Stephen Oldale and Susan Leigh

# West Melton Lodge

## Inspection report

2 Brampton Road
Wath-upon-Dearne
Rotherham
South Yorkshire
S63 6AW

Tel: 01709879932

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

West Melton Lodge is in West Melton village, which is between Rotherham and Barnsley. The home is registered to provide accommodation for 32 older people. Accommodation is on two floors and a passenger lift is provided. There are several lounges and dining areas throughout the home. The bedrooms vary in size and some have en-suite lavatories. The home has landscaped gardens and there is a car park to the front of the property.

This inspection took place on 2 and 3 February 2016 and was unannounced on the first day. At the time of the inspection 25 people were living in the home. The service was last inspected in September 2014 and no breaches of legal requirements were identified.

There was no registered manager at the time of the inspection. 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 provider had appointed a new manager, who had started work a few days before Christmas. The manager told us they were preparing to apply to become registered.

We received mixed feedback from people living in the home and their visiting relatives, although most of the feedback was very complimentary regarding how nice the staff were, and about the care that people received. We found several areas for concern, as some risks to people's health, safety and welfare were not appropriately managed. This included poor cleanliness and infection prevention and control in the home. The environment was not in a good state of repair or well decorated in some areas, and that there were physical hazards, such as trip hazards and security risks. Therefore, people were not always cared for in a hygienic and safe environment.

We saw that people's health care needs were not always accurately assessed and risks, such as risks associated with use of the stairs and the use of bedrails were not always recognised. In some cases, support and advice had not been sought from healthcare professionals. In one case the person's care plan was not being followed. This meant that people's care was not well planned or delivered consistently. In some cases, this put people at risk and meant they were not having their individual care needs met. Additionally, the records staff kept about the care they delivered to people were not checked, leaving people at risk of not having their current, individual needs met.

There were few activities. The level of staffing support available did not adequately provide for people's social and intellectual needs, and allow people sufficient freedom to go out into their local community.

Staff told us they received training, which helped them to carry out their role. However, not all staff had a good understanding of the Mental Capacity Act 2005. There were a number of people who lived in the home who were living with dementia, but not all staff had a good understanding of working positively with people

living with dementia. Staff confirmed that they received supervision sessions with their manager.

The Mental Capacity Act (2005) (MCA) has been introduced as extra safeguards, in law, to protect people's rights and make sure that the care or treatment they receive is in their best interests. The service was not meeting the requirements of the MCA (2005) for people who may lack capacity to make decisions. For example, people's mental capacity was not assessed when particular decisions had been made. Additionally, some decisions made did not support people's rights.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the necessary DoLS applications had been made.

There were 14 people living with dementia who lived in the home, and although some work had been done to make sure the environment was dementia friendly, it was not made wholly suitable for their needs.

People were not always offered choices or encouraged to be as independent as possible. For example, people told us they had very little input into the planning of activities, and there was limited choice in relation to meals and mealtimes.

Although people we spoke with told us the food was nice, suitable arrangements were not always in place to support people to maintain a healthy intake of food and drink. We saw that the management of nutrition was not always effective in making sure that people's nutritional needs were identified, and that they were provided with individual diets that met their needs.

We saw that overall, medicines were ordered and disposed of safely, and administered to people by staff trained to do so. However, the storage temperature was not monitored for all of the medicines kept in the home. There was no guidance for staff about how people might express pain, when their communication had been affected by living with dementia, or under what circumstances staff should administer pain relief to them.

For the most part, positive caring relationships were developed with people who used the service. Staff spoke to people respectfully, and in a gentle and caring way. However, we did see instances when people's privacy and dignity were not protected.

The provider did not have effective systems in place to identify the risks to people's health, welfare and safety and in some instances, had failed to provide appropriate care to maintain people's safety.

Audits were completed to monitor the quality and safety of the service provided to people. However, some of these audits had not been effective, and no action plans were in place to make sure any issues identified were followed up and improvements made.

People told us their views and opinions were taken in to consideration and people felt involved in suggestions and ideas about the home. However, we found that where people had asked for things to be improved, there was no indication that action had been taken to address them.

We found five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider, and will report on this at a later date.

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 not safe.

People were not always cared for in a clean and hygienic environment and suitable arrangements were not in place to prevent the spread of infection.

People's health care needs were not always accurately assessed and that risks were not always recognised. This included the risks associated with use of the stairs and the use of bedrails.

The environment was not in a good state of repair and risks to people's health, safety and welfare, including window security and trip hazards were not appropriately managed.

There were not enough staff to ensure that people were safe and their needs were met.

Overall, medicines were managed safely, but we did identify areas which needed improvement.

Staff were appropriately checked for their suitability before they started working in the home.

### Is the service effective?

**Inadequate**

The service was not effective.

We found that care plans did not accurately reflect people's individual health and social care needs. As a result, people did not always receive care that met their individual needs.

Records regarding the care delivered to people were not always completed appropriately, or checked by managers to ensure that people's needs were being met. This left people at risk of receiving inadequate and unsafe care.

Healthcare services, such as falls prevention and dietetic services were not always contacted when people required their support. This left people at risk of receiving inadequate and unsafe care.

Suitable arrangements were not always in place to support

people to maintain a healthy intake of food and drink and people's preferences were not always taken into consideration.

The training provided to staff was not always effective. This meant that staff may not be able to safely deliver care to people who used the service.

The service was not always meeting the requirements of the Mental Capacity Act (2005) (MCA) and associated guidance. People's mental capacity had not been assessed when particular decisions were made. Some people's relatives had been asked to give consent on people's behalf, when they did not have the legal authority to do so, and some decisions made did not support people's rights.

