their meal. A relative told us that their relative often had to wait for 30 minutes or more before being assisted. Staff told us that this was because they needed to assist other people first.

The chief operations officer told us that they had recently completed a staff dependency audit. This showed that

Is the service safe?

staffing levels and skills mix had been reviewed as well as the needs of individual people, such as, assistance with eating meals, personal care and where people require assistance by two staff for transfers. The chief operations officer told us that the outcome of this audit indicated that the home was sufficiently staffed. However, when we spoke with relatives, one told us, "things are better now and I am happy with the care provided to my wife, but they seem very short-staffed all the time". Two relatives told us that staff turnover "Is high," and "They (staff) seem very short staffed all the time." Other relatives concerned about staffing said they were particularly worried about staffing levels in the evening and during the night. This was confirmed by staff who told us that, during busier times in the morning they were only able to provide basic care. All staff said they would like to have the time to spend with people and not just focus on tasks. Staff also told us that they wished to spend more time with individual people, but said they did not have the opportunity due to time constraints and hectic shifts.

Staff understood whistleblowing and they told us they could report allegations of abuse to the local authority safeguarding department and the CQC.

We spoke with eight staff including the covering manager. Three of the eight staff we spoke with had a comprehensive understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The other staff did not fully understand the MCA and DoLS, although they told us that they had recently completed training. The Chief Operations Officer for the provider told us that MCA and DoLS training had taken place. They told us that they would look at changing the way training was provided to make it more practical and related to issues in the home, as well as encouraging all staff to be involved in DoLS applications.

We saw the registered manager had recently submitted six DoLS applications to the local authority. However the registered manager had not documented this in people's care notes, care plans or risk assessments. Therefore, staff we spoke with were not aware of these applications and the impact this had on the people concerned and others they cared for. Although some people were able to leave the home when they wished to, we saw that others who could not leave due to locked doors. The home had not completed a mental capacity assessment, therefore people were being deprived of their liberty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We reviewed risk assessments for 10 people using the service. We saw these included risks associated with activities, moving and handling and nutrition. We saw that most of these had been updated recently and staff told us that these were reviewed monthly or when people's risk changed.

Staff we spoke with were aware of the risks and what action to take to minimise the risk of one person living at the home locking themselves in their room. However, in another person's risk assessment we saw that staff were required to inform the person of activities available daily to prevent the risk of boredom, depression and aggression. This risk assessment did not explain the triggers staff should be aware of that would suggest this person was bored, depressed or becoming aggressive. Therefore staff were not aware of the action required to minimise this person's risk.

We looked at personnel files of eight staff. We saw discrepancies in seven. In another file we found that the criminal records check had not been fully verified to ensure the staff member was safe to work with vulnerable people. We found gaps in application forms which had not been fully completed. For example, one staff member had not recorded on their application form when they had finished their last two employments. Therefore it was difficult to determine how long they had previously been employed. We reviewed the provider's recruitment policy and saw that they did not always follow their own recruitment policy which stated, 'if the correct employment checks are not made, this could potentially put residents of care homes at risk, or the employment of unsuitable people within the business.' We observed a staff member from head office auditing all staff personnel files on the second day of our inspection. We fed back our findings to the person auditing who told us that she would be addressing these concerns.

This was a breach of Regulation 21 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

Our findings

We asked people how they were treated by staff. Comments included, “not all staff are good,” And “Staff not brilliant, they are not qualified.” However, they named three staff that they felt were the “best.” Others said staff were, “Ok.” A visitor said the staff were, “Helpful, however they keep changing. I go to the regulars (staff) if I need help.”

We reviewed 10 staff supervision records and found that nine had received supervision in the last month. However, we were not provided with any evidence to show supervision had taken place prior to these dates. Qualified staff confirmed that they received monthly supervision and told us that they felt supported by the registered manager. Care staff told us that they received supervision from qualified staff, they said this was helpful and that they felt supported. The covering manager told us that these were the only supervision records available. Therefore, the covering manager was unable to provide documented evidence that staff supervision had occurred prior to June 2014. Staff had not received an appraisal.

