HC-One Limited

Chandlers Ford Christian Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 January 2015 and 2 February 2015. Breaches of 10 legal requirements were found and we issued warning notices for breaches in care and welfare, meeting nutritional needs and consent to care and treatment. The provider was required to meet the regulations by 13 March 2015.

As a result we undertook an unannounced focussed inspection on 24 March 2015 to follow up whether action had been taken to deal with the breach.

You can read a summary of our findings from the two inspections below.

Comprehensive Inspection 7 January 2015 and 2 February 2015

Summary of findings

The inspection took place on 7 January 2015 and 2 February 2015 and was unannounced.

Chandlers Ford Christian Nursing Home provides accommodation and nursing care for up to 45 older people. The home is located in the centre of Chandlers Ford behind the Methodist church and close to local shops and amenities. The home is located on the ground and basement floors of a large purpose built building. The first and second floors are flats with separate access.

Chandlers Ford Christian Nursing Home had a registered manager in post on the day of the inspection. The registered manager left two days after our first visit. The provider told us a relief manager was 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.

At the last inspection on 9 July 2014, we asked the provider to take action to make improvements in respect of acting in accordance with the Mental Capacity Act 2005 (MCA), care and welfare and meeting nutritional needs. This was because the provider had not acted in accordance with the requirements of the MCA, did not always provide care in line with people's needs and had not protected people from the risks of inadequate food and hydration. The provider submitted an action plan which stated that the home would be compliant by 30 August 2014. We found that the provider had not carried out the required improvements.

During our first visit on 7 January 2015 we were so concerned about the management of medicines that we asked a specialist pharmacist inspector to visit the home. They visited on 2 February 2015 and identified improvements in the management of medicines since our last visit.

Medicines were not stored or managed safely. When we visited the home on 7 January 2105 we found large quantities of prescription medicines stacked up in the hairdressing salon. The door was wedged open. Labels indicated that some medicines had been stored unsafely in the room since the beginning of December 2014. We found the treatment room to be open and unlocked and medicines were stored in unlocked cupboards in the room. There was a risk that people, staff or visitors to the home would take the medicines inappropriately. Action had been taken to address these issues by the time of our second visit on 2 February 2015.

Staff understood about safeguarding and when to report a concern and people told us they felt safe. However, people's individual risks were not clearly assessed, documented, reviewed and changed in response to their changing needs.

There were not sufficient numbers of staff to keep people safe and meet their needs. Staffing levels had recently been reduced from seven to five care workers per day shift. Staff were rushed and task focussed, spending minimal amounts of time with people and only to perform a function such as supporting a person to drink. Call bells were ringing constantly and continued for long periods. People told us they waited a long time for call bells to be answered and their meals were served late.

People were at risk of choking because they were not supported to eat food which was suitable to their needs.

Although food and fluid monitoring charts were in place for some people, details recorded were not sufficient to support staff in ensuring people had eaten and drunk enough to meet their needs.

People did not receive support to eat sufficient quantities of food to meet their needs. Support from staff was inconsistent, sporadic and provided by various members of staff with long gaps in between of no support. This was not a pleasant mealtime experience for people.

Staff had not received sufficient training to meet people's needs. Not all staff had completed essential training. There was no clinical training specifically to improve competencies for nurses. Supervision meetings had not been carried out in line with policy and two members of staff said they had not had a supervision meeting in the last year.

There was evidence that advice had been sought from health professionals such as GPs, occupational therapists, speech and language therapists and psychiatrists, however we found that advice was not transferred to care plans and care was not delivered in the recommended way.

The provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The

Summary of findings

MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. This meant that the service was not obtaining valid consent for treatment and care in relation to people whose mental capacity was in doubt.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager did not understand when a DoLS application should be made and was not aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. As a result appropriate applications had not been made.

Although staff were kind and caring they were not able to provide personalised support in line with people's individual needs because the written and verbal handover information was inaccurate and lacking in detail. People were not involved or consulted in their care planning.

Staff were unable to respond appropriately to people's needs due to a lack of detailed and accurate care plans, risk assessments, daily records and shift handovers. Care plans were not in place in relation to people's specific risks and needs such as pressure ulcers, continence, pain and behaviours which may challenge others. There were no care plans in place in relation to specific conditions such dementia, diabetes and osteoporosis.

