Quality Care Management Limited

Quality Care Management t/a Aquarius Nursing Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on the 15 and 19 May 2015. Quality Care Management t/a Aquarius Nursing Home is a nursing home which offers personal and nursing care for up to 38 older people, most of whom live with dementia. The home consists of three Victorian houses with a corridor which links all three houses together. During our inspection 35 people were being accommodated.

The home had a registered manager. 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

Staff had an understanding of abuse and what action they should take if they felt someone was not receiving safe care; however incidents had not always been reported to the appropriate authorities. Risk assessments relating to people were not always completed and had not been updated as necessary.

Staffing levels and the skills mix were planned and organised to meet the needs of people, however there was a concern extra staff could not be resourced when necessary. Staffing recruitment records did not detail all the necessary information before staff started work to ensure people were safe. The administration of medicines practices in the home were not safe.

People felt staff had the knowledge to care for them effectively. However, staff had not received training in all relevant areas or from staff trained to ensure they had the knowledge to meet people's needs. Staff had not received regular formal supervision but felt supported. Some staff did not have an awareness of or understand the Mental Capacity Act 2005 and the principles of this had not always been applied.

Some people did not have their nutritional needs recorded but people received adequate support at meal times. Health needs were assessed and the relevant professionals were involved in people's care provision.

The majority of staff were caring and were mindful to be respectful of people's privacy. People were not formally involved in discussions about their care. Care plans were not personalised in all areas and in some areas did not provide detailed information to guide staff about the support a person needed. The home had a complaints policy and people felt able to complain.

Quality assurance in the form of auditing was not taking place on a regular basis and it was not possible to establish learning from audits took place to bring about effective change.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

Staff had been trained in the safeguarding of vulnerable adults but incidents had not always been reported appropriately.

Risk assessments were not always individualised and did not detail how the risk should be minimised.

Staffing levels did meet the needs of people if all staff on the duty rota turned up, but there was problems with staffing levels at weekends.

Staffing recruitment practices were not always completed and did not ensure the safety of people.

The management of medicines was not safe and people were at risk of not receiving medicines safely.

Infection control procedures were not being followed at all times to ensure the risk of infection was being minimised.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received training but this was inconsistent and not always provided by qualified staff and did not ensure all staff had the skills to meet the needs of people.

Staff did not receive regular supervision, but felt supported by the management team.

People were not protected from inadequate nutrition and hydration..

Staff did not understand the principles of the Mental Capacity Act 2005 and ensure these were applied correctly.

Is the service caring?

Requires improvement

The service was not always caring.

People were not consistently provided with opportunities to be actively involved in decisions about their care.

Most staff demonstrated an understanding of how to treat people with respect privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans did not record people's individual needs or preferences in all areas of care delivery. Activities were not planned to meet people's individual needs.

Summary of findings

Complaints had been recorded responded to, investigated and learnt from.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service had a registered manager, and people and staff felt able to discuss any concerns with them.

The organisation's values if any were not communicated to staff but staff had their own values.

The systems in place for external auditing were not adequate to ensure a quality service was provided to all people.

Quality Care Management t/a Aquarius Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 & 19 May 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection, we reviewed previous inspection reports, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law. During the inspection we spent time talking to six people, four nurses, five members of care staff, the head of care and the registered manager. We also spoke to a visiting professional from the health team. When in the report we refer to the management team we are referring to the registered manger and the head of care. The head of care worked more with the trained nurses.

We looked at the care records of eight people. All details of people's care were kept on the computer system, which staff had access to via I-pads. We looked at the staffing records of seven members of staff. We saw minutes of staff meetings, the policies and procedures file and the complaints log and records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home and relatives also said this. People said they felt confident with staff and management who treated them well. One person said "I feel safe here because I know if I need someone they will be here". People told us the staff were helpful. One person told us, "Staff are always attentive..... if I need them I press my buzzer and they always come". Another person told us staff always responded to their calls for support and said this was "fairly quickly", although they also said the longest they think they have had to wait was "30 minutes".

