Miss J R Hira

Winterton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Winterton House is a care home registered to provide accommodation and support with personal care for up to nine older people, some of whom may be living with dementia. On the day of our visit there were six people using the service, one of whom was in hospital.

This service is not required to have a manager registered with the Care Quality Commission, as the service is provided by an individual who is the manager and registered person. A registered manager is a person who has registered with the CQC 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 inspection took place on 17 March 2017 and was unannounced. At our previous inspection on 4 November 2016 we found that the provider did not meet legal requirements relating to safeguarding people from abuse, maintaining a clean and safe premises, staff training, appraisal and supervision, maintaining privacy and dignity, and quality assurance. We imposed conditions on their registration to restrict admissions and to provide us with monthly updates in relation to risk assessments and infection control. The overall rating for this service was 'Inadequate' and the service was therefore in 'special measures'. The provider wrote to us to say she had taken action and was now meeting legal requirements. However, she did not adhere to the conditions requiring her to send us monthly updates, and during this inspection we found that the provider was still not meeting legal requirements and therefore the service has been rated inadequate overall and remains in special measures.

Shortfalls in the leadership of the service remained. There were ineffective systems in place to monitor the quality of care delivered. The provider lacked oversight on issues such as accidents and incidents and managing risk, and did not ensure there was an open culture which enabled staff, people using the service and their relatives to openly express their views about the service.

Records were not always accurate, were not always kept securely and could not be easily found when needed.

Although people told us they felt safe, they were not always safeguarded from avoidable harm and unnecessary restrictions. Staff had not attended any safeguarding training and were unsure of the process to follow if they were concerned a person was being abused. The safeguarding policy in place needed to be updated in order to reflect up-to-date information.

The provider and staff were aware of some of their responsibilities but demonstrated a lack of knowledge about the Mental Capacity Act (2005) and how it applied in practice. People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

Medicines were not always managed safely leaving people at risk of not receiving their medicines as prescribed.

Staff had not yet received appropriate training, appraisal and supervision. This resulted in people receiving care that was not always evidence based or effective.

People were not always involved in planning their care, or in the way in which the service was run. They were not always offered choices. Activities provided did not always meet people's needs particularly those living with dementia.

People were not always treated with dignity and respect as their wishes were not always respected. People were not always encouraged to maintain their independence.

There was a complaints procedure in place which was also available in pictorial format, however the provider could not show us she had appropriately recorded and responded to complaints.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 remained unsafe. Medicines were not managed safely.

Staff were not fully aware of the procedures in place to safeguard people from harm.

There were unsafe recruitment practices which did not ensure the necessary checks were completed so that only staff who were suitable and had the legal right to work were employed.

Risk assessments did not outline the required steps to take in order to mitigate identified risk.

Is the service effective?

Inadequate

The service remained ineffective. Staff had not received any mandatory training with the exception of medicine management and fire safety awareness. In addition, there were no supervisions or recent appraisals for staff.

Staff were not aware of their roles and responsibilities in relation to the MCA 2005 and had not received any training.

People were happy with the food provided.

Is the service caring?

Requires Improvement

The service remained inconsistently caring. People told us that staff were kind to them. However, we found an instance where people's dignity was not always maintained.

People were not always involved in planning their care. Their independence was not always facilitated.

Is the service responsive?

Requires Improvement

The service remained inconsistently responsive. Activities were limited and not always suited to people living with dementia.

People were able to express their concerns. However, people felt their requests were not listened to, and the provider did not have

an appropriate system in place to record and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led. There were ineffective systems in place which were still failing to recognise and act on out of date staff training, incident and accident management and maintaining safe premises.

The culture of the organisation remained closed with the provider having the final say on care issues with minimum involvement of people using the service, their relatives or the staff.

Winterton House

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 comprehensive unannounced inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 4 November 2016 inspection had been made. This was because the service was not meeting some legal requirements and was put in special measures.

This inspection took place on 17 March 2017 and was unannounced. It was completed by two inspectors.

Before the inspection we reviewed information we held about the service and the provider. This included details of previous inspection reports and the registration details of the service. We also contacted the local authority commissioners and the local Healthwatch in order to get their perspective of the quality of care provided.

