Porthaven Care Homes LLP

Prestbury Care Home

Inspection report

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22 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook a focused inspection on 18, 20 April 2017 and a comprehensive inspection on 26 May 2017, 13, 14, 21 and 22 June 2017 unannounced. At our previous inspection on 5 October 2016 the service was rated Good in all domains and overall.

Prestbury House Care Home is a modern purpose-built three story care home located in the centre of Macclesfield. Shops and amenities are within easy walking distance. The Home is registered to provide nursing care for up to 75 people divided into three separate units. Prestbury House Care Home is part of the Porthaven Care Homes Group. Sixty one people were living at the care home at the time of our inspection.

The service has a registered manager. 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. The registered manager was present during the inspection.

The service was not always safe with risks not always being identified to remove the risk or mitigate the risks for the person. There was no challenging behaviour care plan for 9 people with challenging behaviour and 3 behaviour care plans seen were not detailed enough.

Not all safeguarding concerns documented in the care records seen were being reported to the safeguarding authority and some staff were not competent to know when to report a safeguarding concern. Staff were aware of whistleblowing and were aware of what to do.

Staff recruitment systems were in place however, we raised concern staff were not always being assessed according to their probationary period. Staff who did not have a background in care were not always being supported to be competent in caring for people. Induction included staff reading the staff handbook and shadow shifts. We found the staff handbook did not include any information in safeguarding people.

Supervision sessions were inconsistent and appraisals were not always undertaken with staff. They were not being undertaken in line with the provider's policy issued October 2015 which stated supervision should be undertaken at least once every two months and an annual appraisal. The provider was working towards an action plan to address this.

Staffing levels were not sufficient in meeting people's care needs. People who required staff to be aware of their whereabouts at all times according to their care plan were not receiving this level of oversight from staff. Others were not receiving one to one assistance to ensure they had the optimum opportunity to eat and drink.

Medication management was not always safe with some people not receiving their prescribed creams and food supplements.

Recommendations by healthcare professionals were not always being followed by staff with weekly weights not always being recorded therefore, health monitoring was not always effective.

There was a structure in place for assessing people's mental capacity and best interests meetings seen in the records. DoLS (Deprivation of liberty safeguard's) authorisations were not always being renewed when expired. We found one person's DOLS authorisation had expired. Staff were unaware of what constituted restraint until we asked the provider to include training for staff.

People were not always being supported to have enough to eat and drink. We observed people being interrupted when being supported to eat, another person spilling their liquid down themselves due to not receiving the support they needed.

People told us if they needed to see a doctor this was arranged quickly. We found healthcare professionals were involved such as Dietician's, Speech and Language Therapists and Chiropodists.

People told us staff were kind. We observed both positive and negative interactions. Staff did not always have the necessary training, skills and knowledge in dementia care. The care delivery was not always seen to be compassionate with inappropriate use of language used within care documentation.

Training being provided for staff was not effective. We found it was being delivered in a compressed way with staff watching up to 9 different training DVDs in the same day. There was no training in restraint being offered for staff. The provider took action and now includes a DVD for staff on restraint and additional training in dementia care since our inspection.

People who were able to mobilise around the care home moved freely and were able to access all floors of the care home including the coffee lounge on the ground floor. People were encouraged to be independent.

There were activities for people inside the care home and trips outside the care home. Guests such as the Mayor of the town were being invited to visit the people within the care home.

End of life care was being planned with the person and their family. The care plan we viewed was written in detail with clear guidance for staff.

Person centred care was not being provided with people's backgrounds, likes/dislikes and preferences not well documented in the care plans. Staff were not always following the guidance in the care plans.

There was a system of receiving complaints however, we found one serious complaint/allegation written in the file dated April 2017 which had no investigatory records to confirm what actions had been completed as part of the investigation and also no response to the complainant. The safeguarding authority were not made aware of the serious allegation/complaint until 15 June 2017 during our inspection.

The service was not well led. The concerns we highlighted during our inspection had not been identified through the quality assurance systems in place. We viewed audits undertaken with actions to be taken forward, however the audits had not identified the specific concerns identified as part of the inspection.

There was no system in place of recording hospital admissions. This reduces the opportunity for the

provider to identify any trends in hospital admissions from within the care home.

We found the provider had no policy in fluid management for staff to know how to manage people's fluid intake.

There were residents and relatives meetings taking place. Pastoral meetings for staff were also being provided however the tone of the minutes distributed to staff were not always appropriate to promote a supportive approach/culture towards staff.

The Commission and Safeguarding Authority had not received all notifications or referrals as required which is a registered manager's responsibility.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was unsafe.

Staff were not reporting all safeguarding concerns to the Safeguarding Authority. Not all staff were competent in knowing when to report a safeguarding concern.

Not all risks were being identified to ensure people were safe. Risks which had been identified were not always being mitigated.

Medicines were not always being managed safely.

There were not enough staff to meet the care needs of the people set out in their care plan.

Is the service effective?

Inadequate

The service was not effective.

The system in place of providing effective training to equip staff with the knowledge and skills they needed was not effective.

Staff were not receiving consistent supervision or appraisals.

There was a mental capacity framework seen in the records but not all deprivation liberty authorisations had been updated.

Healthcare professionals were being involved in people's care however, their recommendations were not always being followed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always providing care in a compassionate way with positive and negative interactions seen.

The care being delivered was task focused.

Residents/relatives meetings were taking place.

End of life care planning was in place.

Is the service responsive?

Inadequate

People were not receiving person centred care.

People's life story, likes/dislikes and preferences were not clearly documented within their care plans.

Care plans were being reviewed but not always being updated in the appropriate section of the care plan to ensure the current information was visible for staff to read.

People were not always receiving care when they needed care.

Complaints were not all being documented clearly with a record of an investigation or response.

People were supported to maintain their relationships with numerous visitors/relatives seen during the inspection.

