Mr Paul Bliss

Primley Court

Inspection report

13 Primley Park,
Paignton.
Devon.
TQ3 3JP
Tel: 01803 555988
Website: www.primleycourt.com

Date of inspection visit: 27 April 2015
Date of publication: 18/06/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place on 27 April 2015.

Primley Court is a care home with nursing, registered to provide care for up to 52 people. The home provides care for older people living with dementia or mental health needs. At the time of the inspection we found that the building was undergoing changes to make the service more in line with good practice in dementia care. This included changes to provide smaller units where up to 12 people could live in a smaller group in more homely surroundings, and an internal and external refurbishment of the property.

There was 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.

Summary of findings

People were not always being protected from risks associated with the premises. We found that some areas of the building required attention to furnishings, décor, cleanliness and odour control, and that risk assessments did not fully protect people from risks associated with windows and glazed doors. We have made a recommendation in relation to the management of laundry services.

People were not protected against the risks associated with medicines, as some prescribed creams were being used for people for whom they were not prescribed.

People were not being protected by the home's recruitment processes, as the home did not have a proper recorded system in place to assess the risks presented by staff who may have a pre-existing criminal conviction. The systems for requesting references was not robust enough to protect people.

People did not always receive meals and fluids in a timely way. We saw that some people waited a long time between getting up and having their breakfast.

People did not always receive the care identified in their care plan, and some care plans were not detailed enough for staff to identify the care people needed.

People benefitted from some activities on offer. However not all activities were appropriate for people's needs or abilities. We made a recommendation in relation to activities suitable for people living with dementia.

People were being protected from abuse. Staff had received training in what to do to raise concerns over abuse or abusive practices, including information about external agencies to contact.

There were enough staff on duty to support people, and staff had the skills and knowledge to support people with their care. Staff understood people's rights under the Mental Capacity Act 2005 and in relation to depriving people of their liberty.

People were supported to eat a nutritious diet, and had access to healthcare services that met their needs.

Staff demonstrated a caring attitude towards the people they were supporting. Some information was available around the home to support people orientate themselves but this was due to be increased following the changes planned to the environment. Staff communicated effectively with people and knew them well.

People benefitted from clearly understood complaints procedures which were on display in the home.

Quality assurance systems were in place and learning took place from incidents to improve safety and quality.

Records were being well maintained and were updated regularly.

We found a number of breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 home was not always safe.

People were not always being protected from risks associated with the premises.

People were not being protected by the home's systems for the management of medicines. Some prescribed creams were being used for people for whom they were not prescribed.

People were not always being protected by the home's recruitment processes.

People were being protected from abuse, and there were enough staff on duty to support people and meet their care needs.

Is the service effective?

Requires improvement

The home was not always effective.

Areas of the home required attention to ensure people lived in a homely and well adapted environment. However, alterations were under way to make the premises more suitable in accordance with best practice guidance on dementia care.

People did not always receive meals and fluids in a timely way.

Staff had the skills and knowledge to support people with their care.

Staff understood people's rights under the Mental Capacity Act 2005 and in relation to depriving people of their liberty.

People were supported to eat a nutritious diet, and had access to healthcare services.

Is the service caring?

Good

The home was caring.

People were supported by staff who knew them well and were positive about their care.

People's dignity was respected.

Information about people was kept confidential and staff involved people in maintaining some independence.

Is the service responsive?

Requires improvement

The home was not always responsive.

People did not always receive the care identified in their care plan, and some care plans were not detailed enough for staff to identify the care people needed.

Summary of findings

People benefitted from some activities on offer. However not all activities were appropriate for people's needs or abilities.

People benefitted from clear complaints management processes.

Is the service well-led?

Requires improvement

The home was not always well led.

People benefitted from a strengthened management team who were making improvements to the home. However we also identified concerns and breaches of legislation that had not been identified by the home's own quality management systems.

People were asked to give their views about the service and learning took place about incidents and accidents to prevent a re-occurrence.

Records were being maintained and updated.

