Viewpark Care Home Ltd

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Inspection report

685 Moston Lane
Moston
Manchester
Greater Manchester
M40 5QD

Tel: 01616812701

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 03 and 04 January 2018 and was unannounced.

We last inspected Viewpark Care Home on 08 and 09 August 2017 when we rated the home inadequate overall. At that inspection we identified multiple breaches of the regulations, and ongoing and serious concerns in relation to the provision of safe care and treatment. The service was rated inadequate and remained in special measures. At this inspection, whilst we again found evidence of some improvements, these were limited in scope and the provider had not adequately addressed other concerns. We found the provider was now meeting the requirements of the regulations in relation to submitting statutory notifications, care planning and assessment, and safe staffing. However, there remained ongoing breaches of the regulations that meant the provider continued to put people's health and wellbeing at risk.

We also identified new breaches of the regulations and found previous improvements had not always been sustained. For example, we found repeated breaches in relation to safeguarding and acting in accordance with the Mental Capacity Act. These areas were found to be in breach at out inspection in November 2016, but were compliant at our last inspection in August 2017. We identified multiple breaches of the regulations at this inspection, which were in relation to assessing and mitigating risks to people's health and wellbeing, the safe management of medicines, safeguarding procedures, supervision of staff, consent, deprivation of liberty safeguards, good governance and acting openly and transparently. We will update the section at the end of this report to reflect any enforcement action taken once it has concluded.

Viewpark Care Home Limited (Viewpark) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Viewpark accommodates up to 27 people in one adapted building. Bedrooms are located on two floors, with a passenger lift between floors. There are two dining rooms, two lounges, and a conservatory. The home is situated in a residential area of Moston in north Manchester. At the time of our inspection there were 17 people living at the home.

At our last inspection we found staff were not following the advice of a professional and were providing food and drinks of an incorrect consistency. This had placed this person at risk of harm through aspiration or choking. Although staff had received training in relation to supporting people to eat and drink, we found staff were still not aware of, and were not following the correct guidance for this person. This meant this person was being placed at ongoing risk of harm.

There were sufficient staff on duty to meet people's needs. The provider had increased staffing at night from two to three staff. This was due to concerns raised at our last inspection in relation to the support available to evacuate people in the case of an emergency and concerns raised by the local authority relating to the supervision of people at risk of falls. The local authority had placed a block on any local authority funded admissions to the home. This meant the home was not operating at full capacity.

We found ongoing issues in relation to the safe management of medicines. Staff did not always monitor the temperatures that medicines were stored. When temperatures had been monitored, there was a lack of evidence to show the appropriate actions had been taken if temperatures had exceeded manufacturers recommendations. This meant there was a risk these medicines might not work as effectively. The administration of medicines was not always accurately reflected on the medication administration records (MARs).

We found shortfalls in actions taken to ensure the safety of the premises. We found an action identified in the home's fire risk assessment to ensure combustible materials were not stored on the dryers had not been acted upon. We also found the provider had not obtained a required safety check of the passenger lift. They arranged for this to be carried out during our inspection after we made them aware of this issue.

There were not robust procedures in place to ensure staff employed were of suitable character. We saw two staff members had recorded convictions on their criminal records checks. There was no recorded rationale as to why the provider felt these staff were of suitable character despite these convictions. There were also no risk assessments in place that could demonstrate that consideration had been given to any potential measures that might reduce potential risks to people using the service that the presence of these convictions might indicate.

There had been a recent break-in at the home where the home's safe was stolen. The provider had not replaced the safe after several weeks, meaning people's money was not always kept as securely as it could be. Staff were not following the home's financial procedures policies and people were at increased risk of financial abuse as a result.

People told us they enjoyed the food on offer. We saw people were offered a choice of meal and received encouragement and assistance to eat their meals. Good practice in relation to supporting people in a person-centred way over meal-times had been given by the registered manager. Staff had made referrals to dieticians or a person's GP when they identified people might be at risk of malnutrition.

People living at the home were positive about their relationships with staff who they told us were kind and caring. We saw staff had time to meet people's needs and interact with them socially. However, there were also missed opportunities for staff to engage with people and to set up activities.

Staff understood the importance of respecting people's privacy and dignity. There had been issues at the home with staff passing on confidential information about people using the service to other people outside the home, including former staff. The provider had addressed these issues with the staff team and asked them to sign to say they understood the policies on confidentiality and social media use.

The provider had submitted deprivation of liberty safeguards (DoLS) applications for all people living at the home. However, this was not appropriate as at least one person had mental capacity. This meant they were at risk of their liberty being restricted unlawfully. The provider was not always acting in accordance with the Mental Capacity Act 2005.

Care plans led staff to complete comprehensive assessments by following a check box process. Information was also recorded on how to meet people's needs, along with details about their interests, preferences and social histories. However, this information was recorded with a variable degree of detail. People were not aware of having been given opportunity to be involved in developing or reviewing their care plans, and there was no documentary evidence of such involvement.

The home had employed an activities co-ordinator for two days per week since our last inspection. Although we saw limited activities taking place during the inspection, people gave us positive feedback about the activities on offer. We saw past activities had included visits from entertainers and baking sessions. Staff helped protect people from social isolation by running events such as buffets and meals for people's birthdays and Christmas. They also encouraged interaction between people by setting up games people could play together.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since our last inspection, the deputy manager had left, and the registered manager was now supported by a 'team leader'.

There had been multiple whistleblowers to CQC and the local authority since our last inspection. Issues raised included concerns about the registered manager's treatment of staff. Staff during our inspection told us the registered manager was approachable and supportive. However, we also found evidence that supported whistleblower claims that the registered manager did not always treat staff with respect. Although the provider was in regular contact with the registered manager, there had been no formal supervision provided to them, despite ongoing concerns being raised about the service.