Staff had an understanding of what constituted abuse and could describe what they considered abuse meant. Staff knew about the procedures of reporting abuse and all felt they would discuss any concerns with the management team. All staff had confidence the management team would report any allegation of abuse to the appropriate authorities. The management team were able to tell us about the policies and procedures regarding abuse and what action they would take. The management team were able to show us evidence they worked co-operatively with the local safeguarding team, when concerns had been reported. However when we looked at care records and medicine administration records of people we found there were reports of incidents which should have been reported under safeguarding procedures. For example we saw records of where two people had minor scuffles with each other. The management team told us this had been an oversight and they knew they should have reported these incidents. Whilst the service had taken action internally, these incidents had not been reported to the local authority or CQC. The provider's policy stated they should have been reported. They were not adhering to their own systems and process at all times. This meant there was a risk appropriate investigations might not be undertaken and safeguards put in place to protect people.

The failure to report safeguarding concerns appropriately was a breach of Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People had access to all areas of the home and back garden. However risk assessments for all areas of the environment had not been completed. For example the back garden had a small uncovered pond, which was accessible to people, but no risk assessment had been completed regarding the risks this posed to people. The home had recently had a fire risk assessment which had raised areas of concern, which we were told the provider was addressing.

People did not always have risk assessments in relation to the risks associated with their care. In one example there had been clear risks identified in daily records in relation to a person's behaviour. When looking at the person's computerised care records there were no risk assessments in relation to this behaviour. When discussed with the management team they advised they had just completed the risk assessments regarding this behaviour and showed us the paper versions. Whilst the completed risk assessments were comprehensive for this person they were still not on the computer system and available to staff, so that they would know how to minimise the risks and care for this person to promote their dignity and safety. We learnt that the person had been exhibiting behaviour which placed them at risk for some weeks before the paper form risk assessments had been completed. We also saw records which demonstrated two people had lost weight but no risk assessments had been developed to reduce the risks for these people.

There were stairs between each part of the building and a lift went to two parts of the first floor. A stair climber (which is an aid usually used for short term emergencies by staff to support people to climb) was used for those who had stairs to access their rooms, who could not access these on their own. Staff had not been trained or assessed as competent to use the stair climber. There was no risk assessment in people's records or a general risk assessment for the stair climber. We spoke with two care staff who told us "We have used them for a long time and they can be hard work". Staff and people were at risk of harm through the lack of appropriate assessment of risk.

The lack of timely, thorough and accessible risk assessments was a breach of Regulation 12 (of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The provider had a policy on staffing levels but was not following this to ensure at all times there was adequate staff on duty to meet people's needs. Staffing levels were static and many staff had worked in the home for many years. We were told by staff if everyone on the duty rota came into work the staffing levels were adequate to meet the needs of people. However we were told by staff on a

regular basis the staffing levels on the duty rota were not reflective of who was actually working. A staff member said this was due to sickness, holidays and staff just not turning up. We were advised by staff this was particularly a problem at weekends. The registered manager confirmed they were aware of this problem and would come in most weekends and try and phone staff to come in and work extra duties. A staff member told us, "On some weekends it is so busy you just get people up and sit them in the lounge as there is not enough time to do anything else. Staff and the management team told us the provider would not allow the use of agency staff, even if the home was short staffed.

