KR Care Homes Limited

Bankfield

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
Bankfield is a residential care home, providing personal and nursing care to 34 older people and people living with dementia, at the time of the inspection. The service can support up to 47 people. The home is set across two floors with an accessible garden is in the centre of the home.

People's experience of using this service and what we found
The provider had not followed the latest guidance to support people to receive visits from their nominated family members during the COVID-19 pandemic. Families felt there had been a lack of communication since the new provider took over the home. The provider did not have processes in place to monitor and improve the service delivered. Audits in place were ineffective and did not highlight the findings from this inspection.

Medicines were not always safely managed. A person who received their medicines covertly did not have the correct guidance in place to support the administration to be safe. People who were at risk of pressure sores and agitation did not always have the risk assessed with actions taken to mitigate the risk from occurring. People and staff felt staffing levels needed improving. The staffing dependency tool did not consider the layout of the building and staff expertise. Further improvements were required to ensure staff were always following best practice in relation to wearing personal protective equipment and clothing. The recruitment of staff was not always safe. We made a recommendation for the provider to improve recruitment processes.

People said the staff team were caring but we were informed of a number of occasions when people had not been supported in a caring and dignified way. This included waiting lengthy times for care and support which resulted in people feeling unhappy about their care. People were also isolated in their room with one person not having any access to stimulation for long periods of time. People felt staff were often too busy and call bells rang for long periods in the home which people told us happened regularly.

Care plans did not always reflect people's current needs and people and families told us; they had not been involved in care planning. There was a lack of stimulation for people at the home and there was no formal activity timetable. People were supported at the home, should they be at the end of their life. Further work needed to be undertaken to ensure end of life plans were documented for staff to be aware of people's wishes.

People were supported to eat and drink, however people told us they could not follow a diet of their culture. The registered manager told us, the people were no longer practicing [their religion], and they could have the vegetarian option instead. Staff received training to assist them in carrying out their job role, but further training was required to ensure people's specific needs were cared for.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems

in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for the service under the previous provider was good, published on 18 June 2019.

Why we inspected
The inspection was prompted in part due to concerns received about the management of the home. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see all key questions sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bankfield on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment, good governance and staffing at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bankfield

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of three 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.

Service and service type
Bankfield 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service and checked if Healthwatch held any information.
Healthwatch is an independent consumer champion that gathers and represents the views of the public

about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and 11 relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, registered manager, deputy manager, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a health professional who regularly has contact with the service and the local authority commissioning team.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not safely managed.
- We were not assured people were receiving their medicines as prescribed. We sampled the boxed medicines for six people and found discrepancies in the stock levels for five. For example, one person, according to the stock levels should have had 82 Paracetamol tablets remaining in the box. The box contained 78 tablets and a ten pack of Paracetamol caplets which did not belong to that person.
- Covert medication was not managed safely. One person was prescribed medicines covertly which could be placed into food or drink. There were no instructions available for staff to ensure the medicines were placed into suitable food and drink and not mixed with certain foods and drinks which may make the medicines ineffective.
- Medication records were not always accurate. The medication record for one person was intermittently signed for a prescribed topical cream. We raised this with the registered manager who told us the person applied their own creams. This was not reflected in the person's care plan or medication record.

Medicines were not managed safely. This is a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always safely managed.
- One person had a pressure sore and there was no guidance to support the staff to manage the sore or to prevent the wound from worsening. Staff did tell us regular repositioning was in place to assist in preventing further concerns with skin integrity and district nurses were involved in the management of the wound.
- Another person had often become agitated and could be aggressive towards staff. There was no risk assessment in place and no guidance for staff to follow to mitigate agitation occurring.

The provider had not done all that is reasonably practical to mitigate risks to people. This is a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Internal and external safety checks of the home were completed such as fire, electrical and gas safety.

Staffing and recruitment

- People told us, they often had to wait for support and rang their call bells and staff did not always respond in a timely manner.

● One person said, "You have to wait for the carers. I wet myself not so long ago, it makes you feel dirty, awful. It happens quite often. I have to shout when in my bedroom. I hate shouting, they [staff] come eventually." Another person said, "I asked yesterday for someone to empty my commode, they [staff] said they would come back but they didn't." A third person said, "Yesterday I wanted the toilet, but I couldn't find anyone to ask."
● All but one member of staff we spoke with said more staff are required on each shift. Comments included, "Reduced [staffing] since new owners took over" and "More staff are needed." A dependency tool was used to calculate staffing levels, but this did not consider the layout of the home and expertise of the staff.
● The registered manager told us there were ten people who required the care of two staff members but at times, there were not enough staff on duty to facilitate this. For example, there were three staff working at night across the home.