The provider was unaware of their responsibilities in relation to the duty of candour, which requires services operate in an open and transparent way. We also received evidence that staff within the service had not always acted open and transparently in relation to issues arising in the service.

The systems in place to monitor and improve the quality and safety of the service were not effective. They had not ensured that all previous improvements had been sustained or that the provider was meeting the requirements of the regulations. We identified ongoing issues from previous inspections and ongoing breaches of the regulations.

This is the third consecutive time that the overall rating for this service has been 'Inadequate', and the service remains 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

The service had repeatedly put a person at risk of harm by providing foods and fluids of the incorrect consistency.

Procedures to help keep people's money safe that was managed by the home were inadequate. This put people at increased risk of financial abuse.

We identified ongoing concerns in relation to the safe management of medicines.

The provider was unable to demonstrate they had given adequate consideration to the suitability of staff recruited.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not acting in accordance with the Mental Capacity Act and Deprivation of Liberty Safeguards. This put people at risk of unauthorised deprivation of liberty and decisions not being taken in their best interests.

We received positive feedback about the food provided. People received encouragement and support to eat and drink as required.

People told us they were supported to see a GP or health professional if they had any health concerns. We saw appropriate referrals were made to professionals such as dieticians.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff knew people living at the home well, including information about their preferences, likes and dislikes.

There had been issues with staff discussing people's care inappropriately, including with former employees. The provider

had reminded staff of their responsibilities in relation to handling confidential information.

We saw staff had time to spend interacting with people socially. However, we also identified there were missed opportunities for staff to interact with people or facilitate activities.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care files contained variable levels of detail about their preferences, social histories and care needs.

People told us they were not always involved in developing or reviewing their planned care.

Staff helped prevent social isolation by encouraging interaction between people living at the home and holding social events.

Is the service well-led?

Inadequate

The service was not well-led.

Systems and processes to ensure the quality and safety of the service was monitored and improved were not effective.

Staff within the service had not always acted in an open and honest way in their handling of incidents. The provider was unaware of the requirements of the duty of candour regulation.

Staff told us the registered manager was approachable and supportive. However, we also saw evidence that staff were not always treated with respect.

Viewpark Care Home Limited

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.

This inspection took place on 03 and 04 January 2018 and was unannounced. The inspection team consisted of two adult social care inspectors, a medicines inspector, and an 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 care service.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider was required to send us in relation to serious injuries, safeguarding and other significant events that can occur whilst providing a service. We reviewed feedback we had received about the service, which included information from whistleblowers and relatives of people using the service. Feedback received from people's relatives was both positive and negative in nature. The feedback from whistleblowers led to us exploring how the service manage medicines safely, how they protected people from the risks of financial abuse, and the services procedures in relation to whistleblowing and supporting staff.

We contacted Healthwatch Manchester, and the local authority commissioning and quality monitoring team for feedback prior to the inspection. The local authority shared concerns with us in relation to the performance of the service, which we have reflected in the main section of this report. They also confirmed the local authority currently had a block on admissions to the service due to concerns they had about its quality and safety.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service

does well and improvements they plan to make.

During the inspection we spoke with eight people living at the home. We also spoke with nine relatives or visitors who were at the home at the time of our site visit. We carried out observations of the care and support staff provided in communal areas. We spoke with six members of staff. This included one of the directors of the service, the chef and four care staff.

We reviewed records relating to the care people were receiving. This included daily records of care, medication administration records (MARs) and eight people's care plans. We looked at other records related to the running of a care home, including; five staff personnel files, records of training and supervision, audits and quality assurance checks, and records of the servicing and maintenance of equipment, utilities and premises.

Inadequate

Is the service safe?

Our findings

At our previous two inspections in August 2017 and November 2016, we found the home was not adequately assessing and reducing risks to people's health, safety and wellbeing. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified ongoing concerns in relation to practices at the home that put people at risk of harm.

Staff were assessing risks to people's health and wellbeing in relation to a range of areas. This included malnutrition, pressure ulcers, choking, absconding, falls, moving and handling and specific health conditions. Care plans and risk assessments detailed ways in which staff should reduce the likelihood of a person being harmed. We saw equipment such as pressure relieving cushions and mattresses, crash mats and pressure sensors were in place when required. However, we found staff were not always aware of, and were not always following the steps recorded in people's care plans to keep them safe.

For example, we saw that two people had been assessed as being at high risk of developing pressure ulcers. Their care plans and risk assessments directed staff to support these people to reposition every one to two hours. We asked staff whether they followed this guidance. They told us no-one living at the home required support to reposition as they used pressure relieving equipment, and were able to move about independently. The director and team leader were unclear as to whether staff supported people to reposition but did not record this, or whether people did not require support to reposition. The director told us no-one living at the home had a pressure ulcer at that time. However, there was increased risk that people may develop pressure ulcers as staff were not clear about the support people required to reposition. Whilst the provider was assessing risks relating to pressure ulcers, they were not following the steps they had identified as necessary to help keep people safe.

At our last inspection in August 2017 we found staff were not following guidance from a speech and language therapist (SaLT) in relation to the consistency of drinks a person received, and the consistency of the food they were given. Following us raising these concerns, the registered manager had arranged for staff to attend training on the safe use of drink thickeners and had arranged for a reassessment of this person's needs by the SaLT team. The outcome of the re-assessment was that staff should continue to follow the guidance of providing a puree diet, and custard consistency fluids.