Some steps had been taken to implement environmental improvements, but the environment was not wholly suitable for the people living with dementia who lived in the home.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

Most people, their relatives and other external professionals thought the staff were kind and caring .and we saw staff were gentle and kind.

Although we saw some positive interaction between people and staff we found people's choice and autonomy was not consistently promoted.

We saw instances when people's privacy and dignity were not promoted. For instance, there was inadequate provision for people's privacy in shared bedrooms, and bedroom doors were sometimes left open inappropriately.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People received personal care which was generally responsive to their needs because staff knew people well.

Staff tended to rely on their knowledge of people who used the service as the review format of the care plans was confusing and open to error and care records did not always reflect all information, for staff to be able to meet people's needs. As a result, some of the people did not receive care that met their

individual needs.

There were few activities on offer and a poor level of engagement and stimulation for people. Some people living in the home told us that there was very little to do and they would like to go out more.

The service had a complaints procedure, although no-one we spoke with who used the service said they knew what to do if they had a concern.

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## Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager was in post at the time of inspection.

People were put at risk because systems for monitoring the quality and safety of the service were not effective and no effective action plans were in place to ensure action was taken to address shortfalls or mitigate risks.

Although people and staff were asked their opinions, these were not always acted upon in a timely manner.

# West Melton Lodge

**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 service was last inspected in September 2014 and no breaches of legal requirements were identified.

This inspection took place on 2 and 3 February 2016 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with nine people using the service, five relatives, seven care staff; two cooks the deputy manager, the manager and the operations manager. We also spoke with two external health care professionals during and after the inspection, including specialist community nurses, and spoke with the commissioners of the service.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

We observed care and support in communal areas and looked at the kitchen, laundry and the majority of the bedrooms. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the home was managed. We looked at the written records for eleven people in total. This included looking at care records, risk assessments, food and fluid records, turn charts, daily records, professional visits records, diary records, menus, medication administration records and care plans. We looked at a variety of staff records including training, induction and supervision for all staff and recruitment records for six staff employed at the home. We looked at other records, including the quality assurance and safety audits that were available, quality questionnaire feedback from stakeholder and the feedback from questionnaires completed by 10 staff members.

Inadequate

# Is the service safe?

## Our findings

Most people told us that they felt safe and that staff were good. One person said, "Staff are friendly, helpful and attentive. Everyone here has a good sense of humour and is kind. I'm very happy here."

We looked at how risk was managed for people who used the service and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe. However, some systems were not effective, so people were not protected. The provider used a range of screening tools to help identify risks to individuals. These covered risk areas such as falls, pressure sores, weight loss and mobility.

People's records included assessments, which had been completed to help staff identify most risks associated with the person's care. In the majority of cases, where risks were identified care plans were devised detailing how care and support was to be provided to protect the person from the risk of harm. We saw the corresponding care plans were in place to address the issues. However, the risk assessments did not always provide clear detail on how to prevent or minimise risks and did not always specify how the person should be supported.

We saw no risk assessments in relation to people using the stairs. We looked at the written records for one person, who we were told liked to use the stairs. The person had been assessed as at risk of falls. The information recorded, in their monthly care plan review, indicated that they were becoming increasingly unsteady on their feet and were supported to walk, holding onto a staff member's arm.

There was no relevant risk assessment or care plan in place for this person in relation to them using the stairs. There was no guidance for staff about how to minimise the risks. Although the least restrictive approach was taken, there was no evidence that the person's capacity to understand the risks or to make a decision had been assessed. There was no evidence that the risks had been discussed with the person, or their relative, as part of any best interests process. We discussed this with the manager, who confirmed that no risk assessments were in place for this person or other people who used the stairs. They told us they would ensure that risk assessments were put in place, as a matter of priority, for everyone for whom this was a relevant risk.

We saw that a separate management monitoring records was kept of accidents, including people's falls. We noted that a high number of falls had been recorded. The record reflected that for the six month period from August 2015 to the end of January 2016 there had been 58 falls. We discussed the number of falls people had with the manager and operations manager and were told that they had taken some action to address this, in that people with restricted mobility or at high risk of falls had been given bedrooms on the ground floor. We also saw that in some cases, arrangements had been put in place to alert staff if people got out of bed at night.

However, a number of people had bruises on their faces and arms and when questioned, they told us that they had fallen. We asked two people if any staff had been there to help when they fell and they told us that

no staff had been there. One person's records reflected that they had nine falls in 2015 and none of these falls had been witnessed by staff.

We saw that the accident monitoring record included space to provide an analysis of the accidents that had taken place in each month. However, in most cases the record only stated the circumstances of each fall, and very little useful analysis had been undertaken. The tool did not help in tracking the numbers of falls individuals had over any significant period, and did not help in considering any emerging themes or similarities, such as whether there were patterns in the times or places people had fallen. The tool did not help in planning the deployment of staff or in devising other approaches and interventions, to prevent recurrences.

Not all environmental risks had been appropriately assessed or actively managed. For instance, there were a number of trip hazards, including worn and frayed carpets, and cracked and ripped lino. Examples included torn carpet at the door stop of one bedroom and, a metal magnetic door stop on a dining room door was broken, and had no cover on. This was a trip hazard, with sharp edges exposed.

There was free access to a short flight of stairs at the end of one corridor with a chair lift attached. There was a flight of stairs in the main hall with a rope hung across and a sign saying 'no entry'. This could be easily bypassed. There were window restrictors fitted to the windows on the ground floor, which could easily be opened from the inside and the outside, and could potentially pose a risk to people's safety and security. The manager told us that the issue with the window restrictors had been identified and the maintenance person had been asked to fit new, more robust window restrictors to rectify this. The manager told us they were prioritising the upstairs windows, in order to address the areas of highest risk first. However this work had not yet been carried out.

