Indigo Care Services Limited

The Heathers Nursing Home

Inspection report

Gorsemoor Road
Cannock
Staffordshire
WS12 3HR

Tel: 01543270077

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 December 2018, and was unannounced. At the last inspection completed on 13 June 2017, we rated the service as Requires Improvement.

At this inspection we found some improvements had been made but more were needed and the provider was not meeting the regulations for safe care and treatment, consent and governance arrangements. You can see what action we asked the provider to take at the end of this report.

The Heathers Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Heathers Nursing Home can accommodate up to 53 people in one adapted building, over two floors. At the time of the inspection there were 39 people using the service.

There was a not a registered manager in post at the time of our 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 registered manager was still employed by the company but had stepped down to a deputy role and was making an application to deregister. The provider has plans in place to recruit and an interim arrangement for management was in place. This was the third inspection where the location was rated Requires Improvement. The provider was not meeting the regulations. You can see what action we asked the provider to take at the end of the full report.

People were not supported to manage risks to their safety. People's health needs were not monitored and concerns escalated to relevant health professionals. People were not supported to have maximum choice and control of their lives and staff were not aware of how to support them in the least restrictive way possible; the policies and systems in the service were not supportive of this practice. Governance systems had not been used to identify concerns or drive improvements.

People were not always protected from the risk of cross infection from dirty equipment, however staff were observed using effective infection prevention practices. People were not always supported by sufficient staff. Staff were not always receiving training and they sometimes lacked skills to be effectively supporting people.
Staff were not providing consistent support. People were not consistently supported to eat and drink safely.

People received support from staff that were caring. However, improvements were needed to make sure that this was consistent. People's communication needs were planned for but staff did not always follow the

plans. People's preferences were not consistently documented. People did not have access to meaningful activities.

People had not discussed their end of life wishes and these were not always documented in their care plans. We found people's views were shared but action was not consistently taken to make improvements. People were engaged in checking the quality of the service.

People felt safe and were safeguarded from potential abuse. Medicines were administered as prescribed. Staff had been safely recruited. Accidents were investigated and learning was in place to prevent further occurrences.

The environment was suitable for people. People were treated with dignity and respect. People understood how to make a complaint. Notifications were submitted as required and the manager understood their responsibilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were not consistently supported by sufficient numbers of staff.

People's risks were not always assessed and planned for.

People were not consistently protected from the spread of infection.

People received their medicines as prescribed.

People received support from safely recruited staff.

People were safeguarded from potential abuse.

There were systems in place to learn when things went wrong.

Is the service effective?

Requires Improvement

The service was not effective.

People did not receive support to monitor their health.

People's rights were not protected by staff that worked within the principles of the MCA.

People's needs were not always assessed and planned for.

People were not consistently supported by staff with the right training to provide safe care.

People's nutrition and hydration needs were not always planned for effectively.

The environment was suitable to meet the needs of people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by caring staff, but staff struggled to find time to engage with people.

Communication needs were assessed but plans were not always followed.

People's dignity was maintained.

People were involved in choices about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's preferences were not always understood and followed by staff.

People did not have access to activities and support to follow their interests.

People were clear about how to make a complaint.

People were not supported to develop care plans for their preferences for support with end of life care.

Is the service well-led?

Requires Improvement

The service was not well led.

The systems in place to monitor care delivery were not effective in driving improvements.

People could comment on the quality of the service but improvements were not actioned.

People understood who the management team were and found them approachable

Staff felt supported by the management team.

The provider notified us of incidents.

The Heathers Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection was prompted in part by notification of an incident. The information shared with CQC about the incident indicated potential concerns about the management of risk of people's health conditions. This inspection examined those risks.

This unannounced inspection visit took place on 11 and 12 December 2018. The inspection team consisted of three inspectors and a specialist advisor that was a nurse. A nurse was asked to come and assist with reviewing the nursing needs of the people living at the service.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service. 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 five people who used the service and three relatives. We also spoke with eight staff, two nurses, the cook, the interim manager, the deputy manager, an improvement manager and the head of improvement.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. 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 the care records of six people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including rotas, complaint logs, accident reports, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 13 June 2017 we rated Safe as Requires Improvement. This was because the management of people's medicines was not always safely completed. At this inspection we found the provider had made some improvements to medicines management, however people's risks were not managed safely and the provider was not meeting the regulations for safe care and treatment. Therefore, Safe remains rated as Requires Improvement.