The provider did not have a systemic approach to determine the number of staff and range of skills required to meet people's needs and keep them safe. This is a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff members were not always recruited safely. Of the three newly recruited staff recruitment records we reviewed, we found three references had not been verified so we could not be assured they were from the intended referee.
● One new staff member did not have an up to date Disclosure and Barring Service (DBS) check. The provider had used a previous DBS check which was acceptable during the pandemic, however no risk assessment was in place to ensure the staff member was safe to work with vulnerable people. The provider has since applied for a further DBS check for the staff member.

We recommend the provider revisits their recruitment processes to ensure they are fully robust and reflect regulatory requirements.

Preventing and controlling infection
● Further work needed to be undertaken to improve the management of infection control in the home.
● Staff were aware of the need for personal protective equipment (PPE) and how this should be used during the COVID-19 pandemic. We did observe one staff member not wearing a face mask over their nose and another staff member wore long sleeves rather than elbow length which risks contamination. We raised this with the registered manager who said they would speak with staff.
● The provider was facilitating some visits from the families of people living in the home, but they were not following the most up to date guidance in relation to visiting. Following this, we asked the provider to update their policy to reflect the current guidance.
● People and staff were part of a regular programme of testing which meant any new cases of COVID-19 could be identified and isolated as soon as possible.
● We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of signs of abuse and how to report concerns.
● Staff had received training in safeguarding vulnerable adults and felt confident to report any concerns they had.
● People we spoke with were not sure how they would raise any concerns. Relatives told us they would raise any concerns with the registered manager.

Learning lessons when things go wrong

● Accidents and incidents were recorded and analysed. Where people were falling, equipment such as falls sensor's and crash mats were used in bedrooms.
● Information on the management of falls was collated and where people were at risk a referral was made to the falls team for further advice on fall's management.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink, but further improvements were required to ensure people ate and drank in a timely manner and personal preferences were captured in care plans.
- Some people living in the home had previously enjoyed a cultural diet in line with their religious beliefs. We found this was not offered at the home and people were offered a vegetarian option instead. The registered manager told us people living in the home were now not practicing [their religion].
- We observed mid-morning drinks and biscuits given out and the biscuits were left on the closest table to the person rather than being served in a napkin or on a plate. We also saw for one person, their drink and biscuits remained untouched for over one hour as they were not prompted to eat and drink.
- The chef was aware of those who required fortified diets or who had allergies.
- People spoke positively about the meals provided. One person said, "The food's good. I had spaghetti and sponge pudding and cream, I can't grumble."

Staff support: induction, training, skills and experience

- Staff did not always have the training and expertise to support people with specific needs.
- Staff had not had training in catheter care, skin integrity and falls management and we were not assured staff knew how to manage such needs. Some staff had received the training in previous roles.
- Staff received an induction when they commenced employment with the provider. The induction provided health and safety information and expectations of the new employee's role.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People could see a health professional when required.
- The GP completed a weekly review of people, this assisted in early diagnosis of certain health conditions and treatment.
- Relatives gave mixed feedback on being informed of changes in their relation's health. One relative said they were always informed while another said, "Yes, they have done [been informed], perhaps not as often as necessary."

Adapting service, design, decoration to meet people's needs

- The home had undergone some redecoration and further work was planned.
- People's rooms had a wash basin, and some had their own toilet. Some rooms had been personalised

with items from the person's own home.
● There were three accessible communal areas where people could spend their day.
● There was a large, accessible garden in the centre of the building.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People received an assessment of their needs prior to admission; however, this had changed during the COVID-19 pandemic and the provider relied on assessments from trusted assessors or social workers.
● Prior to the COVID-19 pandemic, assessments were completed with people and their families.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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.