On the first day of our inspection we asked a member of staff how they made up this same person's drinks. We found they were following incorrect guidance and were continuing to make this person's drinks up to the incorrect consistency. Despite us raising this concern with the director, on the second day of our inspection we again found staff had made this person's drink up to the incorrect consistency. Their intake record also documented that staff had given them foods of an unsuitable texture that would put them at risk of aspirating or choking. The provider had failed to take effective action in relation to this known risk. This had placed this person at ongoing risk of serious harm. We raised a safeguarding alert with the local authority in relation to these concerns.

This was an ongoing breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to assessing and managing risks.

At previous inspections in August 2017 and November 2016 we found the home was not managing medicines safely. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements were still required to protect people from the risk of harm from medicines.

The home used an electronic system for stock control and recording medicines administration. This system had been introduced shortly prior to our inspection in August 2017. The director told us the home was moving back to using paper records from the Monday following our inspection. They told us this was due to issues they had found with the way the electronic system recorded medicines administration. We found staff had recorded the medicines people had received, and there were no 'gaps' in the records. However, staff had not kept records in relation to the use of thickening agents used to thicken the fluids of people who had swallowing difficulties.

We checked a sample of people's medicines and found all the medicines they needed were in stock. Medicines could be accounted for by comparing the amount of medicine received from the pharmacy and stock checks by the home's staff with the administration record. We checked one person's medicines and the number of tablets remaining matched their record apart from a discrepancy of three 'pain relief' tablets that were prescribed to be taken when required. This meant the records of administration were not accurate in relation to the administration of this medicine.

We watched the senior carer administer medicines in the afternoon. They gave people their medicines in a safe, friendly and respectful way. Protocols (extra written guidelines) were in place for some people prescribed a medicine 'when required'. When people were prescribed a painkiller 'when required' the type or site of pain to be treated was not specified in the protocol. This could result in staff giving pain relief tablets inappropriately instead of seeking medical advice. Two senior staff we spoke with were unaware of guidance left in the home by district nurses concerning the urgent care one person might need in relation to diabetes.

Three people were prescribed moisturising creams that were applied by carers. We looked at their cream charts and saw that the creams were applied once a day. The creams had no pharmacy label so we could not tell if they were being used in the way prescribed. This meant people's skin might not be cared for properly. Carers were applying one person's steroid cream without supervision or full instructions. Other medicated creams were kept in the medicines trolley and applied by senior carers. People prescribed skin patches containing pain relief medication had a paper application record chart as well as their MAR. We found this chart was not completed properly.

Medicines were stored safely. However, the home could not show us evidence that the cupboard used to store controlled drugs met legal requirements. Controlled drugs (CDs) are medicines subject to stricter legal controls because they are liable to misuse. Staff checked the stocks of CDs regularly. We checked the controlled drugs and found that stock balances were correct. There were no records of daily temperatures in the two rooms where medicines were kept. Records stated that the maximum daily temperature inside the medicine refrigerator exceeded that recommended by manufacturers throughout December. Medicines may be less effective or unsafe to use if they are not kept at the right temperature.

These issues were an ongoing breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

People living at Viewpark told us they felt safe living at the home, and said that their belongings and money were kept safe by staff. One person told us, "Being with other people and not all by myself makes me feel safer, my money is kept safe by staff." Since our last inspection the provider had not notified CQC of any incidences of alleged abuse occurring at the home. However, both CQC and the local authority had received concerns from whistleblowers that had led to multiple safeguarding enquiries, which were ongoing at the time of this report being written. Some of the concerns raised had however been substantiated, such as an allegation that staff had 'drag lifted' a person. Drag lifting is an unsafe technique used to support a person to transfer, which places them at risk of injury. The registered manager had taken appropriate actions, such as arranging for a refresher in moving and handling training as a result.

Staff we spoke with during the inspection told us they would feel confident approaching either the registered manager or directors to raise any safeguarding concerns they had, or to whistle-blow. We saw staff had previously raised concerns with the directors and that they had carried out appropriate investigation of any concerns raised in response. We noted that care staff had completed safeguarding awareness training held by the local authority. However, other staff, such as domestic staff had not completed this training. It is good practice for all staff that have contact with people who may be vulnerable to undertake safeguarding awareness training. This is so they have the knowledge and confidence to report any safeguarding concerns through the right channels, according to the home's policy and in line with local authority safeguarding procedures.

Care staff were aware of, and able to tell us how they would identify and report potential abuse or neglect. We also saw that safeguarding was a regular agenda item on team meetings, which would help staff maintain an awareness of the importance of recognising and reporting any concerns. Despite this, we found procedures in place to help prevent abuse occurring were not always robust.

Prior to our inspection the provider had notified us of two attempted break-ins, and a recent successful break-in at the home in December 2017. During the break-in the home's safe containing people's money, which was not secured was taken. We had also received a number of concerns from whistleblowers alleging poor practices in relation to the management of people's finances, and potential financial abuse. These concerns were shared with the local authority safeguarding team, and the police where appropriate. Safeguarding enquiries were ongoing at the time of writing this report.

Whilst we did not find any evidence to indicate people had been financially abused, we found procedures in place to protect people's finances were poor. The provider was not following procedures set out in their policy, and there were no effective checks or clear records in place that would help the registered manager or directors recognise any financial irregularities/abuse. At the time of the inspection, the safe had not been replaced and a cash tin was being used to keep valuables in. The safe was replaced on the second day of our inspection. If the provider had been following their stated policy there would have been significantly less cash kept in the safe that would have gone missing. The provider was also unable to confirm whether the amount taken was covered by their insurance policy, and the service user guide stated that people's valuables (including cash) was not covered against theft. The service user guide set out what fees were included and excluded in relation to people's stay at the home. Additional charges were made for activities/entertainment, transport, hairdressing and accompanying people on hospital appointments for example. We asked the director to show us records and invoices relating to these charges. They told us no invoices were produced. This meant financial transactions were not transparent and this put people at risk of financial abuse.