During the inspection we observed how staff interacted with people. We spoke with three people who used the service, the provider, and three care staff. We looked at six people's care records, six staff files, four medicine administration records, the training matrix and policies. We observed care in the main lounge where three people were based for most of the day with a fourth person coming in and out of the lounge.

After the inspection we got a call from a relative with positive feedback about care delivered. We also received positive feedback by an email from a health care professional about care delivered.

Inadequate

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe living at Winterton House with the exception of one person who felt restricted. One person said, "Yes, it's ok here. Quite safe." Another person said, "It is quite secure here. More like a prison as you can't go out without permission."

At our previous inspection in November 2016 we found that the service was not always safe. The environment had several hazards including fire hazards which could cause harm to people using the service. During this inspection all cupboards with potential hazards were kept locked in order to reduce the risk of people being exposed to avoidable harm. We saw that some of the papers and clutter had been removed from the office and people's rooms. However, there was still some clutter and staff were still unsure of the evacuation procedure. There were still no completed evacuation plans for people using the service, outlining their specific support needs should they need to evacuate the premises in an emergency. We spoke to the provider about this and she told us she was still in the process of completing these.

The provider had undertaken a fire safety audit of the premises each year, with the most recent undertaken on 18 March 2016. However, we were not assured these audits were a robust analysis of the current state of the premises, as every audit for every year had every 'yes' box ticked and no actions required for the provider, despite the clutter in the building and other issues of concern we observed. Fire evacuation plans were now clearly displayed on the walls. Fire extinguishers were last checked and serviced in March 2016, and the provider told us she had not yet planned for this to be undertaken for 2017. We saw that a fire door upstairs was propped open, which meant it would not work as intended when necessary to protect people with mobility needs if there was a fire.

We found that the provider did not have a system in place to ensure equipment was safe and well-maintained. We saw that many fittings in the bathrooms were worn and rusted, and the plastic coating on the arms of one bath hoist was completely worn away, leaving the bare metal arms of the hoist that people held on to, exposed. We saw a rusty shower chair and a dirty commode chair in another bathroom. This left people at risk of potential exposure to infection or injury if the rusted fittings collapsed or cut their skin.

During this inspection we noted that a call bell system had recently been installed by the provider. However, the pull cords from the inactive call bell systems had not been removed, which left at least two pull cords in areas such as toilets and bathrooms where people may have needed to call for assistance. This was confusing for people as, in an emergency, it was difficult to tell the difference between the operational and inactive pull cords, especially for a person with dementia in a distressed state. This left people at risk of not receiving timely help and assistance if they pulled the wrong cord.

The provider was still not appropriately assessing risks and did not have effective strategies in place to mitigate identified risks. For example, we saw that one person was referred to the service with a history of serious falls, yet this was not reflected in their risk assessments or care plans in any way. Similarly, another person had a history of seizures, yet this was not mentioned in their care plans or risk assessments and one staff member told us they did not know what to do if the person had a seizure as they had not been trained.

This left people at risk of receiving inconsistent and unsafe care due to lack of proper guidance and training for staff.

There were unsuitable procedures in place to deal with situations that required first aid. The provider had not conducted a risk assessment to determine if the service required an appointed first aider, as required by the Health and Safety (First-aid) Regulations 1981. We saw that the provider had completed 'first aid at work' training in 2002, however no more recent first aid or basic life support training had been undertaken by any member of staff. We asked the provider about arrangements for the provision of first aid and basic life support when she was not physically present at the service, and she told us there were none. This left people at risk of receiving poor care delivered by staff without the necessary first aid skills.

At our last inspection people were not always cared for in a clean and safe environment. During this inspection, although a cleaning schedule was now in place, we were not assured that it was always completed correctly or reflected the actual schedule. This was because, on the day of our visit the cleaning schedule had already been signed as completed even though we witnessed staff still doing the tasks such as emptying bins, cleaning the kitchen and emptying the fridge. We saw that areas such as skirting boards and radiator covers were still unclean. This showed that people were not cared for in a clean and hygienic environment.

People were not protected from risks associated with their care because infection control practices were not followed. The infection control policy had still not been updated since 2010. Some people's personal toiletries were also stored in the communal bathroom. This left people at risk of cross-infection if and when toiletries were shared.