Some shared areas and bedrooms had been made homely and were reasonably clean. We did see personal protective equipment (PPE) was available, such as gloves and aprons and we saw that staff used them. We saw staff washing their hands between tasks. However, the infection control arrangements in the home were not effective. We found that some areas were not cleaned to a sufficient standard, and could potentially create a health risk to people who used the service.

There was a strong smell of urine in one particular corridor and in some people's bedrooms. The process for cleaning the plastic potty inserts used in commodes had not been effective, as despite the inserts having been washed out, some faeces still remained. This posed a risk of cross infection. We looked at the cleaning store, the sluice room and another small store room. All were in a poor state of cleanliness and repair, with floor covering that could not, or had not been thoroughly cleaned. The sink in the cleaning store was dirty. The sluice room was small and dark, and had no facilities for staff to wash their hands and no bin to dispose of PPE. This led to staff using nearby toilets and bathrooms for this purpose, posing a risk of the spread of infection.

A number of lavatories were dirty. In some bathrooms and toilets the pull chords for the light switches were dirty. There was sealant around toilets, sinks and taps which was in poor condition with trapped dirt and mould. There were also rusty areas, which harboured dirt on some equipment, such as raised toilet chairs and the weighing scales. The pipework in the toilets and bathrooms were not boxed in for easy cleaning, and had a coating of dust. Some bathrooms and toilets had floor coverings which were cracked, lifting at the edges and stained. The floor covering outside the bathroom and medication room was torn, with a build-up of dirt trapped in the damaged areas.

The laundry room was cluttered and disorganised, with no clear path of travel for dirty and clean laundry.

The laundry floor had an accumulation of debris and dust was in need of repair in some areas. There were also a number of waste and clothing bins in the laundry, some of which were visibly dirty.

We spoke with one staff member who told us that the night staff were responsible for some of the cleaning tasks. They explained that they had done some night shifts and their duties had included cleaning the toilets and the chairs in the lounges. However, the staff member told us there were no cleaning schedules for staff to sign to indicate when cleaning tasks had been completed.

The majority of the issues regarding inadequate cleanliness, infection prevention and control had not been identified by the management team, and very few recent audits had been completed. We saw one audit, which had been undertaken in January 2016. This had identified that dining tables had not been clean enough. However, there was no evidence of any action taken to address this and the manager was unable to tell us if any action had been taken. Additionally, we found there was an accumulation of dried food debris on folding tables and tray tables, which some people used when eating their meals.

During the course of the inspection the management team took steps to address the issues we identified, and some of the dirty areas were cleaned. The manager and operations manager told us that the hours worked by the cleaning staff were adequate, but that one member of domestic staff had been away from work for several weeks, due to illness. However, the evidence we found clearly showed the cleaning had not been undertaken to an appropriate standard for some time. This could put people using the service at risk of acquiring infections.

The provider did not always take the necessary steps to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the home we saw areas where repairs had been completed to a poor standard, or not properly completed. There some were holes visible in walls in some bathrooms, and other areas in the home where filler had been used, but not painted over. Additionally, one large wall in one corridor was bare, stained plaster. We were told that there had been a leak in the roof before Christmas, and the wall had been left undecorated to dry out and to make sure the repair had been successful. This was to be redecorated soon.

The woodwork was damaged on the door to the bathroom marked, 'visitor toilet'. The bath had a surround with peeling paintwork. This room was also being used to store an oxygen machine.

We asked people if there were enough staff and if they had to wait long if they needed help and support. We received mixed views. Some people said they thought there were enough staff, while other said that staff were often very busy and they had a long wait. For instance, one person said, "I do feel safe here. Staff are good and will help me. I did get a bit annoyed this morning. I wanted to go to the toilet and I was waiting a long time, but you can't just say, 'I want you here now'. You do sometimes have to wait."

The staff rotas showed there were three care staff on duty each day and throughout the night. The deputy manager worked on weekdays, sharing their time between care and management tasks, and the manager was not part of the care rota. There were ancillary staff, such as a cooks, and domestics supporting the care provided.

The building was large and the way the building was laid out had an impact on staff availability. There were several areas where people could spend their time, such as lounges, garden rooms and dining areas. We also noted that some people also spent the day in their bedrooms. Some of the lounge areas led from one

to another, whereas others were some distance away. This clearly had an impact on the numbers of staff needed. We also noted that some people also spent the day in their bedrooms.

On both days of our inspection we saw that most people were encouraged to sit, or were placed by staff, in a particular area of the home. This included two lounges and a dining area, all of which were linked, and more easily monitored by one member of care staff. Two care staff undertook various tasks, including attending to people's the personal care needs. This included those people who were being cared for in their bedrooms, at least one of whom required to be turned every two hours.

People were often directed to sit down, when they attempted to get up and walk around. This was to prevent people from falling, and had the consequence of significantly restricting their freedom. We also saw that there were lengthy periods when some people were left sitting in different areas, with no staff members in sight.

We discussed the staffing with the manager and the operations manager we were told that there was a tool, which was used to help define the hours of staffing required to meet people's needs, and that "Staff numbers are result from a combination of service user needs and service user numbers."

We saw the tools referred to by the managers. These were one page assessments which were kept on each person's file. These indicated people's level of need and the staffing hours required each day, to meet their needs. The way in which these assessments had been completed was inconsistent and in some cases, difficult to understand. The manager and the operations manager told us that the previous manager had completed these assessments wrongly. It was unclear how the tool was being used to accurately calculate the required staffing.

The manager told us the number of staff required to meet the needs of people living at the home was also worked out via observations and listening to staff comments. However, in half of the staff questionnaires we saw from December 2015 staff had clearly indicated they thought there were not enough staff. We saw no evidence that this had been discussed with the staff team, or taken into consideration in the planning of the rota.