Primley Court

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 was 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 the 27 April 2015 and was unannounced. The inspection was carried out by two adult social care inspectors 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. In this instance this was someone who had experience of caring for people with dementia.

Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us. During the inspection we spoke with the provider, the registered manager, the clinical lead nurse, nine nursing and care staff members, the chef and later contacted the laundry person by telephone to discuss the laundry arrangements. Prior to the inspection the provider had completed a provider information return or PIR. This included contact details of people who visit the home such as Community Psychiatric nurses and the local authority commissioning quality team. We also spoke with a visiting pharmacist.

We spoke with eight people who lived at the home, and six relatives who visited during the inspection. Some of the people who lived at the home were not able to share their experiences with us as they were living with significant dementia. We used the Short observational framework for inspection or SOFI on two occasions throughout the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate verbally with us.

We looked in detail at the care provided to six people, including looking at their care files and other records. We looked at the recruitment and training files for four staff members, and other records in relation to the operation of the home such as risk assessments, policies and procedures. We looked around the accommodation and discussed changes being made with the provider.

Requires improvement

Is the service safe?

Our findings

The home was not always safe. People were not always protected from risks presented by the premises. We also identified concerns over the robustness of the home's recruitment processes, and the use of people's medicines.

People were not being protected from risks associated with the premises. Risk assessments were carried out on the home. However, we found some areas of the premises needed additional assessment and action to keep people safe, for example to ensure the safety of windows and glazed doors.

This was a breach of Regulation 12 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

In one unused but accessible room we found three safety razors had been left out and other rooms contained evidence of toiletries that could present risks to people if they were misused.

Other risk assessments had been carried out, for example for electrical safety and hot water temperatures. The lift, boiler and hoists were on maintenance and servicing contracts and slings and wheelchairs were regularly inspected for safety. Arrangements were in place for the emergency evacuation of people in case of a fire, and fire fighting equipment and systems were monitored and reviewed. First aid and eyewash kits were available in appropriate locations so that they could be accessed in a hurry.

People were not always protected by safe staff recruitment practices. There was no formal or recorded system in place to assess any risks from staff who may have committed a criminal offence. Where staff had a disclosure and barring check (DBS) which highlighted past criminal activity there was no evidence to show the registered manager had considered the risk to people at the home before employing the staff member. The provider and registered manager told us that they would discuss any convictions with the person concerned and make a judgement about their suitability based on the vulnerability of the people at the home, and the nature and timing of the offences.

In addition, references for one of the people whose file we looked at did not relate to their most recent employment in care work, but to previous employment in another type of employment. This told us that full and safe recruitment practices were not being followed.

This was a breach of Regulation 19 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not fully protected against the risks associated with medicines. We found prescribed creams for individuals throughout the home, including in other people's bedrooms. This included creams for the management of dry skin as well as prescribed creams and ointments. We were told that care staff were using these creams on people as they were getting them up. This told us that creams prescribed and supplied for an individual were being used for other people.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff understood how the systems for the safe administration, storage and recording of medicines worked and had received appropriate training and assessments of competency. Information was available about the medicines in use at the home. On the day of the inspection the supplying pharmacist visited the service and carried out an inspection against the Royal Pharmaceutical Society standards. They told us that they were satisfied the systems were safe having only identified a small number of minor recording issues which were rectified at the time.

People were given an explanation and time to take medicines at their own pace. There were clear instructions for staff regarding administration of medicines where there were particular prescribing instructions. For example where people needed thickened fluids there was advice for staff as to the consistency required to help the person swallow safely. Best interest decisions had been made following assessments of capacity where people were no longer able to make decisions about taking their own medicines. Some people received their medicines covertly, and this had been discussed with the person's GP and advocate or relative before decisions had been made and recorded. We spoke with a staff member about one person's medication.