The provider did not have adequate systems and processes in place to identify and protect people from the risk of financial abuse. This was a breach of Regulation 13(1)(2) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

At our last inspection in August 2017, we found the provider had not acted upon advice from a third party fire risk assessor to review whether three staff were required during the night to help people evacuate the premises safely. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst the provider had made some improvements, we found ongoing issues in relation to the maintenance of safe premises and equipment, which were an ongoing breach of this regulation.

We found the majority of checks and servicing required to ensure the safety of the premises and equipment had been completed as required. For example, we saw hoists and slings had received a thorough examination, portable appliances had been PAT tested and the gas safety certificates were up to date. Whilst the passenger lift had been serviced on a regular basis, we found there had been no thorough examination (LOLER) as required to ensure it was safe to use. The director arranged for a thorough examination to be carried out during the inspection, which found the lift was safe to use.

People had personal emergency evacuation plans (PEEPs) in place that detailed the level of support people would need to evacuate the building in the case of an emergency. The fire alarm, fire extinguishers and had been serviced by an external contractor within the last year. Since our last inspection, the provider had increased the number of staff on duty at night from two to three in response to these concerns, and concerns raised by the local authority in relation to having adequate staff on duty to supervise people who were at risk of falls. The provider had obtained an updated risk assessment since the last inspection, and we found actions had been taken in relation to most of the recommendations made by the risk assessor. For example, the home had provided a wet fire extinguisher in the kitchen, and had started carrying out regular checks of the door closing mechanisms. However, staff were not consistently following other recommendations. For example, we found the door to the laundry had been left unlocked at one point in the inspection. Staff were also not following advice detailed in the fire risk assessment not to store laundry on the appliances due to the fire risk this created. We made the director aware of this concern to address with staff.

The provider had carried out the required checks prior to making staff an offer of employment. However, they were not able to evidence these checks had been used to make informed decisions about whether to recruit staff, and whether they indicated staff were of good character.
The provider had obtained references, identification and a Disclosure and Barring Service (DBS) check prior to staff being employed. DBS checks provide details on any convictions a staff member has, and helps employers make safer recruitment decisions. Staff had also completed application forms detailing a full employment history and any health issues that may need to be considered in relation to their employment. However, we found two members of staff had disclosed convictions on their DBS checks. One staff member had provided a written statement to the provider detailing the nature of the offence, which was noted as being 'read and understood' by one of the directors. There was no further information in the second staff member's file. The provider had not carried out any documented assessment as to whether the convictions meant these staff members posed any potential risk to people using the service, how to mitigate any such risks, or whether this meant the applicants may not be of good character.

The provider did not have robust recruitment procedures in place to ensure staff employed were of good character, and to consider any potential risks in relation to their employment. This was a breach of Regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were sufficient staff on duty to provide them with any care and support in a timely way.

Comments received included, "I am very happy that night staff numbers were increased from two to three. Since then, I have no issues at all, day or night", "There are always staff around, they are brilliant" and "I have experienced no shortage of staff. All my needs are always met."

The director told us there were always three care staff on the night shift, and between four and five care staff during the day. We reviewed rotas, which confirmed the level of staffing in the day was as the director described to us. However, the rota was not always updated to indicate the use of agency staff during the night. This meant it appeared as though there had sometimes been two rather than three staff on duty during the night. The director assured us that agency staff had covered these shifts, and staff we spoke with confirmed any absences or gaps on the rota were always covered.

One staff member told us they thought additional staff were required during the day due to pressures from completing paperwork and assisting people with meals. They told us additional staff would allow them to provide more activities, and support people more frequently to bathe or shower. However, during our inspection we observed there were sufficient staff on duty to meet people's needs in a timely way, including over meal times.

There was a significantly higher number of serious injuries notified to CQC by the provider in 2017 compared with previous years. The local authority had also raised concerns following our last inspection in relation to a high number of falls occurring at the service. A review of the notifications sent to us showed that most serious injuries had resulted from falls, and there was an increase in these notifications towards the end of 2017. During the inspection we saw the provider's own records indicated there was an increase in the number of falls, particularly in September 2017. Following this, the provider had arranged for staff to attend falls management training, and there had been a subsequent decrease in the number of falls occurring in the service.

We found falls and accidents were not always recorded in a consistent manner. For example, we found staff had completed accident forms that were not reflected in either the individual falls logs or the overall falls audit. This would potentially impact on the ability of the registered manager to monitor and take action in relation to falls. However, for the cases we reviewed, we found staff had taken appropriate actions when people had sustained a fall. Staff had considered the cause of any falls, and had reviewed risk assessments, and where appropriate, made referrals to other professionals such as GPs, or the falls team. For example, one person had experienced a high number of falls, and the registered manager had arranged for them to see their GP in relation to a health concern that may have been a factor contributing to the high incidence of falls.

We found the environment at Viewpark Care Home was clean and free from any malodours. Personal protective equipment (PPE) was available throughout the home, as was hand sanitiser. This would help ensure staff were able to take appropriate steps to help prevent the spread of infection when carrying out care that involved contact with people using the service. We saw the toilets and bathrooms contained cleaning checklists that had been signed off when staff had cleaned them. The home had been awarded a level four 'good' food hygiene rating at their last inspection in December 2017. Both of the two kitchen staff had received food hygiene training in 2016. However, the provider was not able to show us any evidence that care staff had completed food hygiene training. As care staff were involved in the service and preparation of food, it is important the provider ensures they understand safe food handling practices.