Risks were not consistently assessed, documented or mitigated.. One person had behaviours that challenged but there was no plan in place to guide staff on how to support the person and help to manage the person's behaviour. Staff were sometimes unclear about how to support the person when they presented behaviours. Advice had not been sought from other health professionals. The interim manager confirmed on day two of the inspection, following our concerns a behaviour management plan had been put in place and a referral had been done to seek advice of a specialist health professional.

The provider had changed to an electronic records system. Some risk assessments and plans had not been updated in the system effectively. For example, we found where people needed support with pressure care, records were not always clear about how the risks should be managed by staff. We spoke to staff and they were aware of the risks and gave us information about how these were managed. For example, where detailed guidance about people's risks associated with nutrition and hydration were not clearly documented, staff could describe how they kept people safe.

The interim manager confirmed there was an action plan in place already to address this. The provider confirmed all care plans were being reviewed to identify high risk plans and complete full checks to ensure the assessments, risk assessments and care plans were accurate and in place to guide staff. The provider further confirmed that additional resources would be in place to support the process of updating plans and this would be complete within one month. The provider said they would monitor the progress of plan on a weekly basis.

Peoples health was not consistently monitored and concerns were not escalated to seek assistance. One person complained to inspectors of feeling unwell, we spoke to staff about this and looked at the person's care records. We saw there were concerns identified in this person's notes about changes to their health. The concerns had not been escalated to a nurse and there had been no action taken to investigate the person's symptoms. We spoke to the interim manager about this and they arranged for the person to be seen by an out of hours doctor, a prescription was given for medicines, and a further follow up visit from the person's own doctor was scheduled for the following day. A care plan was also put in place with checks to ensure correct monitoring was in place for this person.

People's needs were assessed and plans put in place to meet them, however these were not consistently done in line with best practice and did not always document specialist health advice. For example, one person required support to treat a pressure sore, we found there was insufficient information included in the person's care plan to guide staff on treatment. We saw specialist advice had been sought, however it was

unclear what treatment had been advised. We spoke to staff and they were not aware of how frequently the person should be repositioned for example. There was also limited information tracking the progress of improvement for the person. This meant the person was at risk of not having the care and treatment they needed.

People were not consistently supported with safe equipment. One person needed to have bedrails to ensure they were safe when in bed. The bedrails had been noted not to fit the bed correctly. This had been escalated by staff but no action was taken for a couple of weeks. The interim manager acted to address this and the bedrails were made safe immediately. The interim manager told us an investigation would be undertaken to see why this had not been addressed sooner.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had mixed views about staffing in the home. One person told us, "If they are not too busy the staff come when I need help." Another person told us, "If I ring my alarm, the staff come quickly if they are not busy, if they are with someone else I have to wait sometimes up to 15 minutes for them to support me to go to the toilet." A relative told us, "There seems to be enough staff most of the time, I have never known [person's name] to have to wait." The staff told us the home was busy and staffing was not always sufficient, but there had been some improvements recently. One staff member said, "There is not always enough time to spend with people, I would like to do more with them, chat, but there is not really time." We saw people needing help to eat their meal safely had to wait for up to 15 minutes and others that would have benefited from some encouragement from staff with eating were left in the lounge with their meal on a tray table. We saw people had to wait in the dining room as staff were supporting people with personal care, people were waiting for their breakfast in some cases. This meant there may not have been enough staff at some points in the day to support people and this required improvement. We looked at the tool in place to assess how many staff were required to meet people's needs, but it was not clear if this had accurately captured people's individual needs. The interim manager confirmed this would be reviewed to ensure accuracy and staffing levels were adjusted if needed. We will check the effectiveness of this at our next inspection.

People received their medicines as prescribed. One relative told us, "I have no concerns at all about how the staff administer [person's name] medicines. We observed people being supported to take their medicines and accurate medicine administration records (MAR) were completed by the nurse. We found medicines were stored safely, there were lockable facilities in place and checks were carried out on the temperatures of storage areas. Items were clearly dated and there was stock control and rotation in place. There was guidance for staff about how people preferred to take their medicines and staff followed this. The interim manager told us there had been issues with the introduction of an electronic medicines management system. Concerns had been raised about stock management and staff had not felt confident in operating the new system. The provider had taken action to revert back to a paper based medicines recording, stock control and ordering system until these issues could be addressed. They confirmed additional training would be put in place before this was reintroduced.