We noted that for eight of the qualified staff the supervision details on each record stated ‘to understand clearly how to use the Malnutrition Universal Screening Tool (MUST)’. We saw that these supervision records were generic and none of these had separate personal goals set, or discussions about the care they provided to people living in the home. They did not identify any concerns the staff member might have had.

We saw that the home employed qualified general and mental health nurses as well as care staff. We saw that staff had completed a three day induction programme when joining the service. This included shadowing permanent staff to gain an understanding of people’s needs. Mandatory training was provided, which included fire safety, manual handling, first aid, health and safety and infection control. We also saw that most staff had completed training in dementia awareness.

We used SOFI to observe lunchtime on both floors of the home. At the beginning of lunch we saw staff checked that food was at the correct temperature. On the ground floor we observed two separate dining areas. In one dining room each person had the menu explained and were asked their choice of food. We saw one person whose religious needs around food were met in accordance with their care plan. Everyone in the dining area was offered a second serving and more dessert. One person who enjoyed a cup of coffee after their meals was given this. A choice of juices was made available and people were asked what they wanted. We asked people whether they enjoyed lunch, one person said, “very much so,” Another told us, “it was ok.”

We saw people had the choice to have their meals in the dining room or in their bedroom. We saw staff taking trays of food from the dining room to people. We asked relatives their views on the food provided at the home. One relative said, “the food is lovely.” Another told us that they came to the home several times a week to assist their relative with lunch and said this took a long time and commented, “staff gave up too quickly when they feed my (relative).” Another relative told us that, “pureed food provided was unrecognisable, bland and unappetising.” However, another relative had a different experience and told us that staff gave them a meal when they visited and they were very appreciative of this.

However, in the upstairs dining room people were not always given choices. We saw one person who was not given a choice of vegetables and the service was unable to provide an alternative. Therefore this person did not have their choice accommodated. We noted that three people had arrived up to 45 minutes before lunch was served. However, staff did not remind people that lunch was not for another 45 minutes and they would have to wait. We saw salt, pepper and napkins available on each table, as well as a choice of drinks. Menus were available, however, the print and pictures were very small and people told us they found them difficult to read and recognise the food.

Records reviewed showed that one person had been reviewed by the Speech and Language Therapist (SALT) and this was recorded in their care records. Staff were aware of people with special dietary requirements, such as thickeners to prevent them from choking whilst drinking.

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Requires Improvement

Is the service caring?

Our findings

People told us that staff were ok. One person told us "I know some of the staff and they are ok." A visitor to the home told us, "staff are ok, they are very helpful." Another person told us that, "everyone is kind." However, some people told us that staff "are not brilliant." Another person told us night staff did not respond quickly enough to the call bell and shouts for assistance to use the toilet. This person also told us that they were asked , "why do you not wear a pad?" This person told us that they did not want to wear a pad and became very upset. We informed the covering manager who told us that he would investigate the issue.

Seven relatives told us that people were treated with dignity and respect. One relative told us, "Staff related well to [their relative] and were respectful. They know about their life and what they did and had meaningful conversation with them." Another relative said, "they [staff)] are very caring, I never see them go into a room without knocking. People's privacy is respected." However, another relative's experience was different. They had concerns about one staff member who shouted at people. We fed this back to the covering manager on the day of the inspection.

Staff we spoke with were concerned about the lack of privacy for people in the communal bathrooms. We saw the communal bathrooms all had broken locks. Therefore staff were unable to lock doors whilst assisting people with personal care.

Our SOFI observations showed us that whilst some staff interacted in a caring manner, others did not. For example, we saw staff spoke gently and calmly to people and we saw that people responded positively to staff by smiling and appearing relaxed in staff presence. However, during the lunchtime we observed that staff assisting people were more tasked focused and did not always have the time to interact with them.