At our previous inspection medicines were not always managed safely. During this visit, there were some improvements which included regular room temperature checks to ensure that medicines were kept at the appropriate temperature so that they did not lose their effectiveness. However, there were still some significant shortfalls in the way medicines were managed. Although staff had attended training on medicines management, there were no staff competency assessments to show they were competent to administer medicines safely. We saw that topical medicines, which had been prescribed to specific people who used the service, were kept in a bathroom where they could be accessed by anyone within the premises. This left people at risk of receiving topical medicines that had not been prescribed for them.

In addition there were no protocols in place to ensure 'as required' medicines were managed safely. We asked the provider about this and she showed us a folder with blank forms. She was unaware that each person needed their own protocol for each 'as required' medicine, to ensure staff were aware of the precise circumstances in which these medicines were to be administered. We also found that the code "R" was used on four separate medicines administration record (MAR) sheets with no explanation given as to what "R" meant or any action taken. This was not in line with the provider's policy which also needed updating. When we asked the provider about this, she said "R" meant refused and said she would follow the policy. The above practices reflected that medicines were not always managed or stored safely leaving people at risk of not receiving their medicines as prescribed.

The practices evidenced in the above 10 paragraphs were a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have an effective system in place to ensure staff were suitable to support people before they started work. During our inspection in May 2016 we found that the provider did not check staff remained suitable people and made a recommendation about this. Before our last inspection in November

2016, we received information from an anonymous whistleblower who informed us they had worked at the service for five months without any checks undertaken. We also attended several meetings with the provider where she informed us she had obtained the required checks for all staff working in the service.

During this inspection, we looked through the recruitment records for all staff working at the service, and found that the provider had not undertaken any checks at all for one staff member, including whether they had any criminal convictions or were barred from working with people in need of support through a Disclosure and Barring Service (DBS) check as required by law. Another staff member had a criminal records check dated 2003 with no mechanism in place to check they remained a suitable person. Additionally, one staff member was working without the provider seeking any references from previous employers in health or social care, and another had only one character reference in their records which did not contain any information about their character, or suitability to work with people in need of support.
The provider did not have a system in place to check that staff remained eligible to work in the UK while employed by the service. Records showed that one staff member's leave to remain expired in 2009, and another in April 2016, yet this was not followed up by the provider to ensure these staff remained eligible to work in the UK.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always safeguarded from abuse or avoidable harm. During our last inspection, we found that people had unnecessary restrictions placed upon them by the provider, staff had not been trained in safeguarding adults or abuse awareness, and staff could not tell us what they would do if they suspected a person had been abused. During this inspection, we found that staff still had not received updated safeguarding training to ensure they were clear about their responsibilities in relation to protecting people from abuse and were reluctant to speak with us. They could not explain how they would report and record any allegations of abuse beyond reporting to the provider. For example, they did not know that safeguarding concerns were to be reported to the local authority safeguarding team and the Care Quality Commission. The current safeguarding policy still needed updating as it did not contain important signposting information.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought there were enough staff to support them. The provider told us that there were two staff on duty during the day and one at night. We asked for a rota but the provider could not provide one despite looking and being asked several times. We have requested and are waiting to be sent a copy of the rota to ensure there were enough staff on duty to meet people's needs safely and in a timely manner.

Inadequate

Is the service effective?

Our findings

At our last inspection we found that staff were not appropriately supported to effectively perform their roles through training, supervision and appraisal.
During this inspection three out of four people using the service and one relative told us that they thought staff were able to support them effectively. However, there was still no established system to ensure that staff received sufficient training, appraisal and supervision to support them in their roles. The provider did not ensure staff were appropriately trained to meet people's needs. She showed us an undated training matrix which showed that all staff had completed training in fire procedures, and nothing else. The provider showed us she had purchased training after our last inspection and provided workbooks to some staff to complete, however these were not specific to the needs of social care staff and some contained outdated information for example, referring to guidance from 2000 that was no longer applicable.

Additionally, the provider had not organised any of the practical assessments of staff competency that were clearly required in the training workbooks. We asked the provider if she had organised a practical training and assessment session for staff in moving and handling people, and she told us she "hadn't thought about it, but would ask the occupational therapists at Whipps Cross Hospital" to train and assess staff. This response demonstrated the provider's lack of understanding of the requirement to ensure that staff are adequately trained in order to meet people's individual needs.