Is the service well-led?

Inadequate

The service was not well led.

The concerns raised on our inspection had not been identified by the provider.

The culture within the service was not always supportive of staff.

Root cause analyses were not robust enough to ensure all contributory factors were being identified in a serious incident.

The supervision of staff was inconsistent with no clear written objectives being set.

Prestbury Care 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 was planned to check 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.

The first two days of the unannounced inspection on 18 and 20 April 2017 was a focused inspection following concerning information sent to us. We then undertook a comprehensive inspection on 26 May 2017, 13, 14, 20, 21 and 22 June 2017.

The inspection team consisted of three adult social care inspectors, one inspection manager and a specialist nurse advisor.

The inspection was prompted by notification of a serious incident affecting a person who lived at the care home resulting in a police investigation and subsequent charges brought against two staff members. The information in relation to this incident is being reviewed by the Commission. The information shared with CQC about the incident indicated potential concerns about the recruitment, training, supervision and management of staff. This inspection examined those risks.

We reviewed the information we held about the service before the inspection including the Provider Information Return (PIR) which was received from the service on 7 July 2016. This document provides information about the service. The commissioners of the service were contacted prior to the inspection.

During the inspection we spoke with 13 staff members including the manager, 4 relatives/visitors and one visiting nurse. We viewed 14 care plans and case tracked 5 people who lived there which meant we looked at a range of their care records.

In view of the people living at Prestbury Care Home having communication and cognitive difficulties we used observation as our main method of assessment with people who lived there. We undertook two SOFI [Short Observational Framework for Inspection] assessments where we observed the interactions between staff and people who lived there. SOFI is a way of observing care to help us understand the experience of

people who had difficulty conversing with us.

Inadequate

Is the service safe?

Our findings

People who were able to talk with us told us they felt safe. One person said "Yes I am safe here", another person told us "definitely safe". A third person said they always saw a doctor when they needed one.

We asked staff about their understanding of safeguarding. One staff member said "I would report any safeguarding concerns to CQC and report it to the police, abuse can be physical, verbal, financial". Another staff member told us the different types of abuse were financial, physical, emotional and neglect". The staff member gave us an example of when they reported to the manager they had overheard a relative attempting to obtain a person's bank card who lived there.

We found one person living with dementia who had marks on both their arms. We checked their care plan and found there were no body maps or a care plan in place to explain the marks seen. We asked the registered manager about this and they told us the person had a skin condition but acknowledged there was no care plan to explain this. We also found other examples of when bruises had been documented as seen by staff as far back as July 2016 in an incident form but no body maps in place. We asked the registered manager to refer the person to the safeguarding authority and also asked for a review from the person's GP (General Practitioner). It was confirmed by the GP the person's markings on their arms were related to a skin condition. We asked the registered manager to complete a body map and care plan to confirm where the marks were on the person. This is important to ensure staff can safeguard the person and easily identify a new mark which may not be related to the person's skin condition. The registered manager took action and ensured the appropriate documentation was in the person's care plan.

Another person's care plan and care records showed they had markings to their arms. The body map was unclear. We brought this to the attention of the registered manager who took action and ensured any new markings were photographed and a clear body map in place.

A third person's care records were checked. We found documentation confirming that a large bruise had been seen by a staff member on 4 July 2016 to the person's right hand. The accident report stated "I found a large bruise on {service user's} right hand when I was giving assistance with personal care. Un-witnessed injury. No signs of pain. {service user} was unaware of the bruise. See body map." We contacted the Safeguarding Authority who confirmed no Safeguarding referral had been made by the provider in relation to this. The staff member had deduced for themselves the bruise was due to an unwitnessed injury when it was unexplained and should have been reported to the Safeguarding Authority. Further examination of the person's records confirmed there had been other bruises documented which were not reported to the Safeguarding Authority. A document titled "relative communication note" stated "{relative} is concerned {service user} has bruising on both of their hands and arms. I have explained to {relative} the bruises are unwitnessed. {relative} is concerned {service user} has been pulled." The note recorded by a staff member stated they told the relative the person can hit out and possibly bang themselves. They documented they informed the home manager. We checked with the Safeguarding Authority who confirmed they did not receive a safeguarding referral regarding the unexplained bruising to the person's hands and arms.

This is a breach of Regulation 13 Safeguarding of the Health and Social Care Act Regulations 2014 due to not all incidences of marks and bruises being body mapped or reported to the Safeguarding Authority.

Incidents were being logged on an incident form and transcribed onto an incident tracker form. We looked into incidents and found one person had been injured due to them impacting their head on the bar of a hoist on 1 June 2016 and again on 19 April 2017. The person had a moving and handling assessment form in their care plan dated 13 April 2017 which did not identify the risk of them harming themselves on the bar of the hoist or explain to staff how they could reduce the risk of the person injuring themselves on it. We raised concern the care plan contained a moving and handling assessment but did not contain a moving and handling risk assessment and associated detailed care plan. A moving and handling assessment is not sufficient to ensure staff were being provided with enough detailed information of what the risks were and how they could manage those risks. Despite incidents occurring the care plans were not being reviewed in a timely way. In the event an injury occurred we expect the provider to review the care plan and risk assessment in place to ensure all that could be done was being done to mitigate the risks for the person. We raised concern that the moving and handling assessments being undertaken were not specialist assessments for people living with dementia and challenging behaviour and a more detailed care plan and risk assessment is needed to accompany an assessment. The provider had not revised their moving and handling documentation to include a detailed care plan and risk assessment.

Another person had sustained a fall from the hoist resulting in some bruising. We checked their care plan and found no revised risk assessment of their moving and handling despite this. We asked the deputy manager who assured us a revised risk assessment had been completed. This could not be found during our inspection and a risk assessment was written at our request dated 18 April 2017. The accident and incident report form stated it had been reported as a RIDDOR, a body map was completed and family were informed however, the provider had not undertaken a review of their moving and handling care plan or risk assessment.