Staff morale was low and staff were not actively involved in developing the service. The home was not well organised, care was not provided in a consistent way, staff didn't feel listened to and we found errors in people's medicines and care plans which should have been detected through routine audits. Some aspects of the service were unsafe, such as the storage of medicines in the hairdressing salon for up to a month. Staff training was not up to date and staff competencies had not been checked. People said they didn't know who the registered manager was, but they would like to know.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the full version of the report.

Focussed inspection 24 March 2015

Following our inspection on 7 January 2015 and 2 February 2015, the provider was served three warning notices in relation to care and welfare, meeting nutritional needs and consent to care and treatment. These required the service to be compliant by 13 March 2015. We undertook this unannounced inspection to check that the breaches of regulations had been addressed.

We found that regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, continued to be breached. People did not receive personalised care that was responsive to their needs. Risks in relation to dysphagia (difficulty swallowing) had not been appropriately addressed and assessed. It had taken 10 weeks for one person to be referred to a speech and language therapist even though they had severe difficulty swallowing.

There was no care plan in place for a person with a urinary tract infection and staff had not appropriately delivered care to meet their needs. Staff continued to give one person showers even though a relative had stated they preferred baths. It was not clear whether topical medicines were being appropriately administered in line with the care plans because the records were incomplete and inconsistent and care staff instead of nurses made decisions about whether people required cream.

Improvements were noted in respect of the handover process and specific care planning to address the risks of acquiring pressure ulcers. Pain assessment tools meant that nurses were better able to ascertain whether people were in pain and administer analgesia appropriately.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, continued to be breached. The provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA) as people's capacity to make specific decisions was not appropriately and consistently assessed and acted upon.

Summary of findings

Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, was being met. Detailed records were kept in the kitchen about people's individual dietary requirements and the chef was knowledgeable about these. People were served a meal in line with their required consistency and support was offered where appropriate.

Additionally we identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We observed staff members to be providing care in a manner which was not kind and caring and was not in line with the required support identified in the person's care plan.

As a result of this inspection we met with the provider and asked them to produce an action plan showing how they would achieve compliance within four weeks. The provider agreed to provide us with weekly updates demonstrating progress. The provider agreed to voluntarily stop new admissions until they met the requirements.

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

Comprehensive inspection 7 January 2015 and 2 February 2015

The service was not safe. Medicines were not stored safely and there was a risk they would be taken inappropriately. During our second visit we found that medicines were stored safely.

People told us they felt safe although risk assessments were not reviewed and up to date, in order to assess people's changing risks.

There were not enough staff on duty at all times to meet people's needs and this impacted on the care they received.

Is the service effective?

Inadequate

Comprehensive inspection 7 January 2015 and 2 February 2015

The service was not effective. People were not consistently supported to eat sufficient quantities of the right consistency of food to meet their needs. Some people were at risk of choking.

Staff had not received sufficient training to meet people's needs and advice from health professionals was sought but not always followed.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 in obtaining valid consent and appropriate DoLS applications had not been made.

Focussed inspection 24 March 2015

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 in obtaining valid consent.

People were consistently supported to eat sufficient quantities of the right consistency of food to meet their needs.

Is the service caring?

Requires improvement

Comprehensive inspection 7 January 2015 and 2 February 2015

The service was not always caring. Although people said that staff were caring when providing individual care, people did not receive a kind, caring service which met their needs because staff did not have accurate and up to date information.

Privacy and dignity was not always respected. There was evidence that people were left in a state of undress while staff went to answer other people's call bells.

Focussed inspection 24 March 2015

Summary of findings

Privacy and dignity was not always respected. We observed that one person was not treated in a kind and caring manner. Staff had not followed relevant guidance which would have helped this person to feel that they were valued.

Is the service responsive?

Inadequate 

Comprehensive inspection 7 January 2015 and 2 February 2015

The service was not responsive. People's individual needs were not met because the service had not responded appropriately to people's individual needs providing personalised care plans in response to identified risks and conditions.

A variety of activities were on offer in the home, but due to increasing dependencies and a lack of staff, not everyone was able to participate as much as they would have liked.

The service did not respond to concerns raised by staff, relatives and people about the lack of staffing and the impact this was having on people's care.

Focussed inspection 24 March 2015

People's care was not always delivered in line with their individual preferences or in response to manage identified risks and specific needs.

Is the service well-led?

Inadequate

Comprehensive inspection 7 January 2015 and 2 February 2015

The home was not well led. Staff were demotivated and felt that they were not listened and responded to. The lack of leadership and teamwork impacted directly on the care that people received. People were at risk of not receiving appropriate care.

Chandlers Ford Christian Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Chandlers Ford Christian Nursing Home. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 7 January 2015 and 2 February 2015. The inspection identified 10 breaches of regulations.