We spoke with one member of staff who was unaware of this feedback, as they said, "Nobody has said they are concerned about staffing levels, although, we could always do with another pair of hands." Another member of staff implied that there were not enough staff in various ways, but was reluctant to state this openly.

The manager and the operations manager were of the opinion that there were enough staff on each shift to make sure that people were safe. However, from our observations the numbers and deployment of staff had a negative effect on people's ability to move around the home safely. This was supported by the long periods we saw when no staff were present, and the numbers of falls people had experienced which were unwitnessed by staff. This was also indicated by evidence we found, which showed that the assessment tools in use were not effective, and the way the building was laid out had not been taken into consideration in calculating the numbers of staff required.

As the provider did not have an effective system in place to monitor staffing levels, the manager could not provide sufficient assurance about the staffing arrangements. We concluded that there were not enough staff to ensure that people were safe and their needs were met.

This was in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs). We looked in the medication room and saw the records in place for monitoring temperature of the room and of the medicines fridge. These records showed that the temperature had been appropriate. However, a separate medicines trolley was kept secured to a wall in another area of the home and no record of temperature was available for the medicines kept in this trolley. We noted that the central heating thermostat was set higher than the range recommended by manufacturers for most medicines. Staff told us they did not monitor the temperature and were not sure what it was on other days. This meant that the provider could not be sure that medicines were stored within the temperature ranges recommended by their manufacturers. Medicines stored outside of the manufactures' temperature range may not be safe to use.

We noted that some people were taking medication on an 'as required' basis (PRN), for pain relief. Despite some people who used the service having communication difficulties, there were no care plans explaining how people expressed pain or discomfort to help staff know when people might need PRN pain relief. The deputy manager explained that they most often administered people's medicines, as they worked most week days. They told us they had worked in the home for around eight years, and were very familiar with how people communicated. We observed the deputy manager whilst they administered medicines. They were aware of people's needs and how they preferred to take their medicines.

Staff used a medication administration record (MAR) to confirm they had given people their medicines as prescribed. We found the MARs to be completed appropriately. We noted that the MARs recorded the person's name and any allergies they had, but did not give staff information about the side effects of some medicines, or how the person preferred to take their medication.

Medication was ordered and disposed of safely. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). At the time of our visit there was one person prescribed a CD for pain control. These were stored and recorded appropriately. There had been a discrepancy in the written record of the balance of the medicine and this had been picked up by the medication audit process. It was evident that this was an error in recording, rather than in the amount of the CD administered to the person.

Only appropriately trained senior care staff administered people's medicines. The deputy manager told us staff were assessed regarding their competence when they first started administering medicines.

We looked at the personnel files for six staff members. This showed there were effective and safe recruitment and selection processes in place. Pre-employment checks were obtained prior to applicant commencing employment. These included two references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Staff we spoke with told us they had received training in safeguarding adults and the staff records we reviewed confirmed this. Staff were able to describe different types of abuse and where they would report any suspicions of abuse. The provider had policies and procedures for safeguarding vulnerable adults and the manager was familiar with how to report any safeguarding concerns.

Inadequate

# Is the service effective?

## Our findings

There was evidence that people had access to healthcare services. People's records reflected that they were seen by a GP when necessary, and had access to opticians and, district nurses and community nurses attended people in the home. However, we found instances when it was necessary for staff to seek help and advice from healthcare or other professionals, such as occupational therapy services and dieticians, in relation to managing particular risks for people and there was no evidence to suggest that referrals had been requested.

For instance, we saw that one person had bedrails on their bed, which were being used without any 'bumpers' for protection and entrapment prevention. There was no evidence that any advice had been sought from other professionals. Additionally, no information was available about how the decision had been reached to use the bed rails, no risk assessment or guidance was available with regard to their safe use, and no evidence was available of any safety checks or reviews having been carried out. We discussed this with the manager, who confirmed that no risk assessment was in place for the use of the bedrails. They told us they would ensure that bumpers would be used, and risk assessments put in place to address the risks.

In one instance we found that staff had not followed the advice of healthcare professionals. One person had a care plan which had been devised by Rotherham district nursing team. The plan stated that they should be repositioned every two hours to help prevent pressure ulcers. We looked at the 'turn' charts for the person, completed by staff to record and monitor when the person had been helped to turn to a different position in bed. However, there were no occasions when the record indicated that the person had been repositioned every two hours, as stated in their plan.

Additionally, there were multiple omissions in the recording. For instance, the last recorded entry on 30 January 2016 was 15.20hrs and first entry on 1 February was 23.20pm. Therefore, no record was available for a 32 hour period. This meant that it was not possible to monitor whether the person had received the care planned for them. There was no indication that these records had been monitored by members of the management team, as they were unaware that the person's plan was not being followed. The managers assured us they would ensure that all staff followed the person's care plan and properly recorded the care provided.

We also monitored the person's care during the second day of the inspection and noted that the person's care plan was not followed by staff. We saw that the person was sitting propped up in bed, or lying on their back for most of the time that we were in the home. We visited the person in their room in the afternoon and asked how they were. They told us that their back and bottom hurt.  We alerted a staff member to this.

One person had nine falls in 2015. There was no evidence to suggest that staff sought help or advice about managing the risk to the person from healthcare or other professionals, such as the falls team.

In another example, one person's records reflected that they had previously suffered from pressure sore on

their sacrum. This had successfully healed. However, we saw that they spent a lot of time sitting in the same position, on a hard dining chair and staff did not encourage them to move around or sit elsewhere. We discussed this with the manager, who told us they would ensure that this issue was addressed with staff, as a matter of priority.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us that the food was very good. One person said, "The food is lovely. In fact I think it's too good, and there is such a lot. I worry about there being stuff wasted."