We found there had been an incident where one person had entered another person's room at night and urinated on their bed whilst they were asleep in the bed. We checked one care plan which stated they needed a sensor mat in place to alert staff if they got out of bed. It was documented in the care records that the staff were aware the person had spent most of the day previously in the other person's room however, there were no records to confirm they checked a sensor mat was in place. When we visited their room we found there was no sensor mat in place. The staff told us the sensor mat had been removed as the person dismantled it. This meant that although staff were aware the equipment was not suitable for the person, they had not arranged for an alternative sensor to a mat for the person. Risks were not being addressed and mitigated in a timely way to keep people safe.

We found people who displayed challenging behaviour did not have detailed behaviour risk assessments in place to ensure staff knew what the person's triggers were or how to respond. This increased the risk of further escalation of the behaviour. For example, we viewed one person's care plan which described the challenging behaviour but it did not provide details for staff to know how to deal with the behaviours. Another person's care plan we viewed and associated records confirmed there had been incidences whereby the person would bite, hit out and be verbally abusive to staff. We did not see a detailed risk assessment for staff to follow in order to provide them with guidance about how to deal with the person being verbally abusive or when they attempted to bite them. This increased the risk staff would not know how to deescalate and defuse the behaviour placing the person and themselves at increased risk.

One person with dementia was lying in a low bed with a crash mat next to their bed and was seen able to move and sit up to reach for items close to them. There were bowls of grapes and olives seen within reach.

We checked the care plans and saw that the dietician and speech and language therapist had advised a soft diet and snacks to be given in between meals. The staff had not been given clear instruction as to the type of snacks to be provided and had left olives and grapes within reach brought in by the person's family. We brought this to the registered manager's attention and asked her to look into this and remove the olives and grapes. We were informed the dietician had been contacted and snacks should have been a soft diet snack. We asked the registered manager to alert the safeguarding authority of this. We found the registered manager took action and ensured there was a clear sign on the wall advising staff and visitors not to provide olives/grapes. There was a risk of choking for the person which had not been identified by the registered manager or nursing/care staff who were delivering care day to day which is concerning.

This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2014 due to risks not always being managed safely.

We reviewed five recruitment files and found there was a recruitment system in place where staff had proof of right to work in the UK and staff had the necessary checks such as a Disclosure and Barring Service which is to make sure staff don't have any criminal convictions.

We found the provider had written to staff confirming an offer of employment with a 3 month probationary period. There was no letter from the provider confirming staff members had completed all that was required to successfully complete the probationary period.

The policy had been last reviewed November 2015 which stated "All appointments by Porthaven will be made subject to a probationary period of six calendar months. After three months a review meeting will take place between the post holder and their line manager to discuss progress. At the end of the probationary period, and subject to a satisfactory report by the appropriate head of department or line manager, employees will be notified in writing that they have successfully completed their probationary period. The probationary period can be extended should the individual's line manager consider this appropriate". We did not find confirmation letters staff had passed their probationary period satisfactorily. This meant the provider had not confirmed staff had demonstrated over the probationary period they had met all that was required.

We saw five people being administered covert medication. Records showed the pharmacist had not been consulted on how the medication should be taken. In addition the agency nurse had no protocols to refer to on how people took their covert medication. We observed her asking for a cup of tea to mix an opened capsule medication for one person. When we spoke to the agency nurse about this she went to ask one of the carers who told her the person took their medication in yoghurt. This meant there was a risk that people did not always receive their covert medicines safely.

Topical medicine administration charts were also not signed by care staff who had applied the creams. For example, one person had four topical creams prescribed. The frequency of administration had not been documented anywhere and the chart had only been signed with code F which meant applied by carers. One of the creams (aqueous) was not available when we checked. There was a lack information about how staff were to apply the creams. Nurses were signing for creams, which they had not checked if they had been applied. We also found nurses were not always aware when there had been a change for example, a MAR chart for one person showed that some of their prescribed medication had been stopped by the GP and when we spoke to the agency nurse she did not know this.

A person was prescribed forte juice liquid (food supplement) twice a day and records showed this had been given to him once a day for 13 days and staff were recording that it was not required. Also a gel was

prescribed to be applied three times a day and staff were signing not required and it was not clear what site it was to be applied to. It was not clear that this person's pain was being managed effectively. "Opened on" dates were written on most bottles of medicines when opened, however paracetamol suspension for four people had no open dates present to ensure these were within a date which was safe to use.

This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2014 due to prescribed medicines not always being managed safely.

We checked to see if there were enough staff to meet people's needs. Some people we spoke with told us there were not enough staff. Other people told us there were enough staff on duty. One person said "the girls here are worked off their socks". We found the staff appeared rushed. Relatives and visitors had mixed views, some told us there were always enough staff and other people told us there were not enough staff. One relative said "Amazing nursing home but I'm unsure if they realise the staff you need to work with people with challenging behaviour". A visitor told us "There's always enough staff". A relative said "Always plenty of staff". Some staff who worked there told us there were not enough staff to be able to sit and talk to people. We observed this during our inspection and found for example, a member of staff was sitting with one person they were assisting with food and fluid intake but were asked by a nurse to assist another person to the toilet during this time. The staff member left the person they were assisting to eat to assist the other person. We undertook a SOFI Structured Observational Framework and found there were not enough staff to meet the care needs of people. The SOFI was undertaken on 14 June 2017 over a 30 minute period at lunch time. There were two staff in the dining room with a change over of staff at 1pm. We observed staff rushing from one person who needed assistance to another person. Staff were therefore, unable to keep track of who had eaten and had a drink and who hadn't. We observed one person who needed encouragement to eat had not finished eating and left the dining room. Another person ate their meal and left the dining room without being offered a drink.