● People had their capacity assessed and where the person lacked capacity, a referral was made to deprive the person of their liberty, as appropriate. Any conditions to deprive the person of their liberty were recorded.
● Staff have received training on the MCA and DOLS. We observed staff to be gaining consent from a person before any care and support was given.
● Families told us they had been made aware of the referral to deprive their relation of their liberty but had not been involved with the process of assessing their relation's capacity.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always well treated, and equality and dignity and independence was not always supported.
- On asking the registered manager about a person who felt wet and needed assistance to go the toilet, the registered manager told us, the person wore a continence pad. This meant the person was not receiving the support they needed to manage their continence and be as independent as possible.
- One person who was cared for in bed could be heard shouting throughout the inspection. On visiting the person in their room, we found them not to have access to an alarm to summon staff for assistance. There was no source of stimulation for the person, the tv was switched off.
- Throughout the inspection, we heard the alarm sounding which summoned staff assistance. On one occasion, the alarm sounded for 18 minutes. We checked and the alarm had not been reset. People told us and we saw the alarm often sounded for long periods of time which was disruptive to the people living in the home.
- People felt cared for by the staff team, but we observed little interaction from the staff. For example, one person who was supported on a one to one basis had a staff member following them around the home but did not offer any form of conversation. Other people slept in their chairs for long periods of time without interaction from staff.

Supporting people to express their views and be involved in making decisions a

- People were not always involved in expressing their views and making decisions about their care.
- On asking people if they felt listened to and were given help when they needed it, they told us, "They [staff] are always too busy" and "I leave it to them [staff] when I get up, I just wait for them."
- There was little evidence that people were involved in their care, people told us, "There is no discussion, I don't get asked [by staff] but they do their best" and "No discussion about care but my care is dignified."
- All relatives we spoke with said they had not been involved in their relation's care. Comments included, "I have not been involved at all", "We haven't discussed [name] care at all, it feels like we have just left [name] there" and "There has been no discussion about [name] care needs."

The provider did not do everything reasonably practicable to make sure people received person-centred care which met their needs. This is a breach of Regulation 9 (person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always have personalised care plans which captured their needs and requirements.
- One person's care plan did not reflect they had a catheter in situ and a pressure sore which meant staff were not directed to provide the most suitable care for that person. The person's care plan was updated immediately following the inspection.
- Another person's care plan stated they were able to walk unaided but the person was now only able to mobilise by using a wheelchair and the care plan had not been updated.
- Care plans were a mixture of paper-based documents and supported by the electronic person-centred software. The electronic care plans were not always reflective of the paper care plans so it was difficult to understand which information correctly reflected people's current needs.

The provider did not maintain an accurate, complete and contemporaneous record in respect of people living in the home, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a lack of stimulation and activities to prevent people from social isolation.
- The home had an activities coordinator who was new to the role. There were no timetable of activities and people were left for long periods of time in their rooms or in communal lounges. We did observe staff playing a game with a balloon during the inspection.
- People told us, "I'm not one for activities, but it's boring"; "I read in my room, watch tv or do crosswords." and "There is nothing to do really. I like to talk and have a laugh. I am not sure why I haven't seen my husband or family."
- Throughout the inspection, TVs were on each in communal lounge showing different programmes. People asked us to turn the volume down as the noise was challenging.
- A relative told us, "I think they need more activities." Another relative told us their relation was proud of their [cultural] heritage." However, there was no evidence people were supported to continue with their beliefs.

The provider did not ensure people's social, cultural, religious and spiritual needs were met. This is a breach of Regulation 9 (Person-centred care) of The Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider did not always provide information to people in the most suitable format.
- Parts of the home did have signage to direct people to their room or the bathroom.
- We observed at lunch time, some people did not want their pre-ordered meal. There were no photographs of the meals which may have helped people choose their meal more effectively and assist them in remembering their choice.

End of life care and support

- People could be supported to remain at the home when they came to the end of their life.
- Some people had care plans to support their wishes should they be at the end of their life. We found one-person had a Do Not Resuscitate Order in place but no other record of how staff should support the individual at the end of their life. The registered manager told us they would contact the person's relative to obtain the information required.