We observed lunch on the first day of the inspection. There were 12 people in the dining room with just one staff member, who was going in and out of the kitchen bringing meals on plates. It was evident that most people were able to eat unsupported. However, one person's visitor was assisting their relative to eat. They said," [My relative] has started to be a poor eater. I think they sometimes forget that the food is there." The visitor left the room for a brief period, and during that time the person made no attempt to eat. No staff intervened to encourage them to eat.

With the exception of the staff member who served food, there were no other staff members in the area and there was no conversation or social interaction during the meal. People ate in silence and once they had finished, they went back into the lounge. The menu board showed two options of main meal, and people were asked to choose, by the cook in the morning. We were told that people could have a choice if they did not like either option. However, everyone had chicken casserole, with mashed potatoes and vegetables and no alternatives were offered at the mealtime.

We also observe people having lunch in the dining room on the second day of the inspection. On this occasion, there were enough staff to attend to people's needs and staff interacted positively with people.

Each person's file included screening and monitoring records to prevent or manage the risk of malnutrition. For two people the assessments to determine the risk of poor nutrition were not correctly calculated, to show the relevant risk or what action needed to be taken. Additionally, there was not always evidence of external input from healthcare professionals in relation to people's nutrition. For instance, we looked at the records for one person, who was underweight. The headline of person's care plan stated that they had a good appetite, had the capacity to choose their meals from the menu and did not require support with their food. We saw however, that there was updated information provided in the monthly reviews of their plan. This reflected that the person's appetite was deteriorating and often fluctuated, along with their mental capacity, as their dementia progressed. We observed the person throughout the inspection and spoke with one of the cooks and a number of care staff about their nutritional needs. The staff told us the person took a long time to eat and often did not eat their main meals. They preferred puddings and sweet things.

We saw that the person spent a large part of their day sitting at a dining table. Staff did, periodically encourage them to eat and provided a pudding, a biscuit and a drink. The weight monitoring record in the person's file indicated that they had steadily gained very small amounts of weight. Although they did not consistently indicate the quantities of the food the person ate, the food monitoring records showed they were mainly subsisting on sweet things. This left the person at risk of receiving a diet based, primarily on high sugar foods and lacking in any balance, vitamins and minerals. There was no evidence to suggest that staff sought help or advice about managing the risk to the person from healthcare or other professionals, such as dietetic services. There was no indication that these records had been monitored by members of the management team, and these issues had not been identified.

One person's records reflected that they had previously suffered from dehydration and staff had kept monitoring records of what they drank. However, we found that way the forms were set out made it difficult to monitor the quantity of fluid that the person had to drink, as there were no overall totals for each twenty four hour period. No information was included about how much fluid staff should aim to encourage the person to drink.

The current best practice guidance for hospitals and healthcare services from the national patient safety agency states that, although there is no agreed recommended daily intake level for water in the UK, a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day. We found no occasions when the person had received more than 1litre of fluid in a twenty four hour period. In most instances the record showed that they had received 800mls or less. Again, when we discussed this with members of the management team, it was clear that they had not monitored these records or identified these issues.

Over the two days of the inspection we met two cooks. Both were aware of people's diets and their preferences relating to food. On the first day of the inspection we asked one cook if the menus had been devised with the advice of a dietician and they were not clear if this was the case.

On a trolley in the dining area there were jars with sweets and biscuits in. There was a notice saying that these were for people who used the service and their visitors. We did not see any fresh fruit offered to people, although a number of people had hot drinks and biscuits throughout the day. We asked one cook where the fresh fruit and vegetables were stored and were told that frozen vegetables were used for all main meals. The cook explained that fruit used to be left out for people to take when they wanted, but that one person kept biting it. This led to it being put away, and it was now brought out at regular intervals and offered to people. They showed us a cardboard box in the store room, which had a small amount of fruit in, the majority of which was overripe.

This is a breach of Regulation14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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. Some people who lived at the home were not always able to make important decisions about their care due to living with dementia and some people's capacity varied from time to time.

We saw some care records had a generic best interest decision covering all aspects of people's care. This was not in line with the Mental Capacity Act 2005 which informs that best interest decisions should be time and decision specific. We spoke with the manager about this and were told that this was to be updated and replaced with new forms, and henceforth, each decision would be recorded separately.

The home provided support to people living with dementia. There was a lack of appropriate arrangements for supporting people with fluctuating capacity, as the service did not have arrangements in place to make sure that people living with dementia had their mental capacity needs met. We saw very little guidance on

how to support people to make decisions or give consent included in people's care records. Some people's mental capacity assessments indicated that they had fluctuating capacity, without indicating the best time and way to support them.

There were instances where people's relatives had signed consent forms for people's care. This is not in line with the MCA, which states that a person's relative can only consent to care for someone if they have Lasting Power of Attorney (LPA) for care and welfare and/or finance. There were no, clear records available to identify if any lasting powers of attorney were in place, or what legal authorisation a relative may have to act on behalf of their family member.

We saw that there were shared bedrooms. We asked one person if they had chosen to share. They were very clear that they had. They said, "I really like to share with someone else. I don't like to be on my own."

We looked at the records for the other person who shared this room. There was a written note to say that this person did not have capacity to make the decision to share, and their relatives had agreed on their behalf. There was no capacity assessment in relation to this decision and insufficient documentation to evidence this decision had been made in this person's best interests. There were also no appropriate arrangements in place to ensure that this decision was reviewed, to consider whether it remained in the person's best interests. It was unclear from the records we saw whether the person's next of kin had the authority to make decisions, or consent on their behalf.