One person's records stated "17th April 2017 remains unsteady and now has a protective helmet." We were concerned that the reason the person was provided with a protective helmet was due to them not having the appropriate level of staffing to provide supervision at all times as stated in their care plan. Examination of the person's records indicated that staff were to be aware of the person's whereabouts at all times: however throughout the inspection the person was witnessed to be at the nurses station for a considerable length of time without supervision and walking around therefore at risk of falls.

We observed one person living with dementia who had been left unsupervised with an open top cup full of soup. They were observed having difficulty gripping the cup and spilt their soup down them and on the floor. We spoke with the manager and raised concern the person required assistance to drink their soup and had spilt it. They told us they would reassess the person's eating and drinking. During the course of our inspection we were informed an agency staff member had been deployed to provide the person with assistance.

This is a breach of regulation 18 Staffing of the Health and Social Care Act Regulations 2014 due to there not being enough staff to provide care to meet the needs of people.

We visited two people who had excess stock of oxygen stored in their rooms and found out that the oxygen was not stored safely. Usually extra stock of Oxygen is stored in the medicines room/clinic by securing the bottles on the walls and signage on the door. There was a sign on the person's bedroom door but it was very small and not easily identified. A relative confirmed there had been occasions when they were concerned about the management of the person's oxygen including an occasion when a candle lit birthday cake was about to be carried into the person's room when the family intervened and prevented the staff member

from entering the room. The provider undertook their own in-house health and safety check and provided us with a report. There was no mention within the report regarding the storage of oxygen. We therefore, requested the provider referred this to the Fire Service for advice.

Inadequate

Is the service effective?

Our findings

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 supported 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 so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Our findings were that the registered manager had applied for a Deprivation of Liberty Authorisation for all the people at the care home.

The service had a mental capacity checklist in place which was completed to confirm the person's ability to make decisions. We found best interests meetings were taking place to include best interests for prescribed covert medication. However, we queried least restrictive practices in line with the mental capacity act 2005 legislation. One person who was high risk of falls was prescribed a sedative to reduce the risk of falls. We queried this with the registered manager as there was no documentation including a best interests decision whether this was the least restrictive option for the person. The registered manager told us the GP has prescribed it and therefore, it has been assessed appropriately. We discussed with the manager that they must demonstrate they are using the least restrictive method of treatment.

We found the care home had a system in place for tracking as to when a DOLS authorisation was due to expire and needed to be renewed. Despite this system in place we found one person's DOLS for a standard 3 month period had expired in September 2016. □

Not all staff employed by the care provider had any back ground or previous experience in care and were not working towards the Skills for Care, Care Certificate. The Care Certificate provides care staff with a standard set of skills and knowledge which is recognised nationwide. It is the providers responsibility to ensure all staff employed to deliver care have the necessary skills and knowledge to meet people's care needs. We found not all staff had the necessary knowledge and skills to meet people's needs.

One relative said "Some staff are probably not trained enough to deal with challenging behaviour. It does worry me they haven't got trained staff to deal with challenging behaviour".

We talked to staff about their training and reviewed training files alongside the training matrix. One staff member who we asked how they deal with challenging behaviour told us "If someone comes for you, walk away". The staff member explained they had raised concern with their team leader regarding the need for senior staff trained in challenging behaviour to work within the care home to offer support and guidance for staff who work with people with challenging behaviour.

One staff member we spoke with completed a virtual dementia training session which provided them with

an insight into how it must feel to be living with dementia. They told us it did not however, provide training in how to respond to people who displayed challenging behaviours. The trainer informed us 31 staff attended the virtual dementia awareness training course. They told us they considered the DVD training not to be enough especially for carers who have no background or previous experience in care.

There was a designated trainer at the care home three days each week who had taken over responsibility of organising and delivering training relatively recently. They told us they were concerned when they took over the role staff were not receiving first aid training and began to arrange this for staff approximately December 2016. The trainer had a Train the Trainer qualification in moving and handling to teach staff aspects of moving and handling.

Staff told us they had not been offered basic first aid training until around December 2016 and the records we viewed confirmed this. We looked into the dementia training being offered for staff and found there were two DVD's being offered as mandatory training, Dementia ; understanding the condition and Dementia; understanding behaviours. We viewed the two DVDs used and found there was no training included in those DVDs to provide training in restraint. This is important for staff to know how to deal with aggression in particular related to people who do not have mental capacity who display challenging behaviours. The Health and Safety Executive published guidance titled "Health and Safety in Care Homes" which explains that all staff likely to be exposed to challenging behaviour should know and understand the preventive measures identified in those people's care plans. Particular attention should be paid to when: new employees or agency workers are involved; new residents are admitted (especially those with a history of challenging behaviour); there has been a change in a person's mental or physical state, medication, behaviour, mood etc. Training in preventing and managing violence and aggression can provide staff with appropriate skills to reduce or diffuse potential incidents. Such training should be available to all staff who come into contact with residents, including temporary or agency staff. HSG220 (2nd edition) Published 2014.

We reviewed five training files and found not all staff were completing training when they started to work within the care home. One staff member who had no previous experience working in care began working in the care home in April 2015. Their supervision record dated 14 April 2016 stated "mandatory training" was to be completed. We found the staff member had not completed most DVD training until April 2016 which was a year following the commencement of their employment. They scored low 70% in safeguarding, 61% in fire training, 25% understanding dementia the condition. There were no scores for the use of hoist, dignity, mental capacity, first aid or food hygiene. Therefore, the provider could not confirm if the staff member had understood the training and were competent.