People were protected from the risk of abuse as staff had either undertaken or were due to undertake training in safeguarding. Staff understood what to do if they identified

Requires improvement

Is the service safe?

concerns about someone's welfare. One staff member told us about how they would know through people's body language if they were unhappy about something, and would try to find out what was wrong. Staff understood how and to whom concerns should be reported, and information was available throughout the home on external agencies to contact in order to 'whistle blow'. Two staff members told us they had been to the registered manager before when they had been concerned about something they had seen and would not hesitate to do so again. Where concerns had been raised we saw that the home had acted promptly to protect people who lived at the home, and worked with safeguarding agencies to investigate any concerns.

People were protected because the home audited accidents and incidents to see if any measures could be taken to prevent a re-occurrence. We saw for example that an audit was carried out of falls, to see if any patterns could be identified, and actions taken as a result. We looked at one person's file which showed they had fallen three times in the last month. We saw their risk assessment had been updated, and action taken to access different seating for the person to help them with mobilising from their chair.

There were sufficient staff on duty to keep people safe and meet their needs. On this inspection, we arrived early in the morning so that we could speak with the night staff. We found that there were seven care staff and one registered nurse on duty for 49 people at night. In the day this rose to 12 care staff and two registered nurses, a registered manager, a clinical lead nurse (supernumerary), domestic, catering and housekeeping staff, and on this inspection the nominated individual and another representative of the provider company.

People told us there were enough staff on duty. One person we spoke with felt there was a need for another staff member to be on duty in the large day room, as sometimes the area was unpredictable, but other people told us that there were sufficient staff around to support people and meet their needs. It is planned the structure of the staffing will change when the home is divided into smaller units, each of which would have a small dedicated staff team, reflecting the needs of the people in that unit.

Requires improvement

Is the service effective?

Our findings

The home was not always effective. We identified some concerns over the design and maintenance of the building. However alterations were under way to make the premises more suitable in accordance with best practice guidance on dementia care. We also identified concerns in relation to the recording and timings of food and fluids.

People did not all benefit from living in a comfortable or well-maintained environment that was adapted in accordance with good practice in dementia care. Some bedroom furnishings and carpets were in a poor condition and were in need of repair or replacement, and in some rooms there was an odour problem. However, Primley Court was undergoing extensive changes at the time of the inspection. Building work had already started to adapt the large building into smaller units that would be more homely and in accordance with acknowledged best practice in dementia care. Some changes had been made since the last inspection, and work was due to be carried out to improve the exterior and interior of the property. This would include additional signage to support people to orientate themselves better around the building and contrasting colour choices to support people become more independent with for example accessing the toilet. The provider told us that internal redecoration was due to commence in two/three months after the inspection following the completion of building works. This would include people being involved as far as possible in making choices about the colours and décor they wanted. Best practice guidance was also being used for example for high contrast areas to help people with dementia retain their independence as far as possible through visual clues in the environment.

During the inspection we found that one person was having difficulty in understanding the changes to the layout of the building and on two occasions they had taken themselves to a toilet that was not large enough to cater for themselves and their walking aid. This meant they were using the toilet independently with the door open, which was compromising their dignity and privacy. We raised this with staff who took immediate action and agreed to give the person more support and guidance to access another toilet nearby that was of a suitable size.

People did not always receive the food and drink they needed in a timely way. Records did not evidence that people received food and fluids at regular intervals. On the day of the inspection we had arrived at 7am, at which time there were 16 people up in the lounge, and other people up and dressed in their rooms. Staff told us that this was through people's choice and that some people did not choose to get up until much later. Signs on display said that breakfast was served at 9am. We were told that people would be given drinks and biscuits until it was time for everyone to have breakfast. No evidence was available to show that people all received drinks from prior to our arrival at the home until around 9:40am when some people finally received their breakfast.

In addition, the care records were not completed in sufficient detail to enable staff to judge that the person was receiving the nutrition and hydration that they needed. For example we looked at two people's fluid and food recording charts. The food and fluid recording charts in use for the preceding 5 days had not been totalled over the 24 hour period and had not been completed from 6 pm until around 9:30am the next morning. This meant it was not possible for staff to assess or evidence whether people had received adequate hydration or nutrition over night or for the total 24 hour period covered by the chart.