We reviewed care records and saw that these contained details of people's likes and dislikes. For example, one person who liked reading the newspaper told us they had the, "newspaper delivered to me." Another person who smoked said, "staff take me on walks to buy cigarettes." This was recorded in the person's care plan. Staff we spoke with understood people's needs and were able to tell us how they cared for people. Such as, one person who enjoyed watching football, staff were aware of which team the person supported and ensured when their matches were on television they notified them.

We saw that some care records contained a 'this is my life' document, which provided details of people's personal histories, such as, relationships, family tree, special people and friends, beliefs, religion and faith and favourite places. Staff we spoke with knew people's histories and important people in their lives.

Relatives told us that they were involved in the care of their relative. One relative told us, "I attend a review meeting every six months." Another relative said they were shown a care plan detailing the medicines given to their relatives, "they (staff) are good at knowing what (their relative's) medical needs are." We saw that care records contained a 'relative's communication record' which showed contact and discussions between relatives and staff. All the relatives we spoke with told us that they were able to visit their relative at any time. One told us the service has an, "Open house policy."

We were told by the provider that an advocate visited the home twice a week. Staff we spoke with confirmed this. However, we did not meet anyone who used this service and this information was not displayed at the home. Therefore this information was not accessible to them should they require this service.

The provider had not ensured that records relating to people who used the service were accurate and up to date. People had end of life care plans. We saw these had details of people's choices and plans for their end of life care. However, Do Not Attempt Resuscitation (DNAR) forms were not kept with people's end of life care plans. Staff told us that these were kept in a separate folder in the ground floor office. We reviewed six DNAR forms and found several gaps. Five of the DNAR forms had not recorded people's capacity, clinical conditions, involvement with people and their relatives and healthcare professional contributing to this decision. Two relatives we spoke with confirmed that they had been asked by the service about DNAR and end of life care needs. One DNAR order was last completed in October 2012 and had not been reviewed. For another person the incorrect form had been used, therefore this was not valid.

Requires Improvement

Is the service caring?

In one care plan we saw that staff had recorded they should contact the person's family when they became unwell. However, the care records reviewed showed this person had no family.

This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

Requires Improvement

Is the service responsive?

Our findings

Relatives and friends were encouraged to visit at anytime. This was confirmed by relatives we spoke with. Staff were aware of relatives and friends who were important to people and this was recorded in people's care records.

We reviewed care records for 13 people living at the home. We noted that these included areas such as, skin integrity, nutrition and activities. People's likes and dislikes were also recorded. Staff we spoke with were aware of people's care plans and were able to give us examples of people's individual needs, such as one person who required a special diet and daily monitoring of their physical health needs. Staff told us that changes were updated when people's needs changed or monthly. We saw that all care plans reviewed had recently been updated.

We saw that the home had an activities programme. This listed activities such as exercise, hand message, music and watching movies. We spoke with an activities co-ordinator who told us about some of the individual activities provided to people living at the home. For example one person who enjoyed shopping, was supported to go out once a week. This was confirmed by the person's care plan.

On the day we inspected we saw that activities varied from one floor to another. In the afternoon on one floor we saw live entertainment and a music video projected on the wall. People from all floors were invited to attend the event. During our observation we saw very few people engaged with this activity. We saw no other form of entertainment or stimulating activities taking place during our visit for most people. One relative told us that staff often sat together talking and did not engage with people who used the service. "There is no stimulation. I've never seen any interactions." This relative told us that people were often sitting in the lounge watching television. This was observed on the day we inspected. Another two relatives told us that they had concerns about the number of hours their relative spent alone in their rooms without any meaningful interactions or stimulation. One relative said, "[My relative] used to like going into the garden but now they are very immobile." We observed people unable to leave their rooms due to physical ill health did not receive any one to one activities on the day we inspected.