The provider did not ensure staff were supervised appropriately or had an annual appraisal of their work. She told us she had conducted appraisals of two staff since our last inspection in November 2016, however these meetings were not recorded and we could not confirm if these meetings had taken place as one staff member had left their employment with the service, while the other didn't recall having an appraisal meeting. This meant staff did not have formal opportunities to seek guidance about their work or discuss and plan their own personal and professional development. Similarly, staff had not been supervised before or since our last inspection. This meant people were supported by staff who did not receive adequate support in their roles or have up to date or training to enable them to deliver care safely.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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).

At our last inspection we found that the provider and staff could not demonstrate appropriate knowledge of the principles of the MCA and were unlawfully restricting people without authorisation. At this inspection we checked whether the service was working within the principles of the MCA and again found shortfalls. The provider was not able to demonstrate she understood the requirements of the MCA and what this meant for the people supported in the service. We saw that some people's records contained assessments of their capacity to understand and make decisions, and some people had a 'capacity' care plan, however these were not consistent and did not include whether any people were authorised to make decisions on their behalf through deputyship or power of attorney. People were not allowed to go outside without an escort and were deprived of their liberty without the relevant authorisations in place. One person told us, "I really want to go out. But [the provider] will not allow me."

Additionally, the provider did not demonstrate she understood the Deprivation of Liberty Safeguards and what this meant for people supported in the service. One person told us about how they wished to go for a walk, however were not "allowed" to leave the service for their own safety, yet their capacity care plan dated February 2017 stated they had full capacity to understand and make decisions, and the provider had not applied for a DoLS authorisation required to lawfully deprive them of their liberty for their own safety. The provider told us she was in the process of applying for DoLS on behalf of people and we saw some half-completed DoLS application forms, but she had not completed these or submitted them to the local authority since our previous inspection in November 2016.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we made a recommendation about involving people where possible in meal planning. During this inspection we found people were still not involved in planning their meals. One person said, "[Provider] decides on all the meals and does all the shopping." Staff and the provider confirmed the provider did the shopping. People were given a balanced diet. However, the menus were still not available in a format that people could understand. Although there was a blackboard to write the menu of the day this was still not pictorial or in a format that could be understood by three out of the five people at the service on the day of inspection. This did not enable the three people to be supported to make a choice about their meal and did not demonstrate person-centred care.

We saw evidence that people were supported to access healthcare services when required. One person had been supported to access dental services. Another had been admitted into hospital. We also saw evidence that people were reviewed by the GP when needed. Staff monitored people's weight and recorded this monthly. We saw that referrals had been made to the community dietitian and the speech and language therapist when staff or the provider were concerned about their weight or that a person was having difficulty swallowing. However, one person was severely underweight and had been prescribed a high calorie diet as well as thickeners to prevent choking while swallowing, yet there was no assessment of their risk of malnutrition or mention of this in their care plan. They were still only weighed monthly and the staff did not record how much food and fluid they had taken each day to monitor their condition, or record that the thickener had been used to prevent choking.

The service premises did not meet people's individual needs. The service was provided in a large, extended detached house with a large garden. However, most of this space was not used by people or their visitors due to inappropriate design and clutter. The building had a large lounge in the front with wing chairs and tables that would be suitable for people to use. However, the provider used this as an office and it was cluttered, messy and crowded with papers and items. Instead of using this large lounge, people instead sat in the much smaller dining room at the rear of the building as it was less cluttered and more comfortable.

There was not enough room for all people who use the service to sit in this room at the same time, or engage in activities that require space to move around. The garden was similarly unsuitable for people to use or enjoy if they wished, despite its large size, as it was used mainly as a storage area for rubbish and broken equipment.

Additionally, the first floor of the service contained a dark corridor with stairs, and a light switch that was difficult to access, which posed a risk to people who need support to move around or people with dementia. The provider had not sought appropriate guidance, or taken any steps to ensure the premises were suitable for people with dementia to navigate, such as using different colour door frames or wayfinding aids to assist people to move around.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People and their relatives thought staff were caring. One person said, "Staff are good to me." A relative emailed to say, "[My family member] receives loving care in a friendly and family environment."

Despite these positive comments we found that people were not always treated with dignity and respect. We found on two separate occasions a member of staff asked a person "Do you want to go to the toilet?" This was not said discreetly and could be heard by two other people in the room and did not preserve the person's dignity.