The second was undertaken on 24 March 2015 and focussed on following up action taken in relation to breaches of three of the legal requirements we found on 7 January 2015 and 2 February 2015.

You can find full information about our findings in the detailed key questions of this report.

Comprehensive inspection 7 January 2015 and 2 February 2015

This inspection took place on 7 January 2015 and 2 February 2015 and was unannounced. The first visit was carried out by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. Our specialist advisor was a specialist in the care of frail older people living with dementia.

During our first visit on 7 January 2015 we were so concerned about the management of medicines that we asked a specialist pharmacist inspector to visit the home. They visited on 2 February and identified improvements in the management of medicines since our last visit.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law.

During our inspection we spoke with 11 people using the service and a relative. We also spoke with the registered manager, a kitchen assistant, two nurses, three care workers and one domestic. We reviewed records relating to 13 people's care and support such as their care plans and risk assessments. Additionally medicines administration records for every person living in the home were reviewed and four daily records of people's care held in their room.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support.

Focussed inspection 24 March 2015

This focussed inspection of Chandlers Ford Christian Nursing Home took place on 25 March 2015. There were 31 people living in the home. This inspection was carried out to check that the warning notices we issued after our inspection on 7 January 2015 and 2 February 2015 had been met. The inspection focussed on three of the five

Detailed findings

questions we ask about the service; is the service effective? Is the service caring? Is the service responsive? This was because the service was not meeting relevant legal requirements.

The team comprised of an inspector and a specialist advisor in the care of frail older people living with dementia. During the inspection we spoke with three people using the service, a relative and a social worker. We also spoke with the relief manager, the chef, two nurses, two care workers and one domestic. We reviewed records relating to 10 people's care and support such as their care plans and risk assessments. We also reviewed records of daily care in relation to six people.

Inadequate

Is the service safe?

Our findings

Comprehensive inspection 7 January 2015 and 2 February 2015

The service place people at risk because they did not store, handle or record medicines safely. At our first visit, we found that capsules of opiate based drugs were missing from an unlocked cupboard in the unlocked treatment room. This was not good practice. We reconciled the number of capsules in the boxes with records of numbers dispensed and numbers administered. It was difficult to do this accurately because some records were difficult to read. Nurses were unable to explain the discrepancy. There was a risk that the missing tablets had been administered incorrectly or taken by a member of staff or visitor to the home. Records relating to medicines administration and administering of medicines were not safe.

Controlled drugs were stored safely in locked metal cabinets secured to the wall. Controlled drugs are medicines which require a higher level of security. During our second visit, in conjunction with the relief manager, we carried out a complete stock check of all controlled drugs held. No discrepancies were identified; however, the records indicated a lack of routine stock checks by the provider.

On arrival at the home on 7 January 2014 at 8am we saw that the hairdressing salon had the door wedged open. The room contained 33 full bags of pharmacy products, eight large blue pharmacy bags which were full of medicines for the month ahead and 12 large boxes of nutritional products. The dates of delivery ranged from 2 December 2014 to 6 January 2015. Some of the drugs were psychotropic drugs, a psychotropic drug is any chemical substance that changes brain function and results in alterations in perception, mood, or consciousness. This would have been dangerous if taken inappropriately by anyone. There was a risk that medicines had been stored unsafely in the room, with open access to people using the service, staff and visitors to the home since 2 December 2014. We immediately identified to nurses on duty that the storage of these medicines was not safe and nurses moved the bags of medicines to another room and locked the door. This was inappropriate storage and stock control.

The bags contained medicines which should have been stored in a cool environment (below 25 degrees) including eye drops (which should have been refrigerated) and blood glucose testing strips. Blood glucose testing strips can give a different reading if not kept at the manufacturers guide temperature. We did not have access to a temperature probe, however the inspection team, in consultation with the registered manager, agreed the ambient temperature in the room was higher than 25 degrees. Medicines were not stored at safe temperatures.

Medicines were stored in the treatment room in cupboards, a fridge and two medicine trolleys. We found the treatment room with the door unlocked and open. We found cupboards in the treatment room were unlocked (with keys still in the lock) containing a variety of medicines including opiate based pain killers. We found the fridge unlocked (with keys in the lock). Medicine trolleys stored in the room were not secured to the wall. We immediately identified to nurses on duty that this was unsafe and a nurse closed and locked the door. Later we found the door to be unlocked and open. This indicated to us, that leaving the door to the treatment room unlocked was normal practice rather than a one off occasion. Medicines were not stored safely.