We recommend the provider arranges for food hygiene training to be delivered to all staff involved in the handling of food.

Requires Improvement

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 helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

At our inspection in November 2016 we found the provider had not always submitted DoLS applications when people lacked capacity and were subject to restrictive practices. Whilst we found the provider was compliant in this area at our last inspection, this improvement had not been sustained. There was evidence that the provider did not have a good understanding in relation to the principles of the MCA and DoLS.

The director told us DoLS applications had been submitted for all people living at the home. We queried whether this was appropriate and whether everyone living at the home lacked the capacity to make decisions in relation to their care. The director told us everyone living at the home lacked capacity. However, we reviewed one person's care file, which stated this person had 'full capacity'. They had also signed to consent to their planned care, and a mental capacity assessment previously carried out by the local authority found they had capacity to make a specified decision in relation to their care. The director had submitted a DoLS application for this person that stated this person could not be 'allowed' to leave the building due to having had a stroke and being unable to use a wheelchair. We discussed this concern with the director who did not understand that it was not appropriate or lawful to restrict the liberty of a person who had mental capacity to make informed decisions, including whether they left the home.

We reviewed two DoLS applications that had been authorised by the supervisory body (local authority). We found the conditions attached to these authorisations were not all being followed by the home. One person's DoLS authorisation required clear use of mental capacity assessments within this person's care plans. However, we found no capacity assessments had been completed for decisions such as to administer this person's medicines, and the care plans did not reference this person's mental capacity. The second person's DoLS authorisation required that the provider ensured the guidance of speech and language therapists (SaLTs) was always followed. As discussed in the safe section of the report, this was not the case as staff were providing food and fluids of an inappropriate texture.

The service was not acting in accordance with the MCA and DoLS code of practice, and was placing people at risk of being deprived of their liberty without lawful authority. This was a breach of Regulation 13(1)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2017 we made a recommendation that the provider reviewed their processes

for recording and reviewing best interest decisions and capacity assessments in accordance with the MCA code of practice and other relevant guidance. This was due to unclear recording in relation to the administration of covert medicines, the use of capacity assessments that were not decision specific, and a lack of best interests decisions being evident when people were unable to consent to their planned care.

We found the provider had not taken adequate steps to improve their practices and to ensure the service was acting in accordance with the MCA. Staff continued to understand some of the important principles of the MCA, such as, that decisions taken on behalf of a person should be in their best interests. Whilst blanket capacity assessments had been removed from people's care files, there was now limited or no information available as to whether people had capacity to consent to their planned care. There were no documented best-interest decisions in the care files we reviewed in relation to following people's planned care, such as the administration of medicines or provision of personal care.

For example, we saw staff did not support one person to planned healthcare appointments due to their refusal. There were reasonable grounds to suspect this person may lack capacity to make decisions about attending healthcare appointments, but there was no evidence that any capacity assessment nor any best interests decision had been undertaken. There was also no evidence this concern had been discussed with other professionals involved in this person's care until prompted by us questioning the registered manager about this issue.

The director told us they some people's family member's held lasting power of attorneys (LPAs). LPA's provide another person with legal authority to make certain decisions on their behalf when that person lacks the capacity to make them themselves. However, when asked, the provider was unable to provide us any evidence they had checked whether people had valid authorisation, or that they were aware which people had a LPA. This would increase the risk that decisions about people's care and treatment may be made without the consent of the relevant person.

The provider was not acting in accordance with the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they found staff to be competent and have the skills required to meet their needs. One person told us, "Staff are well trained, because they are looking after me very well" and a relative told us, "All I can say is that [family member] is contented and it is because staff are so good at what they do." The training matrix showed staff had completed training in subjects including moving and handling; health and safety; fire safety; safeguarding; administering of medicines; infection control and dementia awareness. We saw there were some 'gaps' in the provision of training, particularly for new staff. This included nine staff who showed as not having completed fire safety training. The registered manager told us this was because new staff completed a range of training as part of their induction, which was not reflected separately on the training matrix. Staff we spoke with told us they felt they received sufficient training to enable them to feel confident in meeting the needs of people living at the home.

Newly recruited staff completed the Care Certificate as part of their induction. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training for new care workers. We saw from the training matrix that nine staff had completed this during 2017 and a further five new staff were signed up to this at the time of the inspection. There were induction checklists in place in staff member's files that had been signed by the staff member and their supervisor to confirm that they had received essential information about the home's policies and procedures. We saw that two new senior care workers had

started at Viewpark in November 2017 and both had completed moving and handling and management of medicines training.

Staff told us they received regular supervisions, which they found useful as they provided a setting they could raise any concerns or difficulties they were experiencing. The supervision matrix showed the majority of staff had received supervision since November 2017. Records of staff supervisions demonstrated that staff were provided with feedback about their performance, which would help them reflect on, and improve their performance.

People's dietary needs and preferences were recorded in their care plans. We saw this information was also displayed in the kitchen. The chef was able to tell us how they would meet the dietary requirements of people living at the home. However, as discussed in the safe section of this report, there was evidence that staff did not always follow guidance from other health professionals.

People spoke positively about the food on offer, and told us they received plenty to eat and drink. Comments included, "I like the chef, he will do anything for you. He made me a nice cheese on toast", "I get lots of good food. Anytime I need to nibble, staff provide" and "My [family member] developed more of an appetite. There is always a biscuit and other snack. The only other thing I can say is that their cup of tea needs to be a bit stronger." Staff provided people with assistance and encouragement to eat and drink as was needed over mealtimes. Staff supported people who required assistance to eat and drink in a patient and respectful way. For example, we heard staff reminding a person what their meal was, and they sat by their side to support them. We observed that one person was reluctant to eat at one of the meal times. Staff offered a range of alternatives, with the person eventually agreeing to a yoghurt.