Recruitment checks had been completed on most staff to ensure they were safe to work with people in a care setting. However it was noticed for two staff members there were no details of their qualifications or previous employment, which was not in line with the provider's recruitment policy. We noted the staffing records indicated the date for one nurse's registration with the Nursing and Midwifery Council (NMC) had expired. This had not been noticed by the management or provider. When we checked the NMC website we found the member of staff had renewed their registration. However it was noted there was information recorded which should have been addressed with the nurse to ensure there was no risk to people. Two recently recruited staff members we spoke with described their recruitment process as thorough. They told us they had completed application forms and had not started work until their Disclosure and Barring Service DBS checks and references had been returned. DBS checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

A lack of appropriate recording and recruitment checks before people started work in the home meant people were at risk of receiving care from people who were not suitable to work with adults at risk. This was a breach of Regulation 19 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The medicines ordering system was effective although there had been two incidents when a person's medicines were not available during the previous three months but we were told this was due to a manufacturing problem. We found medicines in the controlled drugs cupboard which were not recorded in the drug register. An 'as and when necessary' (prn) proforma was used for prn medication. However these were not individualised and as different people express pain in different ways this information should have been recorded. It was not possible to establish where topical (to be used on the skin) medicines should be applied and that they were being applied as prescribed. We found eight tubs of skin cream where it was not possible to read the prescription label, so we could not be sure who it belonged to. We observed two registered nurses administering medicines and saw that these were given on time. The nurses approached people with their individual medicines, explained what the medicine was for and asked for people's consent by saying "Is it alright if I give you this medicine now?" People mostly responded positively to this.

Medicines were not always recorded appropriately to ensure the safety of people. This was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

We found supplies of personal protective equipment such as aprons, disposable gloves and antibacterial gel around the home. However, in three toilets there was no soap for people to wash their hands and in three toilets and two bedrooms the water temperature in the hot taps was lukewarm. This meant it would have been difficult for people to wash their hands safely. Two domestic staff we spoke with were knowledgeable of infection control and how to prevent the spread of infection. Kitchen cleaning records were satisfactory and completed and the kitchen was clean and tidy. Some equipment such as hoists, commodes, and bed tables were not cleaned as we found a number had stains and debris on their surfaces. Most waste bins in people's rooms did not have lids and those that did we found the foot pedals did not work. This meant when people had washed their hands they had to touch the bin to open it to dispose of the paper towel, therefore coming into contact with potential sources of infection. We also noted that bathroom light pull cords were significantly discoloured. We saw that slings to help move people were not individually labelled which meant there was a risk of infection transfer when they were shared. We asked the manager to show us the provider's infection control audits. They told us "We do not do anything like that". This meant the provider could not identify situations which might have created an infection risk for people living at the home, staff and visitors and as a consequence we could not be sure the home was safe in terms of infection prevention and control.

Inadequate

Is the service safe?

Infection control procedures were not always followed. This was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

People we spoke with felt staff were knowledgeable of their needs and knew how to support them effectively. Relatives we spoke with agreed with this. The service had a staff group where most had worked in the home for a long period of time. It was clear from records care staff did not receive regular formal supervision, whereas nurses did. Staff told us they felt supported by the registered manager and that she would make time for them if they needed to discuss any concerns.

The registered manager told us they delivered some of the training to staff, for example safeguarding, fire, and health and safety. However the registered manager told us they were not qualified to deliver this training. This meant staff were receiving training from an unqualified person and we could not be sure the content of the training was appropriate. Staff also had access to a programme of computer-based E learning, which we were told would be assessed by the registered manager. The training matrix for care staff and nurses showed there were many areas where staff had not completed training and we were advised it was a problem for trained staff ie. nurses to attend clinical training. Out of 30 care staff only four had completed training on person centred care, two had completed training on challenging behaviour and fourteen had completed training about dementia Staff had received an annual appraisal and those who had not did have dates booked. It was noted in the appraisals which had been completed staff had made reference to needing training, for example wound care skills, helping people to eat safely and a request for more outside training had been recorded.