This was a breach of Regulation 14 (4) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were offered a balanced diet with daily choices, and we saw that staff took care to present meals well and in an appetising manner. People said the food was "alright", "yummy", "very nice", "fine, quite good" and "food is always very good". They told us they always had enough to eat and that the hot food was served to them hot. People had opportunities to make suggestions about the foods served to them at residents' meetings. Lists were kept of people's likes and dislikes and people were frequently offered drinks throughout the day. We saw people being offered support to eat and this was done discreetly and at an appropriate pace for the person.

People received support from staff who were trained and understood their role. We saw that the home had a training matrix that covered both training for general care needs such as first aid and moving and positioning training along with more specialist training for specific people's needs. Staff told us they received the training the needed. One staff member said "They are good with courses - they keep us up to date." The home also had a matrix highlighting when mandatory training was due to be renewed for staff.

Requires improvement

Is the service effective?

Staff completed an induction including shadowing more senior staff, and newer staff had commenced with the new care certificate induction and qualification. Where there were gaps on the training matrix there was an individual action plan in place to ensure staff completed the training required. In addition the home's management team were working on plans to ensure development of skills and learning from another home operated by the same provider were implemented in Primley Court.

Staff received supervision from more senior staff and an annual appraisal. The supervision delivered to staff was often in the form of training or a themed session, for example on the Mental Capacity Act 2005 (MCA). A staff member told us they had found this useful in looking at their practice. Staff also said that they could go to members of the management team at any time if they were unclear about something or needed support because they found aspects of the work challenging. Staff we spoke with were clear about their roles within the staff team, and told us the home was a good place to work. They were happy with the standards of care they delivered. Some staff had been identified as specific champions of particular areas of work. We spoke with one person who was a bone care champion. They identified their role as making sure that good practice in bone care was followed including the taking of specific supplements and exercise for good bone health.

People at the home told us " I'm happy with the care my relative gets here", and "Staff brilliant. No complaints".

People were protected as the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff had received training in the MCA and could demonstrate a good understanding of the issues around capacity and consent. One staff member described how they cared for a person they had got up that morning. They could describe how the person would indicate their refusal to participate in care and how on occasions a 'best interests' decision would need to be made and recorded in relation to their care, for example following an incident of incontinence, as the person had been assessed as lacking capacity to make the decision. This decision would be confirmed by the nurse in charge. In another instance a 'best interests' decision had been made and recorded with regard to a person with dementia and the taking of insulin. This had been assessed by the prescribing GP and the person's relative had been involved in the decision making. There were clear protocols for staff regarding the administration of this medicine.

Appropriate applications had been made with regard to the deprivation of liberty safeguards (DoLS), which is where an application can be made to lawfully deprive a person of their liberty in their best interest or for their safety, and where the person lacked capacity.

People had access to reviews of their healthcare including community healthcare professionals. We saw evidence in people's files of access to community older people's mental health teams, GPs, chiropodists, physiotherapy, speech and language, dental and optical services.

Some areas of the home such as the laundry were cluttered and contained items that were not there to be laundered, such as old clothing or items being stored. This meant the area could not easily be kept clean. We spoke with the laundry person the day after the inspection to discuss the systems in use. They told us about how they managed to ensure separation between clean and dirty items awaiting laundering. **We recommend the provider seeks guidance and advice from a reputable source in relation to the safe management of laundry systems.**

Good

Is the service caring?

Our findings

The home was caring.

Staff demonstrated a caring attitude towards the people they were supporting. One staff member described the pleasure they got from their job. They said “The rewards, even if it is just a smile, make such a big difference.”

Staff demonstrated caring relationships with people who lived at the home, celebrating successes and achievements with people. We carried out two periods of SOFI observation during the inspection. We saw staff got down to people's eye level when speaking with them, and made appropriate physical contact. We saw a member of staff working to help one person engage with an activity. They tried several times to communicate with the person, using touch and simplified communication until the person understood them and joined in. Staff obviously knew people well and were positive and smiling. Some dementia friendly signage was situated around the home but the interior refurbishment in progress was said to include a significant increase in signage to help people orientate themselves independently.