Staff told us that the registered manager was encouraging them to set up groups. Staff told us that between 10.30am and 12.00pm one member of staff would be available in the lounge to provide one to one activities, such as manicures. We did not observe this at the inspection. We saw the memory aids used to display the date, time and month was not up to date. We saw activities in boxes, such as puzzles, crayons and paper. However, these were not taken out at anytime during our inspection. We met one person who wanted to go out and this was arranged by the activities worker.

We spoke with seven relatives who told us that they knew who to complain to and said that the service listened and acted on their concerns. We reviewed the complaints received by the service. We saw that the registered manager had responded to these in a timely manner. However, one relative told us they were not happy with the outcome of their complaint and had not been made aware of the provider's complaints procedure which would inform them of their right to escalate their concerns to the Local Government Ombudsman (LGO). We saw that the provider's 'How to make a complaint,' leaflet makes reference to the LGO. Staff we spoke with explained to us how they would support someone should they wish to make a complaint. On the day of our inspection we saw that one person was being supported by the covering manager to make a complaint. However, this person told us that they had made a previous complaint which had not been acted on by staff. The covering manager told us that he had arranged to meet with this person to discuss their concerns. This was confirmed by the person.

Requires Improvement

Is the service well-led?

Our findings

People and relatives we spoke with knew who the registered manager was and where to find them if they had any concerns. One relative we spoke with said the registered manager was, "Very approachable."

Although the provider had systems in place these were not always effective to ensure that the building was not appropriately maintained, staffing levels were sufficient to meet people's needs at all times. Recruitment processes were not followed and records kept by the service were not maintained or accurate and records were not available when required.

The provider was aware that areas of the home required improvement and plans were in place to improve the way the service delivered care. The operations director told us that this included a home improvement plan dated May 2014 which reviewed areas such as, staff training, health and safety and maintenance. We saw some areas had been addressed by the service. However, other areas such as maintenance issues seen on the day of our visit had yet to be fully addressed. Attempts to appoint a maintenance person had not been successful. However, we saw that the provider had a maintenance person who had been asked to cover from another home.

We saw a quality assurance plan developed in June 2014. This included areas such as care plan audits, which we saw evidence of in some of the care files reviewed. Health and safety and medication audits.

We saw that a manager's health and safety meeting held on 24 June 2014 addressed a number of areas, such as call bells, maintenance issues and infection control. The provider introduced a system in July 2014 to monitor the quality of care provided to people, which included a 'management walk around.' This involved the managers and qualified staff observing care being delivered by care staff, reviewing observation charts and staff presence in the lounge areas. Feedback would be given to staff and actions to be followed recorded. The operations director informed us that staff would be given the opportunity to question practice and for management to be aware of the day to day running of the service to identify and act on both good and poor practice. The covering manager told us that none of these audits had been completed at the time of our inspection.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the provider was recording incidents and accidents. We reviewed recent incidents that had occurred at the home and saw that staff completed incident forms, recorded information in people's records, which included completing the relative's communication record. Staff confirmed that after an incident/accident a staff debrief took place at handovers where care staff discussed any learning from incidents. However, records showed that staff did not always complete the investigation and follow up details. Therefore the service did not always record learning following an accident/incident.

Relatives we spoke with told us the service had recently sent them a questionnaire to complete. This asked their views about the care provided to their relative and staff at the home. The covering manager told us that the provider had sent out a recent people and relative questionnaire to seek people's views on the service, but these were yet to be analysed. Relatives we spoke with confirmed that they had completed a recent questionnaire

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People were not protected from the risk of inappropriate of unsafe care and treatment because the provider did not have effective systems in place to identify, asses and manage risks relating to health, welfare and safety of people using the service. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered persons and the provider did not have suitable arrangements in place to make a decision regarding service user's capacity to make decisions and consent to their care and treatment. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People were not protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information about them. Do Not Attempt Resuscitation (DNAR) forms were not accurate or up to date. Regulation 20 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The provider did not have effective recruitment procedures in order to ensure that no person is employed unless that person is of good character and has the qualifications, skills and experience necessary for the work. Regulation 21 (a) (i) (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider did not ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activity. Regulation 22.