Their supervision had been inconsistent. They had not received any supervision sessions during 2015. They received 7 supervision sessions in 2016 but none for an 8 month period. This was between 3 August 2016 and 18 April 2017 on the first day of our inspection. The staff member had not received an appraisal since they commenced employment with Porthaven Care Home LLP in April 2015. The staff member had signed to confirm they received a copy of the provider's staff handbook but no other induction was seen or confirmation the provider had satisfied themselves the staff member had read and understood the contents of the handbook. We subsequently found concern being raised about the staff member's moving and handling practices within a supervision session dated 8 November 2016 signed by the registered manager. There were no supervision records following November 2016 to confirm if the training had taken place or if the staff member was now competent in moving and handling. Out of the seven supervision records undertaken only one was completed by the registered manager and all were completed by a different member of staff. Other staff we spoke with told us they received an induction which lasted approximately two days however, we did not see confirmation of this recorded in staff files. The staff file index did not list confirmation of an induction so we could not be sure all staff were receiving a thorough induction. We spoke

with agency staff during our inspection and found one person had not received any induction from the care provider.

Staff were not always receiving adequate supervision. At the time of our inspection one staff member had received one supervision session on 16 December 2016 since commencing working in the care home since March 2016. This meant they had received one supervision session to discuss any concerns, training needs or to receive feedback from their manager. One staff member documented on their supervision sheet dated 3 August 2016 "unwilling to sign" which raised concern whether the staff member agreed with its contents which advised they were to watch two DVDs in dementia care.

We found not all staff had completed their mandatory dementia training and those who had completed the training were not confident in dealing with challenging behaviour. One staff member explained they had watched one DVD but could not recall watching the DVD in challenging behaviour. They told us they had not received training in dealing with challenging behaviour and had been approached by people who lived there who were aggressive or agitated. We asked the registered manager about this who confirmed the staff member had watched the DVD which provides training in challenging behaviours however, the staff member could not recall how to deal with behaviours other than to use a soft voice. Another staff member told us they were inexperienced and had not worked on the dementia unit for a short time and although they had completed the dementia training they felt they needed more additional training to include practical training regards dementia and challenging behaviour.

The provider was asked to review their training for staff. They took action and have begun to include more in depth training in dementia care for staff.

This is a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2014 as staff were not always receiving appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

We spoke with the chef for the care home who confirmed they received a fresh food delivery to the care home daily. The menus were on a four weekly rotation to provide a variety of meals. One relative told us "the chef had been to see {service user} to talk about foods they liked". People were assisted to their seat during meal times. The dining room tables had table cloths and there was music in the background to promote a relaxed environment for people.

Staff did not always know how to support people well. For example, during a SOFI we observed a relative came into the dining room and spoke with a staff member who said "What would you like for {service user}, the relative replied "it gets difficult now there's only gammon. The staff member replied "They're on a pureed diet aren't they?} The relative said "No a soft diet". We made further checks and found one person who was on a special diet was not recorded as needing a special diet in the kitchens where the food was being prepared. This was brought to the attention of the registered manager who requested the information in the kitchen be amended immediately.

We were concerned people were not always receiving enough to eat and drink. People who were prescribed food supplements and had a supplements form. We found one person's form was incomplete and no record that any supplements had been given on some days and no explanation why. Fluid balance charts were not clearly demonstrating what the target total was in 24 hours for staff to know what to encourage the person to drink. Records were not demonstrating weights were always being recorded in line with advice from their Dietician. Food and fluid charts in place were not always recorded accurately and some seen did not have details of what was eaten and only what was offered seen recorded. We found the provider's own audit of

care plans also highlighted concerns such as for example, "Eating and drinking care plans states weekly weights but no evidence of weekly weights, states low risk which is contradictory." We found there was no Porthaven Care Homes LLP policy on fluid management. The registered manager contacted the Director of Nursing who confirmed Porthaven Care Homes LLP did not have a policy for staff to follow and a policy would now be written.

This is a breach of Regulation 14 Nutrition and Hydration of the Health and Social Care Act Regulations 2014. People's nutritional and fluid intake was not always recorded and recommendations were not always being followed to ensure people's nutrition and fluid requirements were always being met.

Records also showed when the person was seen by other healthcare professionals such as the tissue viability nurse, chiropodist, Opticians, District Nurses and GPs, actions plans had been recorded although some of the reviews were not clearly communicated. We also found the recommendations of healthcare professionals were not always being followed. For example, we found one person who was recommended to be weighed weekly had no records of weekly weights so therefore, weekly weight monitoring was not being undertaken.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives about the care for people. One person told us they felt cared for but commented "I feel sorry for them, there's a lot of agency here at the moment who are lovely, they do their best but you have to tell them everything which is not so easy". "One relative told us "They're all a caring person, staff are so kind, they're second to none". A visitor told us the care was "very good". {service user} always looks well cared for." Another person who lived there told us "everyone is kind and helpful they're very pushed for time".

Staff we spoke with told us they wished to provide the best care possible for people. Staff were observed speaking with people in a kind and caring manner. We observed positive interactions between staff and people living there. For example, we observed one staff member speaking with one person in a soft, gentle voice to provide reassurance.

A power of attorney for one person explained the person's religious beliefs were very important to the person. The person was receiving mass twice weekly at the care home and visitors were always made to feel welcome. They said the person initially found being in the communal lounge very distressing but they had become accustomed to it gradually with support from staff. They told us "Staff interact with {service user} very well."

We looked at care plans for one person who was End of life Care and we found that the care plan provided sufficient including the nature of the illness, oxygen management, palliative prescribed medication, pain management and prescribed medication, speech and language therapy reviews, GP reviews, Do Not Resuscitate forms in place with family involvement and a verification of expected death by a registered nurse form completed and signed by the person's GP. We spoke to a staff member about how they were meeting this person's needs and it was clear that staff knew the person well and had clear guidance in place. We saw the person during the presence of their family, the person appeared comfortable and the family were in agreement people had access to healthcare services. Records showed when the GP had been called to review the person, the reasons why a review had been requested and the outcome of the GP visit.