Staff did not receive regular formal supervision or adequate training to ensure they could safely meet people's needs. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they made their own decisions and staff respected these. They told us they decided where and how they wanted to spend their time, what time they got up and went to bed and what they wanted to eat and drink. Nurses had a good understanding of the meaning of the Mental Capacity Act (MCA, 2005) and their responsibilities in respect of it. The MCA provides a legal framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves. Care staff were unaware of the MCA and were unsure of how it impacted on people. Only six members of care staff had completed training on mental capacity and Deprivation of Liberty (DoLS). People's records did not contain decision specific mental capacity assessments which meant staff did not have guidance regarding the decisions people had the capacity to make and those which they did not. We spoke with one nurse who told us "We do not do nearly enough risk assessment here, or mental capacity assessments and we should do, it is not right". We noted when people had bed rails their care plans contained a risk assessment but there was no evidence that the person had been asked to provide consent to using bed rails or, in the event they could not, that a best interest decision had been taken on their behalf in accordance with the MCA. Two relatives we spoke with told us the management team kept them involved in decisions about their family member's care.

Capacity assessments had not been completed to ensure people could give consent to the care they received. This was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The management team in the home demonstrated a good understanding of what constituted Deprivation of Liberty Safeguards (DoLS). DoLS protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Four people had a deprivation of liberty safeguard granted by the local authority. We saw that some applications had been made to the local authority and the management team told us they were currently applying for more DoLS assessments mainly with regards to the locked front door, the use of closed circuit television (CCTV) and in relation to the behaviours of one person.

Meal times observed were relaxed and not rushed. People received their meal in a timely fashion and there were enough staff to support people who needed support to eat and drink. We were advised special diets were catered for and currently two people were by choice on a vegetarian diet. The kitchen staff held a list of all people who required a special diet such as diabetic, soft and pureed diets and other needs. For example, we saw this list told the kitchen staff who didn't like particular food items and who needed their food cut up before it was served to them. They told us they were given a list by staff every day of people's needs and what they wanted to eat. However, people's nutrition

Requires improvement

Is the service effective?

care plans gave little information relating to the person's preferences or needs. For example one person's 'Nutrition' care plan did not refer to the fact the person had been diagnosed with diabetes, which was controlled by their diet. It was noted in this person's monthly 'weight record' they had lost over 10kg in just over three months. However we could not see the care plan had been updated to reflect this or any additional support they needed. People's food and fluid records were not complete or up to date and it was not possible to establish their daily food and fluid intake. We spoke with the management team about this who told us "We are always reminding the staff about this but sometimes it just does not get done".

People were not protected from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People had access to a range of health professionals and the contact with them was written in people's care records. Relatives told us they were kept informed of people's contact with different professionals and of their advice and input. We spoke with a senior nurse from the external continuing health Nursing Home Team who told us, "The home has good staff, it can be very hectic here but the staff always get in touch if they are concerned about someone and they always follow my advice about care, I would say it is a good home with responsive staff".

Requires improvement

Is the service caring?

Our findings

People spoke highly of the staff describing them as very caring. One person told us "They treat me like a family member and not a patient". Relatives told us they felt staff were attentive to people and cared.

The majority of interactions between staff and people demonstrated staff had a good understanding of people's daily needs. Staff in the main took their time and demonstrated a caring and patient attitude when communicating with people. We saw when people were distressed the support provided varied. For example, on one occasion a staff member noticed a person's distress, they knelt down beside them and gently spoke to them about what was causing their upset. They gave reassurances while holding their hand and told them they would call a doctor. However, we also saw examples of where staff lacked the skills and did not demonstrate a caring attitude. For example, we observed a person asking loudly to go to the toilet for ten minutes. We spoke with the nurse in charge and asked for them to receive some assistance as they were becoming more distressed. The nurse asked a member of the care staff to provide support and take the person to the toilet. They and another member of care staff assisted the person appropriately into a wheelchair and moved them round to outside the toilet. A care worker, with both hands on either side of the wheelchair shouted to the person at close range, "You will have to calm down and wait the toilet is engaged". The person was visibly upset and quietened immediately. This was reported to the management team who took action. Over the course of two days we observed that some people became distressed and became agitated. Staff did not seem to be aware that increasing levels of agitation can lead to aggressive episodes. The staff were continually busy with their agreed functions but did not seem aware of these situations until voices of people were raised and an incident was in progress.