People received support from safely recruited staff. We saw the provider ensured checks had been carried out before new staff started work, which included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

People were protected from abuse. People told us they felt safe living at the service. One person

commented, "I am safe in here, safer than outside." Relatives also confirmed they felt the service was safe. One relative told us, "[Person's name] is safe in here, I have confidence in the staff, they are treated properly here." Staff could describe abuse and were able to tell us how they would report abuse and act to make people safe. We saw where allegations were made, these were documented, reported to the nurse and the local safeguarding authority. For example, one person had made allegations, this had been documented in their care plan notes, reported to the nurse and a referral had been made to the local safeguarding team. This showed there were systems in place to investigate and report any signs of potential abuse and concerns that were raised.

People were not consistently protected from the spread of infection. One person had a chair that had rips in place. There was an audit which had identified concerns with this chair, however no action had been taken to address this. The interim manager said, this had been noted and action would be taken to address this. We saw staff used protective clothing to minimise the risk of cross infection and could describe the procedures for hand washing. Relatives confirmed staff followed safe procedures, one relative told us, "I see staff always wear gloves and aprons."

Accidents and incidents were monitored and learning was applied to prevent them from happening again. We found accidents and incidents were evaluated and peoples' plans were updated and action was taken to ensure the risk of reoccurrence was minimised. Analysis of the incidents was completed on a monthly basis to look for trends and make improvements. For example, one incident had led to changes in the way some aspects of the service were checked.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 13 June 2017, we rated Effective as Requires Improvement as improvements were needed to how consent was sought when people lacked capacity to make a decision, and how action was taken when people needed support with their health. At this inspection we rated Effective as continuing to require improvements. This was because the improvements had not been made and the provider was in breach of regulations.

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 found decisions were being made for people where they potentially lacked capacity without a capacity assessment or best interest process being carried out. For example, where people were being cared for in bed or had restrictions such as stair gates on their doors, there was no assessment of the persons capacity to consent to this restriction. The head of improvement confirmed there would be additional resources brought in to undertake a full review of people's capacity, and ensure the correct assessments and records of decisions were in place.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met and found they were. We saw people had their capacity assessed and applications were made for DoLS, however it was not clear if staff understood fully how to ensure the guidance in the DoLS was followed and the least restrictive options were in place.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always assessed and planned for. For example, some people needed specific support with their food and fluid intake, specialist advice had been sought and staff could describe this to us. However, people's care records lacked detail and did not always give staff guidance on how to support people safely. The interim manager told us people's risk assessments and care plans would be updated to ensure the guidance was in place for staff. Some people were eating their meals in the lounge, this meant they were separated from others when dining and there were no staff available to sit with them and offer encouragement. However, we did see staff supporting people to eat their meals in their rooms. Staff were patient and placed a napkin under the person's chin, the person was propped up in bed safely and there were nice interactions whilst the person was supported to eat. Where people were encouraged to eat by staff, this was done sensitively and with patience. People were happy with the quality of the food and told us they could choose what they wanted to eat. One person told us, "There is a choice, I have chosen braised beef today but this is the first time I have been close enough to see the menu." A relative told us,

"[Person's name] is really happy with the meals, they tell us they like the food." We saw people had a choice of meals and were given the support they needed to make a choice about what they wanted.

The interim manager told us staff received an induction and had updates to their training. Staff confirmed they had undertaken training but could not always demonstrate through their conversations they were competent in some areas. For example, staff told us they had received training in the MCA, however on speaking to one staff member they could not describe what this meant for a person's care or how decisions taken in the persons best interest would be recorded. We saw staff had been trained in safe manual handling, however our observations showed some staff rushed transfers and this meant people were unsteady. We found staff were unaware of how people living with dementia should be supported. Training records confirmed some staff had gaps in their training and others required refresher courses. The provider confirmed an action plan was in place to improve training for staff and check competencies.

People were not always provided with consistent care. Staff told us there was a problem with late notice short term sickness. This meant staff changes were quite frequent and agency staff were sometimes used. As people's care records were not accurate without regular staff on duty, some people's needs and preferences may not be understood by agency staff. The provider had an electronic records system in place. The system enabled staff to quickly look back at all entries for people and check on what had been happening. However, we found there were gaps in the information recorded in the system which meant when staff checked they may not receive information which was up to date about care delivery. The interim manager told us they had introduced short daily meetings to discuss people's care with department heads and nurses. We observed one of the meetings and found staff were able to discuss people's care and any concerns about people, look at fluid intake for example and make any adjustments to people's care plans.