These concerns represented breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to the safe management of medicines. At our second visit on 2 February 2015, we found that appropriate arrangements were in place to store medicines securely and within their recommended temperature ranges.

At our first visit on 7 January 2015 people living in the home were prescribed pain killers on an 'as required' basis, referred to as PRN medicines. This meant the prescribing GP considered that the person was at risk of pain. There were no PRN care plans in place in order for staff to identify when a person was in pain. A PRN care plan would have provided staff with information about people's individual signs of pain; this is particularly important where people are suffering cognitive impairment, which affected around two thirds of the people living in the home. There was a pain protocol for two people, this was dated 2012 and was a short standard statement of when a medicine should be administered and was not individualised to people. Therefore, staff were not able to accurately administer pain relief. Medicines were not safely administered. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to the safe management of medicines.

Inadequate

Is the service safe?

At our second visit on 2 February 2015, supporting information on 'How I take my medicines', 'if required' and 'variable doses' was available for each person. The information also indicated whether the person could verbalise their need, which was important in the assessment of pain. This showed that the home had rectified the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to the safe management of medicines identified on 7 January 2015.

Care plans included a number of risk assessments in relation to people's individual risks such as dependency, falls, moving and handling and continence. However it was not clear that the risk assessments had been regularly reviewed and changed in relation to people's changing need. One care plan showed the risk assessment was created on 2 January 2014 but had not been updated since 11 October 2014. Some risk assessments were photocopied in black and white making it difficult to see which areas were highlighted in red as 'high risk.' One person had had their leg amputated, severely restricting their mobility and making them at risk of weight gain. This was not recorded as a risk with appropriate mitigating actions. Records showed the person had gained significant amounts of weight. Two people were self-administering topical medicines; however the risks in relation to this had not been assessed or recorded. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

People were at risk because they were not supported to eat food which was suitable to their needs. One person was served chicken and roast potatoes when records showed they required a soft diet and should have been repositioned before eating in order to help them to swallow. They were served food which did not constitute a soft diet and were not repositioned before eating. It was clear that the person was struggling to swallow. The person was only able to eat a small amount of their main meal in this way and ate no pudding. Despite the person's obvious difficulty swallowing, records showed that they had not been referred to a speech and language therapist for assessment and there was no dysphagia (**Dysphagia** is the medical term for swallowing difficulties) care plan in place. This meant they were at risk of choking. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

There were not sufficient numbers of staff to keep people safe and meet their needs. Staffing levels had recently been reduced from seven to five care workers per day shift. The registered manager was unable to provide records of how the staffing numbers had been calculated in relation to number of people living in the home, their dependencies and the lay out of the home.

Staff were rushed and task focussed, spending minimal amounts of time with people and only to perform a function such as supporting a person to drink. Call bells were ringing constantly and continued for long periods. It was difficult to assess how long because several people were ringing at once. However, in one two hour period, call bells escalated to emergency eight times. People told us they sometimes had to wait for call bells to be answered and this affected when their meals were served. This meant that on some occasions breakfast almost clashed with lunch. One person told us they waited significant amounts of time for their call bell to be answered during the day and often their food arrived cold because there were not enough staff to deliver it in a timely way. Another person said "It's 10.40 and I'm still waiting for my wash." One person called out in the lounge, for assistance, for ten minutes. No staff were available to attend to their needs. After ten minutes we alerted the registered manager to the person's distress. At lunchtime there were not enough staff to help people who required support to eat. One member of staff was required to assist four people which meant that support was interrupted, sporadic and resulted in people eating cold food. There were not enough staff to meet people's needs at all times.

The lack of staffing was not limited to staff providing immediate care to people. Domestic staff told us that they were expected to run the laundry and clean people's rooms. This meant prioritising laundry and therefore cleaning rooms could not start until midday. This may explain why we found a bathroom which was dirty with faeces. Domestic staff went on to say they did not have time to carry out additional cleaning tasks such as shampooing carpets and deep cleans. Catering staff told us they felt obliged to work extra hours because if they did not cover shifts in the kitchen, then care staff were pulled off the floor, leaving care staff even more short staffed. The provider had been unsuccessfully recruiting for a deputy

Inadequate

Is the service safe?

manager since our last inspection in July 2014. The lack of management support had impacted across the service in terms of people's care. There were not enough staff to keep people safe.