We observed people being supported to be as independent as possible during our inspection. For example, we observed one person who was independently mobile moving around the care home freely when they chose to. There was a coffee lounge in the reception area of the care home where people could access their own drinks if they wished.

Some staff members were seen not engaging with people on the dementia unit, appearing uncomfortable. We observed one staff member sitting in a corner of a lounge as though they didn't know how to interact with people in the lounge. Staff demonstrated a lack of confidence to engage with people living with dementia at times. For example, we observed one staff member who's facial expression was fearful when being approached by one person and ran away from the person who displayed challenging behaviour demonstrating they did not have the skills to interact with the person. The care being provided at these times was therefore, not compassionate or caring.

The registered manager was deploying additional agency staff following a serious incident on 31 March 2017, subsequent staff suspensions, dismissals and resignations. Due to the high number of agency staff the staff did not always know the people they were caring for. A relative told us one person who was able to use a call bell had not been provided with it by an agency staff member which resulted in them reverting to banging their fist on the wall to alert staff they needed assistance. Staff were not always aware of people's care needs. One agency staff member told us they did not have the time to read the care plans and relied on asking regular staff if they needed information about people.

We looked into choices for people including a choice of foods. We were informed the policy was to provide a person who is on a low sugar diet with less of a portion of food with sugar in as opposed to preparing different dishes with different amounts of sugar in them. There were no records demonstrating people had been consulted in deciding this. We were therefore concerned people's diet portions of food were being restricted.

We found the language being used within the care plan and risk assessments were not always upholding people's dignity or appropriate according to the person's care needs. We received concerns from the Clinical Commissioning that the care plans for people receiving nursing care did not contain appropriate use of language and concern was raised the person writing the care plans was not always a clinically trained qualified nurse. For example, one person's revised challenging behaviour care plan was titled "Prone to acts of violence". The person who was registered blind with dementia displayed challenging behaviour. Concern was raised with the managers regarding this inappropriate use of language seen. They agreed it was inappropriate.

We observed one person sitting in a communal area where visitors accessed. Due to difficulty holding the cup and visual impairment the person was not aware of it in their hand they were observed spilling the contents of the cup down them and on the floor. The carpeted floor area around the person's chair was stained from previous food spillages.

This is a breach of Regulation 10 Dignity and respect due to people not always being consulted, receiving care which was not always delivered in a compassionate way.

The service were providing resident and relatives meetings. We viewed the minutes dated 27 February 2017 and noted there were five staff members with four relatives, one person in attendance who was unknown and one resident. We were concerned regarding the high number of staff in attendance compared to the number of relatives and residents.

Inadequate

Is the service responsive?

Our findings

We looked into whether people were receiving person centred care and if their care needs were being assessed and reviewed appropriately. Care plans were personalised with a picture of the person. There were sections in the care plan detailing what activities people were engaging in however, we were concerned peoples likes, dislikes and preferences were not clearly documented. The care plans also did not provide a background to the person's life story for staff to know important information such as where the person was born, their previous occupation during their working life and so on. This pertinent information was seen in a separate file within the leisure and wellness files held on the top floor within the care home.

We case tracked one person who was registered blind living with dementia who was high risk of falls. The person had a significant number of falls since February 2017: further analysis of this would have assisted in identifying any key times of the day, locations, shift patterns and what could be done to further minimise falls however there was no falls diary in place to record this information. There were lots of falls that were unwitnessed and on two occasions the person had fallen over objects: a walking frame and somebody else's feet. This is in direct contradiction to the care plan that staff should be aware of the person's whereabouts at all times and that obstacles should be removed. The Moving and handling assessment dated 18th of July 2016 stated staff are to be aware of obstacles and remove them. The person also was not wearing any shoes. We asked the manager why and they told us the person did not like to wear shoes. This was not written in the person's care plan. Therefore, staff were not providing person centred care as they were not following the care plan and providing supervision when walking at all times. The care plan also did not always reflect the person's preferences such as not wishing to wear anything on their feet.

One person who had a grade 2 pressure sore was on bed rest to alleviate the pressure on the area affected however, there was no care plan in place for staff to know what to do to provide pressure care for the person. We viewed an evaluation note which stated "risk remains high and staff to maintain pressure relief." There was no guidance for staff to know how often to reposition the person. The person also had a clenched hand due to their dementia and as a result of this they had marked the palm of the hand with their nails which posed a further risk. We spoke with a visitor who raised this concern with us and told us the hand was odorous and had not been cleaned. We checked the person's care plan and found there was no risk assessment for staff to know how to clean and position the person's hand to prevent them from developing secondary problems such as their nails breaking the skin of their palm.

This is a breach of Regulation 9 of the Health and Social care Act Regulations 2014 as care plans were either missing or were not a true reflection of the care required to meet the person's needs.

The activities within the care home were coordinated and provided by the leisure and wellness staff whose files we viewed. They contained details of people's life story within these files which day to day staff did not refer to when delivering care. Details of whether a memory box was provided for each person living with dementia were documented within the file and also numerous pictures of people enjoying their activities including trips out. We viewed an activities board in reception with an activities poster advertising a "Carry on Singing Challenge", the Mayor of Macclesfield visited the care home on 4 April 2017, a trip to New

Brighton Beach on 20 April 2017, trip to Blackpool on 25 May 2017 and a trip to Macclesfield football stadium on 7 March 2017. Activities for June 2017 included a trip to the Warrington Museum and Art Gallery, residents meeting, 10 mile walk for Alzheimer's Society, Mystery trip on 9 June 2017, Spanish garden party and a pianist visiting the care home. The activities within the care home were extensive and we observed people had access to a hairdresser on site and leisure and wellness staff who were seen painting people's nails. We observed one activity session during the inspection where staff were using a bubbles machine and low lighting to promote a relaxed sensory experience for some people with dementia. During another activities session we observed the activities coordinator using everyday objects such as dusters to enable people with dementia to engage in purposeful activity. We observed one person who was restless engaging in cleaning the table tops and coffee tables during this activity.