There was no evidence in one person's records that the person consented to their care at all. In other cases, the records in relation to people's capacity to consent were contradictory. For instance, there was a DNAR form on one person's file. A DNAR form is a document issued and signed by a doctor, which tells medical teams not to attempt cardiopulmonary resuscitation (CPR). The DNAR clearly stated that the decision had not been discussed with the person as they lacked capacity, so their next of kin had been consulted. We were unable to find any records of a best interest meeting or capacity assessment prior to the development of the DNAR. As such, this significant decision had been made without making sure that a person's rights were maintained. There was a form to consent to the person's care, which the person had signed. There was another consent form, relating to other aspects of their care, which had been signed by their next of kin. It was unclear from the records we saw whether the person's next of kin had the authority to make decisions, or consent on their behalf.

There was a poster in the staff office which provided guidance about the principles of the MCA, including using the least restrictive approach. However, we saw very little written evidence of the best interests process having been followed where there were significant risks to people. For instance, when bed rails were used for one person, and where another person was at risk while using the stairs. We also noted that staff were verbally restraining particular people, by often telling them to sit down when they wanted to walk around. Although this was done with the best of intentions, with the risk of people falling in mind, it was a form of restraint.

Not all staff we spoke with during our inspection had received training about the Mental Capacity Act (MCA). Staff members' understanding of the MCA was inconsistent, with some staff being able to explain how to support people, whilst others demonstrated a limited understanding, particularly in relation to people living with dementia.

This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The manager was aware of the correct procedures to follow and told us that the provider had made appropriate applications under the DoLS process. There was a DoLS authorisation for one person and the appropriate paperwork was in place.

The provider had taken some steps to identify and implement environmental improvements to improve for people living with dementia. Some effort had been made to make the décor more attractive and to provide landmarks, and some memorabilia artwork on the walls. However, most areas were decorated in the same light colours, which made the corridors bathrooms and toilets feel stark and institutional. Although there were light and airy areas, there were also some areas, particularly corridors, which were gloomy and ill lit. There was some signage to enable people to find toilets, bathrooms and bedrooms. However, there could have been more use of contrasting colours to help people to orient themselves and distinguish things like light switches. And more use of names, accent colours or memory boxes to help people identify their bedrooms.

Although there were various lounges for people to spend time in, during the inspection most people spent their time sitting in one or two of the lounges. Strong patterns had not been avoided in carpets. Some people were able to have access to outside space independently, but not everyone. One person told us they would like there to be more, sheltered seating areas in the garden. There were some uneven surfaces, which could pose trip hazards, and generally, the garden could have been designed better to encourage engagement and activity.

We saw that menu choices were not displayed very well. For example, the menu board was quite small and hand written in chalk, rather than using pictures of the food on offer, to help people living with dementia to relate to them. Not everyone had independent access to drinks, or snacks and finger food. There were some sweets and one or two biscuits available in the dining area. However, the jars were difficult to open and we did not see anyone take any. We saw no small, wrapped snacks, (healthy or otherwise) fruit or drinks that people could choose with any degree of independence.

We spoke with staff who told us that new starters shadowed experienced staff as an introduction to their role. They told us they felt confident in their role and felt staff worked as a team. Another staff member described induction to us. They said, "New staff have to shadow another staff member for three days and then we keep an eye on them for about a month. Most of them come with certificates for moving and handling and that sort of thing, because they've worked in other homes."

One of the healthcare professionals we spoke with told us that staff were very committed to people's welfare, always obliging and always keen to learn. We asked staff about training opportunities. Most staff were very positive about the training provided to them. One staff member told us, "We are always being sent on training. There is too much. I've had to do first aid training and challenging behaviour training."

We saw that not all staff had a good understanding of the Mental Capacity Act 2005(MCA), or of working positively with people living with dementia. The manager told us that staff were undertaking MCA training and dementia awareness training with Rotherham Council. Six members of staff had completed dementia awareness and three members of staff had completed MCA training. The manager said this training was on-going, until all staff members had completed both sessions. There was evidence to suggest that some training had not been effective. Not all staff had a good understanding of infection control, in that they failed to recognise the fact that many areas of the home were dirty and did not recognise the risks associated with supporting people to use the stairs.

Staff confirmed that they received supervision sessions and appraisals. Staff supervision is a one to one meeting between the staff member and their manager, intended to provide staff with regular support and guidance. Appraisals are designed to enable staff to discuss any personal and professional development needs. We saw records that staff had received some staff supervision and had annual appraisals. However, staff supervision was intermittent. One staff member said, "We get supervisions every six months." We asked if the staff member thought that was sufficient and they replied "Oh yes. We all know what we're doing." We discussed these issues with the manager, who told us they had set up a system to make sure staff supervision was undertaken more regularly.

Requires Improvement

# Is the service caring?

## Our findings

The majority of people we spoke with said the staff were nice. For instance, comments included, "Yes, they are very caring and they work hard for us." and, "I am very fond of them." However, one person told us, "80% of the staff are marvellous, but there are some who treat me like a child. Some have a bad attitude."

One health care professional we spoke with said they found the staff very kind and gentle in their approach. They said there was a nice, homely atmosphere in the home. They said the staff were tolerant and obliging, and sometimes had success in working with people, when other services had not. They said that one person in particular had settled very well in the home, and was more alert. They added that they had noticed that person looked well cared for, and wore their jewellery and nicely coordinated outfits.

Overall, the staff we observed were kind and compassionate and we did see some warm interaction between staff and people who used the service. People we spoke with said their visitors were welcomed into the home, and as people's visitors were coming in and out, we saw that staff knew them and that they were made welcome. One health care professional we spoke with said they received very positive feedback from one person's relatives, who were very pleased with the way the person had settled in the home.