People told us they were supported to see a health professional such as a GP if they had concerns about their health. Records in people's care files showed there had been frequent visits from GPs, speech and language therapists, physiotherapists and podiatrists. Staff monitored people's weights monthly or weekly dependent on the level of risk indicated in their malnutrition risk assessments. We saw that when staff identified concerns about a person's weight loss, that they had made appropriate referrals to a GP or dietician.

Staff had assessed people's needs following standard assessments and checklists that made up people's care plans. These considered people's needs in relation to a range of areas, including their physical support needs, continence, mental health, sleep and social support needs. Whilst the assessments were comprehensive, we found there was a variable level of information for staff in relation to how to meet people's needs based on the outcome of their assessments. For example, one person's assessment indicated they had previously had a stroke. However, there was no further information about how this impacted the care and support staff might need to give them. However, over areas of the same person's care plans contained far more detail about the how staff should support them to meet their assessed needs. For example, staff had completed a dementia support plan that provided information on this person's preferred routines and way in which they preferred staff to support them.

Since our last inspection, the smallest of the three lounges at the home had been converted into a clinic room where medicines were kept. However, there remained adequate communal space for people using the service. This consisted of a conservatory, large lounge, smaller 'quiet lounge' and a separate dining area. There were a number of adaptations to make the environment more accessible to people living with dementia. This included different coloured bedroom doors and pictorial signs on rooms such as the lounge and bathrooms. The main corridors within the home had also been given street names, which were displayed on large signs. This would help people orientate and find their way around the home and to their

bedrooms. We saw there were 'memory boxes' outside people's bedrooms. These could be used to display small personal items, photos or other objects that would help people living with dementia identify their bedroom. However, all the boxes we saw were empty at the time of the inspection.

Requires Improvement

Is the service caring?

Our findings

People told us they had good relationships with care staff. We observed frequent friendly and light hearted conversations between people living at the home and care staff. It was apparent from our discussions with staff, and these observations that the staff on duty knew the people living at the home well. Comments we received included, "I have not been here for long, but I am happy at the way I am treated by staff. They treat everyone differently", "I am always treated with respect and compassion", "They are nice staff, they don't tell you what to do" and "The staff seem to take good care of [relative]. I wouldn't consider placing them anywhere else." We also saw evidence of recent cards of thanks from the relatives of people who had lived at the home. One read, "From the bottom of our hearts, thank-you for the love and care you have given to our loved one. You have all been absolute stars."

During the inspection we saw staff treated people kindly and with dignity and respect. We saw that staff responded promptly to people who were in discomfort, or who needed assistance. For example, one staff member responded with compassion when one person indicated their fingers were hurting. We heard them say, "[Person] where is it sore love? Is it your fingers? Show me where it's sore. I'll get [staff member] to have a look at it for you." Staff recognised another person was experiencing discomfort when supporting them to transfer from their wheelchair. They contacted this person's GP to come and review whether any additional care or treatment was required.

We observed that staff had time to spend with people to meet their needs and interact socially. However, we also observed occasions where there were missed opportunities for interaction with people living at the home. For example, we observed staff sat talking with each other in the main lounge. At this time the smaller lounge was not supervised and there was little taking place in the way of activities for people.

Staff told us they would involve people in their care as much as possible, by continually offering choices to people, such as in relation to the meals they had. They commented that it was important to remember 'it is their home'. Relatives we spoke with told us they were made to feel welcome by staff at the home. One relative told us they had been provided with the opportunity to be involved in reviewing their family member's care plan, which they felt good about.

We saw in minutes of team meetings that there had been recurrent issues in relation to staff sharing confidential information about the people they were supporting outside the home, including with former members of staff. A comment was recorded in the team meeting minutes that, "Again, information is being leaked outside the home." In response to this, the provider gave staff copies of the confidentiality and social media policies, which they were asked to sign. We saw paper based care records were kept in lockable storage. The director told us laptops were kept in locked storage when not in use, and confirmed that electronic records were encrypted to help prevent them being read by unauthorised persons.

Staff were able to give us practical examples of how they helped maintain people's privacy. For example, they told us they would ensure doors were shut when supporting people with personal care. We saw people at the home were supported to maintain their dignity, for example, by offering people the use of a clothes

protector over meal times. However, at one point in the inspection we observed a person's clothes had ridden up, resulting in them exposing themselves. We brought this to attention of a member of care staff who supported them to re-arrange their clothes. However, it was unclear how long this person had been in this position, as they were sat in the small lounge, which was not supervised as regularly by staff as other areas in the home. The home had extensive CCTV covering communal areas. We saw there was a sign in the reception area informing people that the recordings were taking place. People we spoke with were positive about CCTV being used in the home, which they felt helped keep them safe.

Staff supported people to be as independent as possible. People's care plans detailed the support they needed, and also what they were able to do for themselves in relation to their care and daily routines. Staff told us they would encourage people to wash and dress themselves when they were able to do so, which was confirmed by the people we spoke with. One relative told us their family member was encouraged to eat and drink independently.

The director told us no-one living at the home had any specific support needs relating to their culture, religion or any protected characteristics. We saw the assessments in people's care plans led staff to consider people's religion and any culturally significant events that they might need to be aware of in order to provide them with effective, person-centred support.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2017 we found assessments were not always completed in a timely way when people moved into the home. We found this to be a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we were not able to assess how well the service assessed and responded to meet the needs of people who moved into the home. This was as since our last inspection, the local authority had stopped funding placements at the home due to the concerns they had about performance and safety. There had therefore not been any recent admissions to the home. We found limited improvements had been made to the care plans since our last inspection, and the provider remained in breach of this regulation.