These were breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment and induction practices were safe and relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People living in the home told us they felt safe and staff showed an appropriate understanding of the term safeguarding and when they would report concerns. One member of staff said "Safeguarding means to keep people safe from harm such as abuse, if I found a bruise I would record it and report it. If the senior person did not listen I would go higher even outside the organisation to the Local Authority."

Inadequate

Is the service effective?

Our findings

Comprehensive inspection 7 January 2015 and 2 February 2015

Although food and fluid monitoring charts were in place for some people, these charts did not include a target intake for the day. This meant that staff would not be able to clearly identify whether people had drunk sufficient fluid to meet their needs and would not be able to encourage people to drink more if they were not meeting their target. One person was served two hot drinks during a six hour period. The person was unable to drink unsupported and staff did not support them to drink. This meant they were at risk of dehydration.

We identified discrepancies between records held in the kitchen, about people's dietary requirements, and the handover sheet, used by care staff to provide care. There was a risk that people would receive food that was not of the required consistency and would therefore not receive adequate nutrition. The lunch experience for people was confusing, at times undignified and provided inconsistent support for people to eat their meal. People did not receive support to eat sufficient quantities of food to meet their needs. For example, one person was served their lunch and then left for 18 minutes while a care worker supported someone else. After 18 minutes the care worker returned, supported them for a short while and then left them unsupported again for a further 19 minutes. After 19 minutes a different member of staff returned to support them. Another person was left for 23 minutes in total and supported variously by a care worker, the hairdresser and the activities co-ordinator. The above evidence was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to meeting nutritional needs.

Staff had not received sufficient training to meet people's needs. Records showed that not all staff had completed essential training. For example 32% of staff had not completed food safety training. There was no clinical training specifically to improve competencies for nurses. When asked about competency assessments, a nurse told us "I cannot recall having that kind of assessment but I can see why it would be a good idea." This meant there was a risk that nurses were not kept up to date with the necessary skills and knowledge. This is a requirement of their registration with the Nursing and Midwifery Council.

The policy for the home was that staff would receive a minimum of six supervision meetings a year. Supervision meetings are important because they are an opportunity to monitor and evaluate performance, share objectives and discuss concerns and areas of personal development.

Supervision meetings with staff were not held in line with this policy. Only 21% of planned supervisions had taken place. Two members of staff said they had not had any supervision meetings in the last year. The above evidence was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to supporting staff.

There was evidence that advice had been sought from health professionals such as GPs, occupational therapists, speech and language therapists and psychiatrists, however we found that advice was not transferred to care plans and care was not delivered in the recommended way. For example, one person had been given a recent diagnosis of dementia. This information was not in their care plan and there was no plans in place to support their dementia needs. The same person had also seen an occupational therapist, who had written detailed recommendations about how to support in terms of their sensory needs. The advice had not been transferred to their care plan and staff were not following the advice. Another person had seen a speech and language therapist (SALT) who had identified a deterioration in the person's ability to swallow. The SALT had recommended that the person should receive stage two thickened fluids however the handover sheet, used to provide care, stated that the person should receive stage one thickened fluids. This meant the person was at risk of choking. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Records showed that on 7 January 2015, 11% of staff had not completed training in the requirements of the Mental Capacity Act 2005. Two members of staff showed an understanding of mental capacity, however did not understand how an assessment should be made and by whom. This meant that staff were not able to apply the requirements of the Mental Capacity Act 2005 to service users in the home. Around two thirds of people suffered

from some form of cognitive impairment, however mental capacity assessments had not been carried out in respect of people whose capacity was in doubt in relation to specific decisions. We found, in cases where capacity assessments had been carried out, that they were inaccurate, incomplete, not in line with our knowledge of the person and had not been reviewed. This meant that the service was not obtaining valid consent for treatment and care in relation to people whose mental capacity was in doubt. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to consent to care and treatment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager did not understand when a DoLS application should be made and was not aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Although the home was exercising potential deprivations of liberty in the form of bed rails and not allowing people to leave for their own safety, only two DoLS had been applied for. This meant there was a risk that people were being illegally detained against their wishes. For the two people who were being legally deprived of their liberty, the restrictions which had been agreed for their own safety, were not communicated to staff. For example, they were not recorded on the hand over sheet. This meant that staff were not able to apply the agreed restrictions because they were not fully informed of the detail. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to safeguarding people who use services from abuse.

Focussed inspection 24 March 2015

We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Records showed that the approach to mental capacity remained inconsistent and muddled. It remained the case that staff and management required further training in this area in order to provide a clear and consistent approach to mental capacity which addressed the risk of whether people were able to give valid consent for their care and treatment.