Most staff we spoke with had been working in the home for some time and knew people well. While we saw that staff were gentle in their approach to people, some staff did not have as much confidence and skill as others, in working with people with more complex communication needs, related to living with dementia.

Whereas people told us they were involved in the overall planning of their care. We noted some instances when people were not offered choices or encouraged to be as independent as possible. For instance, we noticed that there were locks on people's bedroom doors, of the type that allowed staff to gain entry if the door was locked. However, we saw all the bedroom doors were unlocked, regardless of whether the person was spending their time elsewhere in the home We discussed whether people had their own keys to their rooms with the deputy manager, who said, "I have worked in the home for a long time and have never seen anyone be offered a key to their room when they were admitted. There would not be enough keys available to do that." This also meant that people's rooms not protected against other people going into them.

Some people living in the home told us that they had limited or no input into deciding on the activities or the times of meals. One person told us, "Nobody has ever asked me when I would like my meals." Another person said, "They sometimes have a singer, but they just book that."

We heard one cook asking people which choice of meal they wanted for the following day. The main meal was in fact the same, but with a choice of dumplings or Yorkshire pudding. In another instance, one person said they were hungry and asked for something to eat. The cook responded that it was lunch soon and offered the person a drink instead. Another staff member intervened at this point. They told us that the person was usually given a snack when they asked. They went and fetched a scone. However, they did not offer any options, or check if it was what the person wanted.

People told us that they could get up and go to bed when they wanted. However, during the afternoon, one person told us, "I don't feel very well today. I feel worn out and I'd like to have a lie down." We told a nearby staff member that the person wanted to go to their room for a rest, but the person's request was not acted upon. We saw the person some time later, half asleep, slumped uncomfortably in their chair.

We looked at how the staff supported people's dignity. All the people we spoke with had appropriate clothing on and looked well presented. Observations showed us that people were addressed appropriately. We saw and heard some staff and people using the service chatting and laughing about different things. This indicated that people felt comfortable with the staff on duty.

Personal care was undertaken behind closed doors in order to preserve people's dignity and staff knocked on doors before entering. However, in contrast to this we saw an instance, where there was less thought about people's privacy and dignity. For example, some people were sharing bedrooms. In one room we saw a small and flimsy, portable screen, which would not have adequately maintained a person's privacy when receiving care. One bedroom was very near to the main front door. The bedroom door was left open the majority of the time so people could be seen in their night clothes from the corridor by the front door.

Some of the written information on display was in an accessible format and had pictures to assist with people's engagement and understanding. One notice board displayed advice on how to contact a local advocacy advice, a service user guide, food allergy information and the complaints procedure. However, on one day of the inspection we saw that people's dining experience was not inclusive or supportive.

The food choices were written on a chalk board on in the dining room. Several people were not able to read the board. There were no picture cards displayed to help people make choices. Additionally, the menu board was not been updated from the day before and there was a large calendar on the mantelpiece which was still showing the previous day and date. This is not helpful for people with memory loss.

Requires Improvement

# Is the service responsive?

## Our findings

Most people told us they were very happy with the care they received and people's relatives were complimentary about how well the staff looked after people. We saw that people received personal care which was generally responsive to their needs and most people had a 'life history' completed to help staff understand more about the person and their experiences. However, this was because most staff knew people well, rather than because people's care was well planned. We saw that staff tended to rely on word of mouth to learn about people's needs and preference and to keep track of any changes required in people's care.

We saw plans for areas such as, personal care, mobility, night care, nutrition and diet, well-being and spirituality, behaviour, falls and moving and handling .The care plans were evaluated on a monthly basis. However, this was not always effective, as there were a small number of instances when it was not picked up that changes in people's needs indicated that new plans and risk assessments needed to be put in place, as described under Safe and Effective in this report. This was particularly the case for one person, whose needs, including their communication needs had changed, due to their advancing dementia, and whose mental capacity sometimes fluctuated.

The review format of the care plans was confusing and open to error. The headlines of the care plans were not updated, so they remained the same and did not reflect when people's needs had changed. Updated information about people's needs was recorded in the review section of their plan, along with some detail about the way they needed to be cared for. This left room for confusion and meant that staff, particularly those who were less familiar with people's needs, had to read through all of the monthly reviews to be sure they were up to date. In some cases this was several pages.

We asked people if they felt involved in the planning of their care. We were told they did. People's visiting relatives also told us that they were felt involved. One relative said, "I am here every day and am very involved."

One health care professional told us that when they visited the home they saw that people were often engaged in different activities. They added that they had visited recently and people were singing along to old time songs. People relatives we spoke with told us there were some activities when they visited, but not always. One relative said, "When there aren't, I put it down to staff shortages."

We saw very few activities on offer, and a poor level of engagement and stimulation for people. On the first day of the inspection a hairdresser was doing some people's hair in one of the lounges. On the second day a reflexologist visited. These were listed, on the activity board in one lounge, as the sole, planned activities for the two mornings. However, these activities did not include or involved most people in the home, so people were left just sitting, or dozing in their chairs for most of the day.

People we spoke with told us there was not much to do apart from the television or music. One person said, "We occasionally have somebody come in to sing to us, but I think that was at Christmas." Another person

told us they had a hobby they were not supported to follow. They said, "I'd love to go outside, but I need somebody to come with me and they won't take me." We discussed this with the manager who assured us that the person did take opportunities to go out, with staff support.

We asked people whether there were any activities to do. Several people told us they were perfectly happy to sit with others in the lounges, and to join in the conversation when they wanted to. However, some people said there were not enough activities, such as card games or dominoes and the comments we received included, "You'd be lucky.", "Nothing happens here. Let's face it, we're all just waiting for God.", "I get fed up just sitting in here (in the lounge). They bring us in because they don't like us staying in our own rooms, but it's horrible in here. It needs brightening up. It's miserable.