At our last inspection in August 2017 we commented that people's care plans were in the process of being moved onto a new format. We had noted that the level of detail recorded about how staff should meet people's assessed needs was variable and in some cases lacking information. We found this to be a continuing issue. Whilst the forms used led staff to carry out detailed assessments, the additional details that staff had recorded about how to meet people's assessed needs often consisted of just short sentences. This would increase the risk of people not receiving consistent and person centred care.

People's social histories, interests and preferences were recorded in their care plans. For example, staff had recorded details about people's preferences about how they received their medicines, preferred foods and routines. We saw the care plans contained a section to record people's 'goals'. However, we found these sections contained generic statements that lacked imagination and goals that should have formed part of people's routine care rather than particular aspirations. For example, we saw recorded goals included to remain living at Viewpark, and for a person's needs to be met with dignity and respect.

Prior to our inspection, we received feedback from the local authority quality monitoring team. They told us they had found details about one person's religion and preferences were not correct when they had discussed this person's care plan with them. Staff we spoke with demonstrated an awareness of people's preferences in relation to how they received their care. For example, one member of staff told us one person preferred to receive support from male staff, and enjoyed watching football. People we spoke with told us staff respected their preferences and choices. For example, one person told us, "I opted to stay in bed this morning, and staff let me."

Care plans had been reviewed on a monthly basis, although we saw several instances where there had not been a review of the care plans in December 2017. Despite these regular reviews, we found the content of care plans was not always accurate. One person's care plan stated a family member was responsible for all their finances for example when this was not the case. Although there was evidence that staff respected people's choices, we could not see that people had been involved in developing or reviewing their care plans. There were no records to show people had been involved in care plan reviews, and people we spoke with were either unsure, or told us they had not been involved. One person said, "I don't think I am that involved [in care planning], but it would be nice if I could." A second person told us, "I should hope I am involved in what's written in my care file, but I don't think so."

This was an ongoing breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider was not involving people in developing and reviewing their planned care and support, and ensuring their needs and preferences were accurately reflected.

Since our last inspection in August 2017, the home had employed an activities co-ordinator, who attended the home two days per week. We received positive comments from people about the activities provided. These included, "I love the singers who often come here to sing and, as you can see, I like colouring", "There is always something happening to keep us active and entertained" and "You can come any time day or night. The residents and staff are always doing something." During the inspection we saw staff playing board games with people, or providing people with paper and pencils to draw or colour. The activities diary showed a range of activities took place, including games, dinners, baking, pampering, singalongs and visiting entertainers. However, most activities were supported one to one with people, and there were missed opportunities during the inspection for staff to engage a wider group of people in activities.

We found some people's care plans recorded friends, family and others involved in people's care, whilst this was absent from other people's care files. Care plans were also variable in the detail they provided about how staff could support people to engage and be involved in their community. For example, one person's care plan documented that they liked to go for walks in the local woods and to go out with a family member. However, another person's care file stated 'unable due to dementia' under the community involvement section of their care plan. This demonstrated that the service was not taking and enabling or person-centred approach to exploring how this person could be involved in their community.

Staff supported people to help prevent social isolation. For example, one staff member told us they would facilitate setting up games that two people living at the home could play together. This would encourage social interaction between people. We also saw that events had been held to celebrate people's birthdays and Christmas for example. One relative told us, "We recently had a Christmas party, we all enjoyed it" and another said, "My [family member] was really shy. They're not one for mixing. They join in now, they've [the staff] done really well with them."

People we spoke with told us they would feel confident in raising any concerns or complaints they might have. One person told us, "I do not have any complaints but if I had, I would speak to whoever staff member is nearby." A visitor we spoke with told us, "At the moment we have no problems. I was able to sort out a few concerns before. [The registered manager] has been very good, everything is normally solved through a simple discussion." We saw a complaints procedure was displayed at the entrance to the home, although at the time of this inspection, the director was not able to locate the current complaints policy. It is important that staff are aware of and following a complaints policy to ensure consistency with how complaints and managed. Shortly after our inspection the registered manager confirmed the correct complaints policy had been made accessible to people at the entrance to the home. We saw the registered manager or one of the directors had investigated any formal complaints people had raised. Where appropriate, we could see that the provider had taken steps to help resolve complaints, or they had issued an apology.

The director told us there was not currently anyone using the service who had any specific communication support needs arising from a disability or sensory impairment. The standard assessments in people's care plans led staff to consider whether each person had any support needs in relation to how staff or others communicated with them. This included whether a person wore glasses, used a hearing aid, or would benefit from the use of pictures to facilitate communication for example.

No-one living at the home was receiving end of life care at the time of our inspection. At our last inspection the registered manager told us they intended that staff would complete training in the gold standards

framework for end of life care. The director told us this was still their intention, although this had not progressed since our last inspection in August 2017. The gold standards framework is an evidence-based approach to providing effective end of life care to people. We saw basic information about funeral arrangements and end of life care wishes had been recorded in people's care files where they had been willing to discuss this with staff.

Inadequate

Is the service well-led?

Our findings

Since our last inspection in August 2017, CQC had received further information from whistleblowers that included concerns about the manager's approach and treatment of staff. Staff we spoke with during the inspection told us they felt well supported by the manager who they told us was a good listener and was approachable. Feedback from people using the service was also positive, with one person telling us, "I do know [registered manager]. They are a very good manager, very approachable." However, we also found evidence to support whistleblower claims that the registered manager did not always treat staff with respect.