One person's care plan stated they did not have capacity. We heard staff offering the person choices of clothes to wear that day and the person choosing their clothes. This meant the mental capacity assessment was not decision specific as required by the MCA as the person had capacity to make some choices. Although the person's care plan stated they did not have capacity to make decisions, we heard a nurse offer the person analgesia. The person was unable to respond to this question. There was a bed rail consent form in place for the person but no related mental capacity assessment to determine whether they were able to consent to the use of bed rails. The consent form stated that it formed part of a best interest decision but there was also no best interest decision recorded in relation to the use of bed rails.

Another person had a mental capacity assessment included within their care plan which had been signed by a relative, stating they had no capacity. It was not clear whether the relative had power of attorney for care and welfare and was therefore authorised to sign the capacity assessment. A mental capacity assessment would not be required if the relative had power of attorney in respect of care and welfare as this gives them the power to make decisions. Elsewhere in the care plan it stated that the person could make some decisions if given the right support and was able to respond using 'yes' and 'no' cards. This meant that the mental capacity assessment was not decision specific as the person was able to make some decisions and may have had fluctuating mental capacity. The person's care plan stated they had no capacity to make financial decisions however, there was no mental capacity assessment recorded around the person's ability to make financial decisions. The person's consent to photography stated that the person had refused to sign it but had given verbal consent. This was not consistent with other parts of the care plan where it stated that the person did not have capacity.

One person refused the stage one thickened fluids which had been prescribed for them. This put them at risk of choking and aspiration pneumonia. The person told us they understood the risks associated with their decision because this had been explained to them when they were

in hospital. The person had been resident in the home for a month before our inspection. When asked whether the risks of drinking un-thickened fluids had been explained to them by member of staff in the home, they said they had not. The home had not ensured that the person had the capacity to understand the risks relating to the care and treatment they were delivering and the possible outcome of such a decision. There was no record in the person's care plan of a mental capacity assessment around this decision.

All of the above were continued breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to consent to care and treatment.

Detailed records were kept in the kitchen about people's individual dietary requirements. These included information about whether they required support to eat, any allergies and dietary and drink preferences. The chef was knowledgeable about people's required consistency of food and knew who required a pureed diet and who was vegetarian for example. During lunch it was clear that people were served a meal in line with their required consistency and support was offered where appropriate.

Since our last inspection changes had been made to the lunchtime routine. People who ate in their rooms, were served their lunch and received assistance half an hour before lunch was served in the two dining rooms. This system worked more effectively and meant that staff were available to provide support in the dining rooms during lunch.

During lunch there was a pleasant atmosphere, people were offered choices and alternatives where required. Everyone was served a drink when they sat down to lunch. Staff were on hand to assist and provide encouragement where needed. One person commented that they had enjoyed their lunch. This meant that people received a much improved lunchtime experience.

One person who had been identified as being at risk of malnutrition, had a malnutrition care plan in place. Records showed that they had been weighed weekly and that the person's weight was slowly increasing. This showed that the home was taking appropriate action to address the risk of malnutrition.

All of the above meant that the home had addressed the breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to meeting nutritional needs.

Requires improvement

Is the service caring?

Our findings

Comprehensive inspection 7 January 2015 and 2 February 2015

The registered manager told us there was a system in place for regularly reviewing care plans and discussing them with people, however the people we spoke with told us they had not been involved in their care plan and it had not been discussed with them. One person said "I've not discussed or seen a care plan," and another person said "Nobody's mentioned a care plan."

Privacy and dignity was not always respected. One person described how they would be left in a state of undress while staff rushed off to answer call bells. They felt uncomfortable being left in this way. People were not referred to in a dignified way on documentation. For example the handover sheet, when describing people's continence needs just documented 'pad' next to people's names. One person was sat in the lower lounge all morning. We observed staff walk past the area where the person was sat seven times. During this time not one member of staff spoke to or acknowledged the person. Lunchtime was also an undignified experience for people who required support to eat. People were supported in a haphazard way, supported by several different people and often left for long periods of time with no support. During that time their food became cold and unappetising.

On arrival in the home, we were admitted by a member of night staff, who was on their way home. We immediately went to the nurse's station to observe the staff hand over between the night and the day shift. Inside the room, no one spoke to us, asked us to state who we were or checked our identification. They continued to discuss personal information about people without knowing who we were. This meant that people's privacy was not respected. These were a breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, respecting and involving service users.