People were not always enabled to maintain their independence. For example, we saw that two people were assisted by staff to mobilise. Both people could benefit from mobility aids to enable them to have a degree of independence, however these were not sought by the provider and no further action had been taken to ensure the people were safe and comfortable moving around. Another person who had capacity wanted to be enabled to manage their finances, but was still waiting to be sign posted to an appropriate professional to support them with this.

Care plans were still not available in a format that people with communication difficulties could understand. The language used in some daily records demonstrated that staff had limited understanding of some people's needs. For example, one record showed there was a clear pattern of aggression during personal care in the mornings. The care plans did not record this, or any ways to defuse the situation or any attempts to identify the triggers to the person's responses. Staff repeatedly used words such as "aggressive", "rude," and "stubborn" rather than trying different strategies such as changing the times personal care was offered or explaining in a way the person would understand what was happening.

The provider did not always ensure that people's cultural and spiritual needs were met while they lived in the service, or that these were respected by staff. We saw that one person's 'spiritual' care plan stated that "[the person] is not a spiritual person" and "[the person] is a non-believer", yet the action for staff to support them in the area of spirituality was to "encourage [the person] to continue praying and talking to God so [they] keep [their] belief". The person told us they "wished staff respected me and my wishes".

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some caring interactions between staff and people using the service. We saw one person was assisted to go to bed as they kept dozing off in their chair with their neck in an uncomfortable position. People were assisted to wash their hands after having a finger food lunch. Staff were knowledgeable about people's regular visitors and were able to keep people informed of when their relatives would next visit.

Requires Improvement

Is the service responsive?

Our findings

People told us they were cared for by regular staff that usually responded positively to them. However, we found shortfalls in the way staff responded to some people. One person told us, "I want to go out but no one is available to take me out. I am told I need someone." We saw staff did not respond to this person's request but referred them to the provider. This resulted in the person being frustrated by the lack of engagement or meaningful activity.

The provider undertook assessments of people's needs when they first moved into the service, and developed care plans based on these. However, these did not always reflect people's needs and were not consistently reviewed or updated when people's needs changed. For example, one person's care plan stated they were fully independent with oral care and did not require any prompting or assistance from staff in this area. However, their records showed that they had required treatment from the community dentist for a painful condition caused by poor dental hygiene in July 2016. This was not reflected in their care plan despite this having been reviewed four times since then and marked as "no change". There were no changes to the way staff supported this person to maintain good oral health after this had occurred, or to prevent reoccurrence of the painful condition.

Additionally, we saw that care plans did not always include information about the topic stated on the care plan. For example, one person's 'communication' plan referred to them needing eye drops, and did not contain any information on how the person communicated or a plan for staff to support them with this. Care plans were inconsistent and did not always show that people had been involved in planning their care.

People had no involvement in planning the activities and therefore did not always enjoy or participate. One person said, "I am very bored. They tried getting a dart board for me but that's not a good board. I prefer to go out." There was a programme of weekly activities on the wall in the dining room although not displayed in an easily accessible place. This was yellowed and had clearly been attached to the wall for a very long time. We saw that the activity scheduled for the day of our visit was 'chair exercises'. The radio and television were both on at one point and we saw one out of four people in the lounge doing some pedalling exercises. We asked the provider about stimulating activities for people with dementia, and she told us that a person "had gone to the dentist". Therefore people were left sitting and dozing for a great part of the day which demonstrated a lack of understanding of the need to engage people in meaningful activity.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they would speak to the registered provider if they felt they needed to complain about anything. One person said, "I am ok here. No complaints." Another person said, "I have complained but still waiting for someone to take me seriously." A pictorial complaints policy was displayed on the wall in the entrance. The provider told us she had not received any complaints since our last inspection. However she was unable to find the complaints log to show us this. She also acknowledged when we asked that a person had complained but this had not been logged. According to the provider the complaint had been resolved;

however she was unable to demonstrate that the complaint had been appropriately responded to.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People knew who the provider was and said she was very visible and involved in daily care. At our last inspection we found that the service was not well-led as the provider did not have appropriate oversight of the service, did not understand the principles of quality assurance and did not seek or act on feedback from others. During this inspection we found no significant improvement in the quality of the management of the service. Shortfalls had not been addressed and there remained a closed culture where the provider had the final say in every aspect of service delivery. A sign in the entrance demonstrated the culture of the service: "I can only please one person per day. Today is not your day and tomorrow doesn't look good either". Another sign in a lounge demonstrating culture stated, "Bad day in progress, approach at own risk."