People were supported in an environment which was suitable for their needs. One relative told us, "The home is bright and colourful with plenty of space for people to walk around safely." We saw there were items of interest on display in the corridors and lounges for people. However, we did not see staff use these to engage people in conversation or prompt people to speak with each other. We saw there were pictures in place to assist people with orientation. There were adapted bathrooms in place and a lift to the first floor. The lift was out of action that day, a repair had been requested and an engineer was due to attend.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 13 June 2017, we rated Caring as Good. At this inspection we found improvements were needed to how staff supported people and Caring was rated Requires Improvement.

People and their relatives told us they felt staff were kind and caring. One person said, "The majority of staff are smashing, the odd one rushes [when helping the person], but it really is only the odd one." A relative told us, "The staff have a good relationship with [person's name] they have a chat with them." They went on to say, their relative had improved since being at the home, they had put on weight and their health had improved. They told us this was solely down to the care they had received at the home. Staff told us they had a good relationship with people and knew them well. One staff member said, "I feel as though a care plan can only tell you so much about a person, you have to get to know them and build a relationship." We saw some positive interactions with people and staff. For example, one person had a chat with staff in their bedroom, the staff member was attentive and the person was laughing and joking.

However, some staff did not appear to have time to interact with people as they should. One person was distressed as something they needed from their room had not come into the dining room with them. Staff did not appear to notice the person was upset as they passed through the dining room. The nurse did speak with the person after a short time to find out what was wrong, then they gave the person their medicines and they asked staff to collect the item for the person, who then calmed down. On another occasion, staff were busy getting people up and were walking up and down the corridor passing a room where someone was shouting out without going in to see what the person wanted. We spoke to staff and asked them why the person was shouting, they explained they did this every morning until they got up. We observed the person stopped shouting when staff went in the room. This meant staff availability sometimes impacted on the ability of staff to be caring as the staff had become task focused.

People told us they were supported to make choices and were supported to maintain their independence. One person told us, "I can choose to stay in my room, I prefer this." Another person told us, "I am able to make choices for myself about things." We saw staff offered people a choice of where to sit and what they wanted to eat and drink. We found people were encouraged to do things for themselves. However, on two occasions we saw staff remove people's walking aids from them and place them out of reach. This meant the person could not move around the home if they chose to. We spoke to staff and they said they would be worried the person may fall if they walked without staff there, they had not considered how the person could be supported to walk independently and how this may impact on the person's independence and freedom.

People had their communication needs assessed and plans were in place to meet them. However, we saw some staff were not following these plans. For example, one person required staff to use a pen and paper to write information down so they could understand what was being said. We found staff were not consistently following this plan. This meant the person struggled to understand what was going on and make choices.

People and their relatives told us staff treated people with respect and maintained their privacy and dignity.

One person told us, "The staff always knock my door before coming in. They close the door and curtains before helping me with my personal care." A relative told us, "the staff maintain people's dignity here, I would not want my relative anywhere else, the staff are what make the place nice." We heard staff speaking with people in a respectful way and we saw staff were discreet when offering people support. Staff understood the importance of ensuring people had dignified care and could give us examples of how they supported people to maintain their dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 13 June 2017, we rated responsive as Requires Improvement. This was because people's needs were not always responded to and there was limited interaction and stimulation for people. At this inspection we found improvements had not been sustained and the service continued be rated as Requires Improvement.

People and relatives confirmed they had been involved in their assessment and care plans. One person told us, "I was involved in the care plan, but I don't remember anyone talking to me about the things I liked and my life history." A relative told us, "The staff have asked us about [person's name] life history and their interests to help them get to know [person's name]." The relative added staff had responded well to concerns about the person's hearing and made a referral to a local hospital for assessment. Staff told us they thought they understood people's preferences. We saw assessments and care plans considered social interests, hobbies and interests, religious and cultural needs and described people's personality types. However, care plans did not consider important relationships and needs relating to gender or sexuality, for example with some care plans not detailing descriptions of how people preferred to be supported. This meant there were inconsistencies about how people should be supported and what their individual preferences were.

People were not consistently supported to engage in meaningful activity. A relative told us, "There are things going on some days, [when we visit] but it's just nice knowing [person's name] has some company." Staff told us they wished they had more time to spend with people to engage them in activity. We saw people mostly spent time sat in the lounge without interacting with other people or staff. There were items all around that could spark a conversation with people but staff did not use the items to engage people. This meant people were sitting for long periods of the day in silence and looking around them. We saw people were engaged with staff when staff had time, and we could see some people with dementia would have benefited from more interaction. The interim manager told us there was a need to look at staffing levels and make changes to the culture to ensure people had a more person-centred experience.