Improving care quality in response to complaints or concerns

- Complaints were recorded and responded to in a timely manner.
- People told us they didn't know always how to raise a complaint, but they could rely on staff or their relatives to assist them.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider and managers were not always clear about their roles and regulatory requirements and did not always engage people and their relative's.
- The provider registered Bankfield as a location in March 2020. The registered manager told us some of the concerns we found had been inherited from the previous provider. However, provider told us, this was not the case. This meant we were not assured the current provider had addressed the concerns they advised they had inherited from the previous provider in appropriate time scales.
- The provider was not following the latest guidance on visiting to support relatives to see their relations during the COVID-19 pandemic. Relatives told us, "I phoned to book a window visit. [Staff] said they are only available in the afternoon as they are busy in the morning. I am now not allowed in as I haven't had the injection [vaccine]. You have to do a COVID-19 test, isolate then do a [lateral] flow test. There are no visits at weekends", "We are not allowed to go in" and "The registered manager said I can't go in as I haven't had the jab [vaccine]." Following this, we reviewed the provider's policy on visiting and asked them to update it to reflect the latest guidance.
- On asking staff about visiting procedures, they were unaware of any changes to the process.
- Relative's told us they were not always kept up to date with changes in the home or for their relation. One relative said, "We have no relationship. There has been a change of ownership which makes it feel more like a business than a care home." There was no evidence recorded of communications between the provider and relatives.
- The provider was in the process of moving from paper-based care plans to online care plans. There were no action plans, timescales or prioritising of the care plans which we found did not always contain pertinent information to people's care and safety.
- The registered manager said they planned for a number of improvements to take place across the home which included the management of care plans, medicines, staffing and training, and improving the décor, but there was no written plan for these improvements and the provider had not prioritised what was required to be completed first.
- The turnover of staff was high, and relatives told us, "There has been a lot of staff changes, I only know one staff now, I feel like a stranger in there." The registered manager told us a number of staff had left and they had recruited new staff members to support the existing staff team.

Continuous learning and improving care

● Some improvements had been implemented by the registered manager who joined the home some months earlier, however further improvements were required to ensure there was consistent learning and improvements in care and support for people.
● There were audits completed to monitor and improve systems within the home such as care plan audits, medicines and recruitment audits, but they had not highlighted any of the concerning findings at this inspection.
● There had been no training analysis of what support staff required to enable them to carry out their role effectively such as catheter care, falls management and the management of skin integrity.
● The provider had not sufficiently identified risks in relation to pressure area care and agitation which meant staff were reliant on being told how to manage risk by word of mouth rather than having a detailed assessment and person-centred approach.
● In response to people telling us they needed to wait for long periods for care and support, we asked the provider to check the response times for call bells. Prior to the inspection, this was not being checked and we found one person had needed to call the local hospital to say they had fallen on the floor. The hospital then phoned the home for staff to go to the room and support the person. We were also told the nurse alarm cannot not be heard in some parts of the home. The registered manager was aware of this and said there is always a staff member on the ground floor who can hear the alarm. This had not been highlighted as part of the provider environmental audit in March 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● The provider was not always promoting a positive culture.
● There was a limited approach to information sharing. For example, staff were involved in a daily, recorded handover, however the handover only highlighted where there had been some concerns and did not discuss the well-being of everyone. We were told a verbal handover was also given.

The provider had not followed the latest guidance to support people to receive visits from their nominated family member. The provider had not engaged people and their families about their care and support. The provider had not written plans to enable improvement's to be made across the home and there was no process to ensure care plans and risks assessments were updated onto the electronic system in a timely manner. Audits to monitor and improve the service were ineffective and did not capture the findings from our inspection in relation to training for staff, recruitment, care planning and risks to people. The provider had not ensured they had oversight of when people needed support and if staff responded in appropriate time frames.
This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider worked with other professionals to ensure health related concerns were responded to.
● Staff had been able to attend staff meetings and received supervision. One staff member said the registered manager was approachable.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was aware they must act in an open and transparent way with people, their relatives and stakeholders under duty of candour.
● The provider had reported changes and events that had affected the service to the Care Quality Commission when required.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not do everything reasonably practicable to make sure people received person-centred care which met their needs. The provider did not seek the views of people who use the service and those who can act on their behalf. The provider did not ensure people's social, cultural, religious and spiritual needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed. The provider had not done all that is reasonably practical to mitigate risks to people

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have a systemic approach to determine the number of staff and range of skills required to meet people's needs and keep them safe.

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 17 HSCA RA Regulations 2014 Good governance The provider did not maintain an accurate, complete and contemporaneous record in respect of people living in the home, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. The provider had not followed the latest guidance to support people to receive visits from their nominated family member. The provider had not engaged people and their families about their care and support. The provider had no written plans to enable improvement's to be made across the home and there was no process to ensure care plans and risks assessments were updated onto the electronic system in a timely manner. Audits to monitor and improve the service were ineffective and did not capture the finding from our inspection in relation to training for staff, recruitment, care planning and risks to people. The provider had not ensured they had oversight of when people needed support and if staff responded in appropriate time frames

The enforcement action we took:

A warning notice was issued to the provider.