People were provided with information to help them make choices. A staff member was seen at breakfast time helping one person make a choice about their meal. They said “You are not sure what to choose, so I will get you both to look at”. They did this and the person was able to make an independent choice about what they wanted. Staff were seen to be very patient and gentle when assisting people who were experiencing difficulty walking around the home. They were also seen to be good at using distraction techniques to diffuse potential confrontation situations between people living at the home.

Staff were able to describe to us the individual care people needed and wished and details about their life prior to coming into the home. This helped to ensure that they understood the person and their behaviours and wishes in the context of the life they had lived. It also meant that they understood things that were important to the person. One staff member told us about one person they had supported that day, and described them affectionately as someone who made friends easily and was a jolly person rather than just describing someone who had needs associated with their dementia. This told us that staff were moving towards viewing people holistically.

People’s confidentiality was respected and the care records were written respectfully and in appropriate language. People’s dignity was respected when staff were supporting them. Some people for example had dropped food down their front while eating or drinking independently and we saw that staff removed this and helped people to be clean and tidy. Staff spoke quietly with people when asking them about care or if they wanted to go to the toilet. Everyone we spoke with confirmed that the staff were very kind and compassionate people who respected their dignity when assisting them by closing doors and curtains. Staff were heard to knock on bedroom doors before entering.

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive.

People's care needs were not always clearly defined in their care plans in sufficient detail to allow staff to carry out their role. Since the last inspection the home had purchased and was implementing a new computerised care planning system. This included information about people's life histories and their wishes about their care. We looked in detail at 4 care plans on the computerised system and cross referenced these to the older paper records being kept until the new system was fully operational. We also looked at 2 other plans. The computerised care records did not contain the same level of detail as the paper records that we saw. For example we looked at the care records for one person. The care records on paper contained significantly more detail about how the person liked their care to be delivered, their communication, and the impact of their dementia on their daily life. We were told that this was because some of the detailed plans had not yet been transferred over by the registered nurses onto the new system. Only two of the people we spoke with admitted knowledge of their care plan, but all of the visitors confirmed that they had been consulted about their relatives care. Staff we spoke with told us they were allocated time to read care plans as a part of their role.

People did not always receive individualised care and support delivered in the way they wished or as identified in their care plans. During the inspection we observed one person being moved by two care staff by being lifted under their arms, which is poor practice. We checked on the person's computerised care plan and found the information recorded there did not give sufficient detail to determine the way to safely support the person to transfer. Another person's care plan indicated they should have bed rest every afternoon to support pressure area care. Their positioning chart for an 8 day period showed this happened on only four occasions. No reason had been recorded as to why the person had not had a period of bed rest on the other days. This told us that people's care plans were not always being followed.

This is a breach of Regulation 9 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People benefitted from an effective system to manage complaints or concerns about the home. Prior to the inspection we had received information that the home had not responded to a concern raised by a family member. We saw on the inspection evidence of actions the home had taken, which had included invitations to discuss the concerns in a meeting with the registered manager and feedback on other actions taken. We saw that any complaints or concerns were analysed to identity trends. The provider told us that a recent concern from relatives had been in relation to the management of laundry. The provider was taking action as a result. People and visitors told us they would be happy to raise concerns with staff on duty or the management team. A visitor told us "They treat the "whole person' here. On balance my relative is truly receiving care, and is given love and respect", and other people told us "No complaints" and "It's very good here. They are looking after me very well".