The majority of care records were kept on the computer system, which required staff to have a password to input information. This ensured information was kept confidential and people's records were kept private. Whilst all comments from people and relatives about involvement in decisions about care and treatment were of a positive nature, their involvement was not recorded in people's care records. Care plans made very little reference to people's involvement and decision making regarding their own care. Care plans did not include much information relating to people's interests and choices. There was no information within care records demonstrating people had been involved with their care plans. People's daily records were basic and referred to people having "a good day" and "ate well". This did not provide sufficient information to describe the quality of people's lives that lived at the home.

The lack of records regarding people's preferences and involvement in decisions was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Most interactions respected people's right to privacy, although on one occasion a staff member walked straight into a person's bedroom without knocking. Staff treated people with respect and used screens to protect people's privacy and dignity when providing support in communal areas. People had their independence promoted and people had freedom of movement around the home and the back garden. One person told us they had arrangements with the management of the home so they could go out whenever they wanted.

Requires improvement

Is the service responsive?

Our findings

Two people and two relatives told us they were involved in their care planning. People said staff spoke to them about what they liked/disliked and wanted. Relatives told us care plans were shared with them to ensure they were up to date. However one person told us they had not been spoken to by staff about their care and did not know if they had a care plan. People were confident that staff took them seriously and said they would raise a complaint if needed. However no one we spoke with had any complaints and said they had never had the need to complain.

People had assessments completed before they came into the service to give staff some idea of how they would need to provide care to meet and plan for the person's needs. From this a care plan was developed, which was added to as necessary. The care plan covered many areas, which included information on a range of areas.

We found some parts of people's care plans were not always reflective of people's current needs. They had not been updated to reflect people's changing needs and associated risk assessments had not been completed where appropriate. Parts of care plans were not personalised and reflective of people's individualised needs. For example in one person's 'hygiene' care plan it stated the person was 'unable to maintain their own personal standards of hygiene'. The plan of care gave no detail of how care should be delivered to meet the person's individual needs. Notes on actions recorded staff had assisted with, 'bed bath, eye care, mouth care, dressing and body care'. The last nine entries showed the care had been given by eight different members of staff, who did not all necessarily know this person's preferences and choices.

The records of a person who was receiving care for a wound were not up to date. There was no clarity about the start of the person's leg wound care and the current situation was not recorded accurately. The waterlow (gives an estimated risk for the development of a pressure sore in a given person) care plan had not been updated to reflect the person's changed circumstances.

We looked at the activities people were engaged in but these were basic and did not describe people's engagement in activities they enjoyed. For example, on most days most people's records stated "enjoyed watching the television". We observed people were sitting for long periods with the television on. We asked a member of the care staff who selected the programmes. They told us "oh the TV is always on the night staff put it on for residents who get up early". The television was at one end of the room and people were seated adjacent to it which meant that most people had to turn their heads to watch the programmes. When we looked at the records of people who spent all of their time in bed we found they spent long periods on their own with no recorded contact with any of the staff.

The lack of care planning and information did not support people to receive personalised care to meet their needs. This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they knew how and who to complain to. They told us they felt confident members of the management team would listen and act on their complaint. The complaints log detailed information about complaints. We could see these had been responded to and the information in the complaint had been shared with staff to ensure there was learning from the complaint.

Requires improvement

Is the service well-led?

Our findings

People and their relatives told us the management team were approachable and they could talk to them at any time. One relative described them as proactive and everyone said they listened to them and had confidence in their ability. Staff felt able to speak to the management team and felt they would be listened to. A member of care staff told us, "It is difficult to get everything done because there is so much to do and people have a lot of needs, so sometimes it is a rush, the manager is good and her door is always open but we are sometimes a bit short of staff".