We asked the director what support and supervision was given to the registered manager. They showed us there was regular email contact with the registered manager, and told us one of the two directors regularly visited the home. However, they acknowledged that there had been no formal supervision carried out with the registered manager. It is important that adequate support and supervision is given to all staff, including registered managers. The lack of supervision would mean the provider was not as able to monitor the registered manager's competence and performance and offer them any support required.

The provider had not ensured that the registered manager had received adequate supervision to ensure they had the support and competence required to carry out their duties. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the director if there had been any incidents that fell within the requirements of the duty of candour regulation. The duty of candour requires that providers act in an open and transparent way in relation to people's care and treatment, and sets out requirements about what they must do if something goes wrong. The director was not aware of the duty of candour regulation, but assured us no incidents would have been reportable under this regulation when it was explained to them. As the provider was not aware of this regulation, there were no assurances that they would follow the required processes in the event of a notifiable incident. Shortly after our inspection site visit, CQC received credible evidence that staff within the service had not always acted in an open and transparent way in relation to previous concerns about the safe management of medicines.

The provider was not acting in an open and transparent way, and there were no processes in place to ensure requirements in relation to the duty of candour were followed. This was a breach of Regulation 20(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2017 we found systems in place to help the provider monitor and improve the quality and safety of the service were not effective. We also found staff had not maintained accurate records of care provided. These issues were breaches of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we did not identify any issues in relation to the completion of care records. However, we identified an ongoing breach of this regulation in relation to good governance.

The audits and checks had failed to enable the registered manager and provider to identify the issues we found during the inspection that resulted in breaches of the regulations. We saw the provider had visited the service and provided the registered manager with actions to take. However, it was not clear that there was any standard structure to what these audits looked at or how the provider checked that actions had been completed.

The registered manager or delegated staff carried out audits of care plans, accident records and the environment. In addition the registered manager also completed checks where they carried out observations of the care staff were providing. We saw the care plan audit had been developed and now included structure to ensure detail about changes to a person's weight, a review of accidents/falls, a review of the person's risk assessments, file contents and a check of the person's medicines records were included. This would help identify any concerns that might need to be acted on in relation to that person's care. However, there was no evidence that this tool was used in a way that would identify how the quality of care plans could be improved, such as to make them more person-centred.

Staff, including the team leader and registered manager had completed a 'staff check list'. This included details about any people currently in hospital or whom the staff team had concerns about, the staff present for handover that day, a check of people's rooms and a check of the building security. These checks would be important to complete on a consistent, daily basis. However, the records showed staff had completed them sporadically at intervals of between five and nine days.

At our last inspection in August 2017 we saw there was a simple audit of accidents and incidents carried out. We had noted that not all the accident forms had been transferred to the file used to complete this check. This would impact the accuracy of the information and it would therefore be of limited use. We found this was still the case and that accident records relating to falls and incidents were not always transferred to this file. This would make it difficult for the registered manager to accurately identify any trends that might alert them to actions required to improve the safety of the service.

As discussed in the safe section of this report, we found a repeated failure of the provider to ensure staff were following guidance from a health professional in relation to supporting one person to safely eat and drink. The provider was aware of these concerns and had taken actions such as providing staff with relevant training. However, they had failed to check that staff had the required competence, were aware of and understood this person's eating and drinking guidance. This had resulted in this person being placed at an ongoing risk of harm. Audits of people's money that the service was handling were not robust and placed people at increased risk of financial abuse.

The preceding paragraphs demonstrate that the provider did not operate effective systems to monitor and improve the quality and safety of the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw feedback had been collected from people using the service through questionnaires they had been given. As at our last inspection, we found no evidence that the findings of these questionnaires had been analysed, or that the feedback people gave had been used to develop and improve the service. Relatives and people we spoke with told us they were given opportunity to attend regular 'community meetings'. These would provide them with an opportunity to give their feedback and thoughts on the running of the home, as well as be provided information on any developments. Meeting minutes showed there had been five meetings held since September 2017.

Staff told us they felt the staff team worked well together, and that morale within the team had improved

recently. We saw staff had attended team meetings, with the most recent meeting being in July 2017. We saw topics discussed included policies and procedures, confidentiality, infection control, safeguarding and rotas. We also saw the registered manager discussed good practice with staff and discussed issues raised by other professionals with them. This included feedback provided by CQC, the local authority and safeguarding. However, as previously noted, we found such steps had not always been sufficient to ensure adequate improvements were sustained at the service.

At our last inspection in August 2017 we found the registered manager had not submitted a notification of serious injury as required. This was a breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009. Since our last inspection the provider had submitted statutory notifications to CQC, and we found no evidence that any required notifications had not been submitted.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not involving people in developing and reviewing their planned care and support, and ensuring their needs and preferences were accurately reflected. Regulation 9(1)

The enforcement action we took:

slow track NoD progressing to FTT

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not effectively assessing and managing risks to people's health, safety and wellbeing. Medicines were not managed safely. Regulation 12(1)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service was not acting in accordance with the MCA and DoLS code of practice, and was placing people at risk of being deprived of their liberty without lawful authority. The provider did not have adequate systems and processes in place to identify and protect people from the risk of financial abuse. Regulation 13(1)(2)(5)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems to monitor and improve the quality and safety of the service. Regulation 17(1)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust recruitment procedures in place to ensure staff employed were of good character, and to consider any potential risks in relation to their employment. Regulation 19(1)(2)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager was not acting in an open and transparent way, and there were no processes in place to ensure requirements in relation to the

	duty of candour were followed. Regulation 20(1)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that the registered manager had received adequate supervision to ensure they had the support and competence required to carry out their duties. Regulation 18(2)

The enforcement action we took:

We cancelled the registration of the provider and registered manager.