People were encouraged to take part in activities, and information was gathered on their pre-existing hobbies and interests. We saw the activities organiser spent time working with people on an individual basis in their rooms and also in larger group activities. In the small ground floor lounge a visiting relative was playing a keyboard to accompany a trained singer. People were encouraged to join in some of the songs by staff handing out "song sheets". The relative told us "I am a great believer in the benefit of music and singing for people with dementia which is why I come and do this"

The activities organiser also spent time in "one to one" activities with individuals such as poetry reading and discussion, encouraging residents to re-commence painting, Bible reading or simply spending time talking or just being with a person. Records were kept to ensure that people benefitted from this activity on a rotational basis. People also enjoyed dog walking or going out on occasional trips. There was monthly communion and a service by the local "Living Waters" church. However, we also saw care staff organising an activity which was less successful for people because it was not targeted appropriately to meet people's strengths and abilities. The impact of this was that people were left deflated and feeling negative. One person who had participated said "I'm completely useless" following the activity. **We recommend the provider seeks advice and guidance from a reputable source about the provision of positive and individualised activities for people living with dementia.**

Requires improvement

Is the service well-led?

Our findings

The home was not always well led. We identified concerns about the service and breaches of legislation during this inspection that had not been identified by the home's own internal management systems.

People expressed confidence in the home's management. People knew the registered manager's name and said that she was accessible and approachable. Staff told us it was a happy place to work and that they were satisfied with the standards of care that they delivered. They told us they would be happy for a relative of theirs to be cared for at the home.

Since the last inspection the management team had been supplemented by a new position of clinical lead nurse. This role was in addition to the registered nurse hours and both supported the registered manager and ensured that the home could respond quickly to people's needs and unforeseen events. There were clearly defined roles within the management team, and people were clear as to who to go to for specific issues.

The provider had assessed the service in relation to best practice in dementia care and was in the process of making significant changes as a result, some of which were only partially complete. Changes underway included improvements to the environment, organisation and task focus, care planning systems, training, and ethos and philosophy to make the care provided more individualised. Staff, relatives and people living at the home had been informed about and involved in the planning for developments at the home, which were being made following changes at another home operated by the same provider. This had led to significant culture change and improvements in person centred care which the provider was keen to bring to Primley Court. Staff we spoke with were looking forward to experiencing the changes with a new model and philosophy of care. The home was also working with other local initiatives in making the changes such as the local older people's mental health centre and Plymouth University. Other quality initiatives at the home included the Gold Standard Framework accreditation for end of life care, investors in people, and membership of the vegetarian society and the dementia action alliance. The home's management team had also worked well with the local authority quality improvement team who we spoke with prior to this inspection.

Regular audits were carried out on the service, for example for hand washing, falls and health and safety. Risk assessments were carried out to reduce foreseeable risks where possible. Staff told us there were effective systems to ensure that where faults were reported to the maintenance person they were actioned quickly. The home had recently been awarded a 5 out of 5 rating for food hygiene practices from the local environmental health service.

People were encouraged to have say about the way the home was operating. Questionnaires were sent out every six months to stakeholders to gather their views about the quality of the service. These were analysed and action plans drawn up as a result to improve the quality of people's experience. Relatives were also encouraged to attend regular relatives meetings. People who lived at the service also had meetings to discuss any potential improvements to the home or changes they would like, for example to menus. The home also had a suggestion box and operated a system for anonymous raising of concerns via their website. The registered managers from this and other homes operated by the same provider met regularly to share good practice.

People's care records were in process of being transferred to the new computerised system, and a new workstation was being prepared so that care staff had access to the system to record daily updates for people. Passwords were in place to control access to records. Paper care records were being stored securely in the home's office. The care records had been reviewed regularly. Other records were well maintained and had been reviewed regularly, The provider had contracted with a professional advisor to provide policies and procedures and was awaiting amended versions to reflect the new regulations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, or did not meet people's assessed needs. Care delivered was not always in accordance with people's care plan, and plans did not always contain sufficient detail on people's needs. This was a breach of Regulation 9 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that the premises were safe to use for their intended purpose and are used in a safe way. This was because risk assessments had not identified concerns with regard to windows and glazed doors. This is a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not being protected as the provider had not ensured that the nutritional and hydration needs of service users were being met. Tis was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People were not being protected as the provider had not got proper systems in place to assess that staff employed were fit and proper persons to be employed by the service. This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.