Minutes of staff meetings were seen which demonstrated staff were able to raise any issues of concern with management. These were usually staff specific, so nurse and care staff had separate meetings. These were recorded and it was possible to see what action the management team had taken when issues were raised. For example at the care workers staff meeting there were details about people wearing make up and the quality of how this was put on. This was addressed and staff were given advice by management on how to support people with this. During one of the nurses meetings the issue of record keeping had been raised and it had been agreed by management this was an area which needed to be improved on.

The service was not well-led in all areas. For example there were no infection control audits and we identified several issues that meant the provider's infection control measures were poor. The medicines audit was usually conducted monthly but had not been for the previous two months. It was a basic tick box system which did not include most of the issues we identified. This meant the medicines audit that was used at the home was not sufficiently thorough. Surveys had been carried out with staff, people and relatives. However these were not dated and there had been no analysis of this information. The registered manager advised there had not been time to carry out this analysis. We also found details of incidents between people living in the home which had not been reported to the safeguarding team by the registered manager.

The home used CCTV in all of its communal areas, stairs, reception and offices. In people's care records we reviewed we noted they contained consent to the use of CCTV. However, these had not been regularly refreshed over time. The management team were unable to answer some of our questions regarding the CCTV. For example they were not sure if audible recordings were taken, who had access to the recordings and for how long they were stored for. Whilst in the home we did not see any signs about the fact the home used CCTV. We looked at the home's Statement Of Purpose and found this included no details about the use of CCTV. The home's policy on CCTV stated there were "No cameras facing toilets, staffrooms or in any of the lounges". However CCTV was now in the lounges. The manager reported they were unsure when this had happened. They said it was an area that had grown. There was no analysis on the use of CCTV but the manager advised us it had at times identified when and where a person had fallen. However without any formal analysis of the use of this equipment it was difficult to assess if it was fulfilling its use, which was identified as, 'To protect and safeguard residents and staff in the home'. The provider had not taken into account the relevant legislation and published guidance. There was no analysis of accidents and incidents in the home, which meant there could be no learning from these events.

The management team told us they were not supported by the provider and were very much left to manage and run the home. We asked to look at any reports of meetings with the provider. We were told by the management team these had not happened for some time. They told us the last meeting in December 2014 was cancelled at the last minute. They told us all decisions regarding finances had to be scrutinised and they could wait up to three weeks for an answer. They gave an example where they had wanted to purchase some new pressure relieving cushions but had to wait for approval from the provider. The registered manager advised the reason they presented a lot of the training was because otherwise this would not be funded and therefore not provided. There was no overview of the auditing the management team undertook, so it was therefore left to the management team to carry out all audits, with the provider not providing an overall quality assurance mechanism. Staff told us they had their own values of how to care for people but they were not aware of any values of the organisation. Only four care staff and three nurses had completed the training entitled 'Principles of care and Your Organisation'. The lack of staffing levels at some weekends and the reluctance of the provider to address this issue demonstrated a lack of awareness of their responsibilities.

Requires improvement

Is the service well-led?

The lack of a robust quality assurance system was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not always acted on appropriately.

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 A lack of appropriate recording and recruitment checks before people started work in the home meant people were at risk of receiving care from people who were not suitable to work with adults at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Capacity assessments had not been completed to ensure people could give consent to the care they received.

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 9 (1) (3) (I) People were not protected from the risks of inadequate nutrition and dehydration. 9 (1) (3) (b) There was a lack of records regarding people's preferences and involvement in decisions. 9 (1) (3) (d) The lack of care planning and information did not support people to be involved in making decisions regarding their care.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 12 (1) (2) (a) (b) (d) (h) (f) (g) The lack of timely, thorough and accessible risk assessments. Medicines were not always recorded appropriately to ensure the safety of people. Infection control procedures were not always followed.

The enforcement action we took:
We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of a robust quality assurance system to ensure compliance.

The enforcement action we took:
We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive regular formal supervision or adequate training to ensure they could safely meet people's needs.

The enforcement action we took:
We have issued a warning notice.