The provider did not have a system in place to assess and manage risks relating to the service. We asked how accidents and incidents were recorded and monitored to determine what happened and to prevent reoccurrence, and the provider told us she did not monitor these in any way and there had been no incidents or accidents in the service since our last inspection in November 2016. However, a few minutes before this, the provider had told us about how a person had fallen two days prior to our inspection, was taken to hospital by ambulance, was admitted to hospital and remained there. She told us she did not consider this an incident or an accident and had not recorded it as such.

People were not meaningfully involved in the way the service was run. On the wall of the entrance to the service the provider had a 'My Home Life' tree. This is an initiative to encourage people who use the service, their loved ones and visitors to make suggestions about how to improve the service, by anonymously writing their suggestion on a card and sticking it on the tree. We saw there were several suggestions attached to the tree, including "replace toilets", "we love to have fruits at suppertime", "I like more fun in care home like parties, dance and music" and "taking the residents out will improve their life more". We asked the provider what happened once a suggestion was made, and she told us she did not have plans to implement any of the suggestions made, nor did she have any mechanism in place to feed back to people once they had made a suggestion.

Additionally, the provider did not hold meetings for people or their relatives to give feedback about the service, nor undertake surveys or questionnaires to allow people to make suggestions for improvements.

The provider did not have an effective system in place to manage records relating to the care and support people received, or the management of the service. Records were filed in plastic bags around the front lounge of the service, where they were accessible to any person who entered the premises. Records were not stored confidentially and were not easily found when they were needed. For example, we asked the provider for staff recruitment information. She spent 15 minutes looking through various plastic bags before she found them. Some records were also kept in vacant bedrooms in the service, however, the provider wasn't sure which records were stored there and they similarly took a long time to find. Superseded and outdated records were filed amongst current records, where they were filed at all, which made it very difficult for staff to determine what was current information and what was no longer relevant.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not aware of the requirements of their registration with CQC, and did not follow them. The provider did not submit notifications of important events affecting people or the management of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Additionally, there was still no sign displayed to show the most recent rating by the Commission that relates to the provider's performance at those premises. We asked the provider about this and she could not explain why she was not displaying the current rating.

This was a continued breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspections in May and November 2016, and this inspection, the provider failed to demonstrate she had the necessary skills and competence to provide or manage a service to people in need of support. The provider had not kept up to date with changes in legislation and policy that affected the provision of the service and ensured that people received safe, appropriate care and support of adequate quality. She did not seek appropriate help or guidance when these failings were pointed out to her, or take action to address areas of concern.

This was a breach of regulation 4 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not operate an effective system for identifying, receiving, recording, handling or responding to complaints. Regulation 16(1) and (2).

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 Care did not always meet need or reflect people's preferences. Care or treatment was not always designed with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9 : 1 (b) (c) 3 (b)

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always provided in a safe way. The registered person did not ensure risks to the health and safety of service users were assessed. They did not do all that was reasonably practicable to mitigate any such risks. The premises used by the service provider were not always safe to use for their intended purpose. The equipment used by the service provider for providing care or treatment to service users was not always safe for such use as it was dirty and in need of repair Medicines were not manged safely. The risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated was not always assessed.

Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017

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 People were not always protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. People were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (1) (2) (5)

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively. Systems or processes did not enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity were not always assessed, monitored and mitigated. Records were not always maintained securely or an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Other records as are necessary to be kept in relation to the management of the regulated

activity were not always securely maintained.

The registered manger did not always seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e)

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017

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 operate effective recruitment procedures to ensure persons employed were of good character. Regulation 19(1)(a) and (2).

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Regulation(offence) 20 A 3 There must be displayed at each premises from which the service provider provides a regulated activities at least one sign showing the most recent rating by the Commission that relates to the service providers performance at those premises

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider did not demonstrate they had the skills or competence required to carry on the regulated activity. Regulation 4(1), (2) and (3)(a).

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have sufficient skills and knowledge to enable them to support people living with dementia. Persons employed by the service provider in the provision of a regulated activity did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. They were not always enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (2) (a) (b)

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration. The service closed on 13 July 2017