Staff were kind, though busy, and did not spend a great deal of time with people. When they provided care and support, it was to provide a function. During lunchtime there was cheerful banter between staff and people showing that staff were aware of people's personal lives, however staff did not have detailed knowledge of people's care and treatment needs. A system of 'intentional rounding' was used in the home. The system is designed as a physical check to ensure that people's needs are being met every hour. However, staff did not engage with people when carrying out the checks and used it as a simple 'tick box' exercise. One member of staff said "I do not know much about it, we just have to tick the box when we do anything for people." One record we reviewed looked like it had been completed all in one go at the end of the day rather than on an hourly basis. This meant there was a risk that staff were not engaging with people's care needs on an hourly basis.

A person whose verbal skills were compromised indicated to us they would like the television turned on. We summoned staff using the call bell but two different members of staff were unable to communicate effectively with the person and did not understand what they wanted. It was clear that staff did not know how to communicate and there was nothing in the person's care plan describing the best way to communicate with them. Staff didn't have a detailed knowledge of people's individual needs enabling them to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

People were complimentary about the care staff. They told us they had noticed a lack of staff and that they received personal care later than they would like. They also said that meals were delayed or 'strung out' over longer periods of time, however they were all sympathetic to the staff describing them as "kind" and doing their best in difficult circumstances. One person said "Staff are lovely – they really try." A member of care staff told us how difficult it was to meet everyone's needs, "Fewer get to the lounge in the daytime – sometimes it's easier just to leave them in bed."

Staff treated people with affection however they told us how they missed being able to spend quality time with people. People told us how they missed the extra contact with staff, they used to have. Time constraints meant that staff didn't have the opportunity to interact with people, especially those being nursed in their rooms, increasing the risk of social isolation.

Focussed inspection 24 March 2015

We witnessed two staff behaving in an uncaring way towards a person with dementia, who was being nursed in bed and had visual and hearing impairments. The person's

Requires improvement

Is the service caring?

care plan stated that the person may feel disorientated upon waking. Staff should make sure they clearly introduce themselves, speak clearly and provide reassurance, showing the person photos of their family. The care plan also stated that the person can become distressed easily and that staff should interact with them during personal care to boost their morale. We heard a staff member enter the room, without introducing themselves or providing reassurance and go to the sink to fill a bowl of water. The person continually asked who was there and asked if it was their breakfast time. The staff member stated they were going to give the person a wash, but the person appeared not to have heard and continued to ask who was in their room. The conversation lasted for over three minutes. Staff did not greet the person warmly and respectfully and did not approach the person in a manner which took account of their particular needs. The care plan was not followed and care was not delivered in a way which was kind and caring to the person.

One member of staff was observed to stand over the person's bed supporting them to eat their breakfast. This was not a respectful or personalised way of supporting the person. The staff member was not at the person's level interacting with them.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to dignity and respect.

Inadequate

Is the service responsive?

Our findings

Comprehensive inspection 7 January 2015 and 2 February 2015

Staff were unable to respond appropriately to people's needs due to a lack of detailed and accurate care plans, risk assessments, daily records and handovers. This meant that people were not receiving the detailed personalised care they required.

Records showed that on 6 December 2014 one person had a grade two pressure ulcer. A grade two pressure ulcer means that the skin had been broken. There was no care plan in place to instruct staff how frequently to dress the wound and no other care plans in conjunction with treatment for the wound such as diet, fluid intake or pain management. Although no appropriate care plan was in place records showed the wound as healed on 25 December 2014.

People had conditions which caused them pain. There were no care plans in place to help staff monitor people's individual signs of pain and when they might need pain relief. This was particularly important for two thirds of service users who had a cognitive impairment which affected their ability to communicate pain. There were no clear guidelines in place for staff to assess individual service user's pain and a pain assessment tool was not in use. This placed people at risk of pain or at risk of increasing pain.

The hand over process and the hand over information, used by care staff to provide care, were ineffective and lacked the detail staff needed to provide individualised care and respond appropriately to their needs. Care staff were not involved in the hand over process and could not clearly hear what nurses were saying to each other. This meant it was not possible for care to be continued seamlessly and safely. Care staff told us they were given all the information they needed at handover, however we observed that there was no effective transfer of verbal or written information. This meant that care staff were not given the right information to meet people's needs. The hand over sheet omitted any detail, including the name, of a person who had been recently admitted to the home. This meant that staff did not receive any detail about to care for the person.