People and relatives told us they understood how to make complaints and would be confident these would be addressed. One person said, "I have made one complaint, this was listened to, investigated and a response was given to me." A relative said, "I haven't made any complaints but would be confident these would be investigated and considered." We saw where complaints had been made, they had been investigated and a response had been given in line with the provider's policy.

There was nobody receiving end of life care at the service. However, we found the home had entered a pilot with a local hospice which assessed people that were coming to the last 12 months of their life and enabled planning to begin and support accessed when the time came for the person to receive end of life care. However, we found this information had not been drawn into a care plan for this person. The interim manager told us the care plan was being drafted and put in place straight away and this would consider the persons advance wishes, pain management and information and guidance for staff about people's spiritual beliefs for example.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 13 June 2017, we rated Well led as Requires Improvement, as the systems in place to monitor the quality and safety of the service were not driving improvements, the provider was in breach of regulations. At this inspection, we found the provider continued to be in breach of the regulations as they had not sustained the improvements made and Well-Led continued to be rated Requires Improvement.

We found at the time of the inspection, improvements had not been sustained and the provider had failed to reach the minimum standards of good. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. We recommend accessing support and guidance to achieve and sustain an overall rating of 'Good'. As the location has failed to achieve and sustain a minimum overall rating of 'Good', this supports a breach of regulations.

The providers systems for checking people's assessments, care plans and daily records had not identified the concerns we found with how people's needs and care delivery was documented. This meant people were at risk of not receiving consistent care and of potential harm as guidance for staff was not in place.

The provider's systems for monitoring people's health and wellbeing had not been used in line with the provider policy. For example, daily meetings to evaluate people's care should have been in place to monitor people's health and wellbeing and evaluate and update their care. However, these had not taken place and this meant opportunities to identify where people needed concerns escalating to a health professional had been missed. There were quality checks in place which looked at other aspects of the service for example, medicines audits, however these had not been consistently completed. Therefore, the provider could not be assured that medicines had been stocked, stored and administered safely.

The systems in place to check on people's care delivery were not being used effectively. There was a system in place to flag when people did not have a 'must do' aspect of their care delivered. The system required nurses to check that flags for things like repositioning, food and fluids were carried out. However, we found the checks had not been carried out and there were gaps in people's records. For example, one person had a pressure sore grade three and there were five missed entries for repositioning for this person over a 24-hour period. The provider had recognised this was an issue and there was an action plan in place to ensure staff received training updates in using the new system.

These issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found safeguarding incidents, MCA assessments and training should have been reviewed and any issues logged on a tracker with an action plan in place to make improvements. The head of improvements told us the correct audit and escalation procedures had not been used and issues that were identified were not actioned and followed up. The provider had identified a regional management process had not worked and the person responsible for the oversight of the service no longer worked for the company. Once the issues were identified in late November, the provider deployed an improvement team to conduct a full audit and

develop an action plan. The audit had identified concerns and the provider had put a plan in place with additional resource including an interim manager to address the issues.

The provider took immediate action to address the concerns and they had already begun to review care plans. Following our feedback, it was agreed additional resource would be bought in to highlight high risk care and update plans. An immediate daily check on care delivery had begun, and this was to continue, with daily meetings to evaluate people's care and ensure things were escalated. The provider has given assurances that there has been learning from this process and there were changes being made to the governance to assurances this cannot happen again. The provider also told us they would temporarily stop accepting admissions whilst they stabilised the service.

People and their relatives were asked for their views on the service. One relative told us, "There are meetings and we talk about concerns, such as about staffing levels. The management team seem approachable I would raise issues if I had any." People and relatives had completed a quality questionnaire. The feedback should have been analysed and used to drive improvements with feedback given. However, we found this process had not been followed. We saw relatives had been invited to attend meetings, minutes of these were in place and we could see people had raised concerns and contributed their views during the meetings. For example, relatives had raised concerns about the staffing levels at the home, this had been discussed during the meeting, however no action had been taken to address people's concerns.

The provider had submitted notifications to Care Quality Commission (CQC) in an appropriate and timely manner in line with the law. Services that provide health and social care to people are required to tell us about important events that happen in the service, we use this information to monitor the service and make sure the service is keeping people safe.

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
Treatment of disease, disorder or injury	The provider was not ensuring the principles of the MCA were followed. People had not had their capacity assessed or decisions taken in their best interests recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not supported to manage risks to their safety and escalate concerns about their health to other professionals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems in place to check the quality of the home were not used as required to effectively identify concerns and drive improvements.