There was a complaints system in place and all complaints seen in the complaints file apart from one had been responded to by the registered manager. There was a complaints process visible on the reception desk for people to view and read. Most people we spoke with told us they would make a complaint if they needed to. The only complaint not responded to however, was a serious allegation. We were therefore, concerned not all concerns/complaints were being investigated thoroughly or responded to by the registered manager. We received confirmation of an email sent to the registered manager on 9 April 2017 by a relative who raised concerns a person's oxygen had been turned off by staff and the person's colour was blue when the relative found them. There was no detailed information of an investigation by the registered manager and considering the seriousness of this allegation, the Commission are concerned there was no contemporaneous notes of an investigation. The registered manager told us they had investigated and had not responded to the relative in writing as to the outcome of the investigation. We were also concerned the safeguarding authority were not made aware of the serious allegation/complaint at the time and confirmed to the Commission they were informed about it on 15 June 2017.

This is a breach of Regulation 16 Complaints as there was no contemporaneous record of the investigation the registered manager undertook or a response to the relative raising the serious allegation/complaint.

Inadequate

Is the service well-led?

Our findings

We found there were mixed views about the management at the care home. One staff member told us the manager was "the best manager they've ever had, very approachable and very nice". Another staff member said "I feel more settled now with the management team we have, they have an open door policy". A third staff member told us "I don't find the manager approachable, I find {registered manager} intimidating", another staff member told us "{registered manager} doesn't want to know".

We looked into the governance and quality assurance checks in place completed in January 2017. These included the monthly audit schedule submitted by the 15th of each month. Audits seen within the Governance file included in infection control, pressure sore audit, Action plan for weight loos, Medication audit, leisure and wellness self audit tool and accidents monthly logs. We viewed another governance file for February 2017 which contained a monthly home audit, death notifications, health and safety inspection report, nursing care documentation audit and accidents. Audits undertaken in March 2017 seen in the file included monthly reports, complaints audit and a cotside checks audit. The quality assurance checks were mostly undertaken by the deputy home manager. We found the analysis of information was not always robust, for example, the monthly log of incidents did not state where the incident occurred or a time so therefore, the analysis of incidents was limited.

During the inspection we looked into whether the service demonstrated good leadership and a positive culture by speaking with staff and viewing minutes of recent meetings. We viewed minutes of a General Staff and Pastoral Support Meeting which took place on 2 May 2017. This is a meeting to support staff. We found the tone of the minutes which were circulated to staff was such that they did not always provide support for staff. For example, one staff member voiced they did not know what DoLS meant. The response to the staff member was that they were told what it meant and they had received the training. There was no acknowledgement or actions from the minutes to include consideration to staff who have already had training in MCA requiring additional training to support them. The minutes also stated "The meeting discussed the recent onslaught of inspectors and external professionals who had been in the building over the past few weeks".

The minutes also commented on another staff member's conduct "They discussed that a member of staff in a recent inspection (this time by the local authority) had sort to distort training details and had then had to be challenged over her facts. The Cheshire East monitoring team had been concerned at this person's conduct as they felt this had been done deliberately". The Commission were also concerned regarding the use of language being used in communications with staff, for example the minutes stated "Moving and Handling: All moving and handling care plans were in the residents care file and this must be followed. Failure to do so is a reportable safeguarding issue and could lead (if the resident is harmed) to a charge of assault. Either way it is considered gross misconduct by the company and was subject to disciplinary". The Commission were concerned regarding the tone and misleading message provided by management to staff.

We were concerned staff were not always being listened to by management. One staff member explained

they had expressed to the manager they did not wish to work with people living with dementia. The registered manager confirmed the staff member had spoken with them about this but the manager explained they considered placing the staff member on the dementia unit a better option than recruiting more agency staff. This decision was made by the manager despite the staff member expressing they were finding it difficult to work with people with dementia. We also received concerning information during our inspection not all staff felt they could approach management. The provider investigated this during our inspection and found no evidence to substantiate this.

Another staff member told us they were aware of another staff member who also expressed not to work on the dementia unit within the care home. Staff were following the advice set out in the staff handbook which stated "If you feel stressed by your workload or work situation, you must bring this to the attention of your line manager. Managers must ensure that their colleagues are coping with their workload and should be alert to signs of stress exhibited by individual employees. Workload should always be discussed during supervisory meetings with employees". The supervision records we viewed did not confirm workload was being discussed at those times.

We found Porthaven Care Homes LLP policies and documentation were not always robust. The registered manager confirmed there was no policy for staff to follow regarding how to manage people's fluid intake. We were informed by the registered manager that the Director for Nursing at Porthaven LLP confirmed there had not been a fluid management policy written previously and they agreed this would be beneficial. We were assured this would be written and implemented across all Porthaven Care Homes LLP locations. We also requested a hospital admissions tracker for us to view the number of admissions over the past year and found there was no analysis of hospital admissions being undertaken by the provider. This is important to be able to analyse how many admissions were as a result of infections or falls and so on. Without this pertinent information trends or learning from events is more limited.

The staff handbook which formed the induction for staff did not contain any information for staff to inform them of their safeguarding responsibilities. Although staff were provided with a DVD in Safeguarding, we found some staff were not receiving their training upon the commencement of their employment. This meant some staff who did not receive safeguarding training straight away upon them starting to work in the care home would not have known what to do to ensure they always safeguarded people when appropriate.

Despite us raising concern on 18 April 2017 the moving and handling assessment form was not sufficient to provide staff with the detailed information required to safely transfer people, the provider had not revised their moving and handling documentation. We requested the provider contacted the Local Authority moving and handling team who are aware of the current guidelines for writing moving and handling care plans and associated risk assessments for assistance.