Some people we spoke with spent a lot or most of their time in their bedrooms. They, said staff rarely had time to spend with them, unless performing care tasks. One person said, "I watch my TV in my room. That's all I do. There's nothing else to do. I like my own company, so I stay in here with my TV."

Staff we spoke with told us there was no staff employed specifically to provide or coordinate activities for people and it could sometimes be difficult for them to find time for activities with people. During our visit there was music on in some lounges and some people watched TV, or read newspapers. We saw one staff member actively engaging with people and dancing with one person, but for the most part, when staff had time to engage with people in the lounges, this was taken up with tending to people's requests for drinks and or other requests. There was therefore, a lack of stimulation and some people's social and intellectual needs were not being met, particularly those living with dementia.

The level of staffing support available did not provide for people's rights in relation to their social and intellectual needs, or allow people sufficient freedom to go out into their local community.

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

We saw there was a system in place to address any complaints that arose. This included a complaints procedure which was displayed in the home. However, not everyone we spoke with who used the service knew what they would do if they wanted to complain.

However, the relatives we spoke with told us they would speak to the staff or the manager. They said they had no concerns. The manager told us that there had been no complaints or concerns raised since they had been in post. They were unsure where the previous record was kept. Therefore, we were unable to review how many complaints had been received, or how they had been dealt with by the provider.

Inadequate

# Is the service well-led?

## Our findings

At the time of this inspection the service had a new manager, who commenced in post before Christmas, and they were not registered with the Care Quality Commission. 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 manager was supported by a deputy manager and a team care staff. The manager was supernumerary, whereas the deputy worked as part of the care rota. All the staff and relatives we spoke with spoke positively about the manager and deputy manager.

One person's relative told us, "They were without a manager for a while. After the last one left, the owner was here to cover. I asked them when there would be a new manager and they said that it was important that they got the right person, who fitted in with the culture here."

We asked staff if they felt the change of leadership would make a positive difference. One staff member said, "Well, nothing needs changing really. I mean, there are always little things but nothing major." These sentiments were also echoed by the new manager and the operations manager. However, during the inspection we had found areas for concern in relation a number of areas of the way the home was run.

There had been some disruption in the management of the home, as the previous manager, who was in post for approximately a period of a year, had left in September 2015. We saw various audits been used to make sure policies and procedures were being followed. This included health and safety, infection control, care plans and medication. However, these had not always been carried out consistently by the management team or provider, since the previous manager had left.

The medication audit had proved effective, as a discrepancy had been picked up and addressed by the medication audit process. On the second day of the inspection we saw the records of an infection control audit for January 2016 when issues had been identified. However, we saw no evidence that follow up action had taken place to address the issues.

We identified a number of areas of concern that had not been identified by the management audit processes. These concerns included the cleanliness, infection prevention and control in the home, concerns about the way that risks were managed. Risks to people's health, safety and welfare were not appropriately managed and analysed. For example, we found that falls were not adequately analysed to determine the cause, to help prevent them from reoccurring. This put people at potential risk of harm.

We saw that mattress audits were not undertaken with sufficient frequency. Additionally, one audit, from December 2015, had recommended that a mattress be replaced due to staining. No one could tell us if this had happened. The new manager told us they had started care plan audits. However, again, the majority of issues we identified with people's assessments and plans had not been identified by the home's audit

processes. For example, some people did not have the appropriate risk assessments in place to ensure they were provided with safe care. This put people at potential risk of harm.

One care plan audit we saw from December 2015 had found that there was no 'life history' or records of consent on one person's file. We saw that this had not been rectified at the time of the inspection. We saw that people's daily care records such as for their diet, hydration and pressure care were not reviewed by managers to ensure people were receiving the appropriate standard of care, or in order to improve people's care experiences.

Guidance of the Mental Capacity Act and its Code of Conduct were not followed and there was a poor level of engagement and stimulation for people. This did not met people's individual needs, and showed that most of the audits undertaken in the home had not been effective. Maintenance was reactionary and there was no planned programme for improvements. We discussed these issues with the manager, who told us they intended to implement new cleaning and maintenance systems, to ensure standards improved for people.

We saw evidence that people had been asked to comment on the quality of the service provided. Although it was not dated, people's feedback was displayed on a notice board and the majority of responses were positive. However, we saw no evidence that an action plan had been developed to address the areas identified for improvement. For example, 14 people wanted more or better activities. No action plan or response had yet been drafted.

A number of staff told us they had worked in the home for five or more years, and they loved working in the home. They said they worked well as a team. They told us they attended staff meetings. They said they could voice their opinions at the meetings and they felt they were listened to. However, we saw negative feedback from staff via the staff questionnaire from December 2015. This included the staffing levels, the management of the service, and the support staff received. There was no evidence that this had been acknowledged, or acted upon in a timely way, although the operations manager told us that the providers intended to produce an action plan in response to the feedback that they had received.

The provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The service was not always meeting the requirements of the Mental Capacity Act (2005) (MCA) and associated guidance.<br><br>Care and treatment was not always provided with the consent of the appropriate person. This is a breach of Regulation 11 (1),and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>People were not supported to have a balanced diet that met their needs. This is a breach of Regulation14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Meeting nutritional and hydration needs) |

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not always take the necessary steps to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This is a breach of Regulation 12 (1), (2) (a), (b), (c), (d), (e), (h) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. This is a breach of Regulation 17 (1), (2) (a), (b) (c), (e) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance). |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not have suitable arrangements in place to ensure that there were enough staff, who were suitably qualified, competent and skilled in order to meet the needs of people living in the service.<br>This is in breach of Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing). |

**The enforcement action we took:**

Warning Notice