Health and Safety Executive guidance for care homes states "The risk assessment and care plan for an individual resident should adequately cover their moving and handling needs, both day and night, including: what the resident is able/unable to do independently; the extent of the resident's ability to support their own weight and any other relevant factors, eg pain, disability, spasm, fatigue, tissue viability or tendency to fall; the extent to which the resident can participate in/cooperate with transfers; whether the resident needs assistance to reposition themselves/sit up when in their bed/chair and how this will be achieved, eg provision of an electric profiling bed; the specific equipment to be used, including (if applicable) type of bed, bath and chair as well as specific handling equipment, ie type of hoist and sling, sling size and which attachments are to be used; the assistance required for different types of transfer, including the number of staff needed. Hoisting tasks may require more than one worker to assist in safe transfer; moving and handling in the event of emergencies, such as fire evacuations, residents' falls etc." We

found the moving and handling documentation in place at the care home was inadequate and did not contain the level of detail required.

We raised concern on the inspection regarding the lack of oversight of the training being provided to staff. The provider was asked to review their dementia training and as of April 2017 began to include "minimising the use of restraint" as part of the dementia mandatory training. This along with basic first aid was now being offered for staff. However, we found a lack of oversight of the training continued. The registered manager and Nominated Individual were unaware the staff training was being condensed with up to 7 sessions of varied topics being covered in the same day.

Upon raising concern regarding the lack of specialist assessment for people living with dementia in the care home we were informed by the Nominated Individual the Director of Nursing for Porthaven Care Homes LLP was a specialist in dementia and moving and handling. When we checked we found this was not the case. The provider has now taken action and has confirmed a staff member will be attending a two day course titled Dementia Specialists Leadership Course.

Following a serious incident the provider took immediate action and dismissed two staff as of immediate effect. However, the Commission raised concern the provider were not taking appropriate action in investigating all staff implicated to ensure there was no further risk to people living at the care home. We requested the provider undertook a root cause analysis and received a report which did not identify key areas of concern.

Oversight of the care home involved visits by the Regional Manager, Nominated Individual and Chief Executive. They were supervised by the Regional Manager however, when we requested to see documentary evidence the registered manager did not have copies of their own supervisions. The Nominated Individual was able to provide us with dates when the supervisions took place. The registered manager supervised the deputy manager who was able to provide supervision records. We raised concern about the quality of the care plans/risk assessments and language used within them written by the deputy manager. The registered manager agreed terminology used was not appropriate however, we were concerned there was no improvement of this seen during our inspection between 18 April and 22 June 2017 and the same practices were on going despite the registered manager being aware.

In view of the concerns raised regarding safeguarding we asked the registered manager what they considered reportable to safeguarding. The registered manager responded "everything is reportable. If I am unsure I will talk to {Safeguarding Authority}." This did not reassure us as documentation we reviewed during the inspection confirmed new marks/bruising had not been reported to the Safeguarding Authority. We therefore, were not assured learning had taken place from the concerns we had raised.

We requested the provider undertook their own audit of care plans during the inspection. The audit summary was provided to the Commission for us to review. The audit had bene completed by several managers from other areas/locations but not the registered manager. This audit identified several areas of people's care plans which were in need of review or updating.

This is a breach of Regulation 17 Governance due to the governance systems in place not identifying the concerns raised as part of the inspection.

The Commission and the Safeguarding Authority did not receive all notifications required which was the responsibility of the registered manager.

This is a breach of Regulation 18 of the Registration Regulations 2009 of the Health and Social Care Act Regulations.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	We found the provider had not always notified the Safeguarding Authority of Safeguarding concerns and of other incidents within the care home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans were not written with enough detailed information about the person's preferences, likes of dislikes. Some risk assessments/care plans required to deliver person centred care were absent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	We found people's dignity was not always upheld. One person was observed with soup spilt down themselves in a communal area. The language being used by staff writing the care plans contained some inappropriate use of language.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Mental Capacity assessments were not always updated in the care plans. We found one DOLS

	authorisation had expired in September 2016 which had not been renewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service had no policy for staff to follow to manage people's fluid intake. This meant staff were not given guidance how to monitor people's fluid intake effectively. We found staff were not always recording what people had drank or eaten. People's weights were not always recorded weekly when recommended for effective monitoring of food intake.

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 Care plans and risk assessments were not always reflecting the care needs and lacked enough detailed information for staff to follow. Not all people who displayed challenging behaviour had a behaviour risk assessment or care plan in place. Staff were not always following the advice from healthcare professionals.

The enforcement action we took:

We Served a Notice of Decision Imposing Conditions on the Providers Registration

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 We found not all safeguarding concerns had been reported to the Safeguarding Authority placing people at risk of abuse. Body maps were not always completed and when completed where not always detailed enough.

The enforcement action we took:

We Served a Notice of Decision Imposing Conditions on the Providers Registration

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 The quality assurance systems in place had not identified the concerns we found on the inspection. Training was being condensed with some staff completing up to 7 training sessions on different topics within the same day. The manager agreed this was not an effective way to deliver training but had not identified this as a concern from their own checks within the care home. We found some statutory notifications confirmed the

registered manager had not always referred when appropriate to the Safeguarding Authority or the Health and Safety Executive. Other statutory notifications lacked detailed information for the Commission to review incidents.

The enforcement action we took:

We Served a Notice of Decision Imposing Conditions on the Providers Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff employed did not always have a background in care and were not always receiving an appropriate level of support required to provide safe and effective care.

The enforcement action we took:

We Served a Notice of Decision Imposing Conditions on the Providers Registration

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 The system of delivering training was not effective. Staff could not recall training which they had completed. Staff were completing up to 7 different training topics/sessions in the same day which resulted in difficulty for staff in recalling the training completed. Dementia training did not include what constitutes restraint and the majority of care staff's basic first aid training was out of date.

The enforcement action we took:

We Served a Notice of Decision Imposing Conditions on the Providers Registration