The hand over sheet also lacked accurate and key details about people's care and treatment. For example, there was no information about who was subject to Deprivation of Liberty Safeguards and what the safeguards were. There was no information about who needed support to eat and drink and people's repositioning requirements, for those being nursed in bed, in order to prevent pressure ulcers. Information about the severity and complexity of people's illnesses was missing and there was no information about people's wounds and how they should be treated. Nine people were being treated for infections but there was no detail about specific care required in relation to the infection such as increased fluid intake or pain relief. Two people received their nutritional intake through a percutaneous endoscopic gastroscopy (PEG) however the handover sheet only recorded that one person received their nutritional intake in this way. Information about people's continence included words such as 'pad' which did not give staff any meaningful information about service users continence needs and how to provide their continence care. Staff were not able to use information on the handover sheet in a meaningful way to respond to people's needs.

One person exhibited behaviour which meant they repeatedly rang their call bell. During the inspection we heard call bells ringing constantly all day. In one two hour period, call bells went to emergency eight times. This meant that the call bell had been ringing for some minutes without staff responding to it. We were told by staff that they do not answer this person's call bell because of their behaviour. There was no care plan around this person's behaviour and no professional behavioural advice had been sought. This meant this person's needs had not been assessed and appropriately responded to.

Care plans did not contain evidence that they were person centred. For example one person had been diagnosed with osteoporosis. Their records did not contain any specific reference to this condition in the moving and handling or mobilisation care plan. There was no reference to the chronic level of pain people with this condition usually feel and how it should be addressed. There were no instructions for staff about how to support the person with this condition. Their individual needs had not been assessed and a care plan had not been written to meet those needs.

Inadequate

Is the service responsive?

We found evidence that the home did not use continence risk assessments or care plans. Continence was assessed on admission to the home but this was to assess the number of incontinence pads to order rather than identify the individual support people required. Some records included information such as 'continence managed by pads.' This was not an individualised care plan describing to staff how to manage the continence needs of individual people. In addition daily records showed that people often went long periods of time without their continence needs being checked For example gaps of 14 hours 30 minutes and 10 hours 40 minutes were observed in records. Staff were not responding appropriately to people's individual needs.

One person, who had recently received a diagnosis of dementia received care which did not meet their individual needs because the home did not follow advice received from professionals. Records showed they slept most of the day and were restless and agitated during the night, however staff failed to mention this to an involved specialist and therefore the specialist did not assess this area of their behaviour. A letter from an occupational therapist stated that the person enjoyed the radio and it was important that staff put the radio on because lying in bed in a quiet room for long periods when engagement is poor can lead to social isolation. During our inspection the radio was only put on for part of the day. The letter went on to say that it was important to their mental stimulation that the person had different things to do. There were no activities recorded in the person's records.

People with reduced mobility or who were being nursed in bed were at risk of pressure ulcers. There were no risk assessments or care plans to address the risk of acquiring pressure ulcers. Daily records did not record that people had been repositioned regularly to reduce their risk of acquiring pressure ulcers. This meant that staff would not have been able to reposition people appropriately because there was no guidance for staff about how often they should do this, in line with assessed needs. Staff were not able to respond appropriately to people's need to be repositioned regularly in order to reduce their risk of acquiring pressure ulcers. All of the above evidence was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

The home was not responding appropriately to people's concerns and complaints. Relatives, staff and people said they had spoken to the registered manager about the impact of reduced staffing but no changes had been made. One member of staff said "Some relatives are not happy – carers are missing breaks to keep two people available on the floor." Another member of staff described how they had reported to the registered manager about finding a person completely soaked in urine one morning but no action appeared to have been taken. Many staff were concerned and upset by the reduction in staff numbers and said they had spoken to the registered manager about the impact on people's care. One person said "We are not allowed agency staff any longer, according to the manager. He says it all comes from head office. On one shift I was told by him to help in the kitchen as well as doing my own work." Some members of staff said they were angry about the reduced staffing as this restricted their ability to do their job properly. We asked one member of staff if they had discussed their concern with the registered manager and they said "We've told him, but it's his choice, what can we do?" A visitor to the home told us that a lot of staff wanted to leave because they did not feel listened to. A complaint in September 2014 raised the concern that there were not enough staff on duty in the home. The complaint had been responded to in the form of a written response but no action had been taken in response to assessing the appropriateness of staff numbers, in fact staffing levels had been reduced still further since the complaint. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, assessing and monitoring the quality of the service.

People needed topical creams applied as part of their personal care. The daily records contained details of where the cream needed to be applied and how often. However, the records demonstrating this had occurred were incomplete. For example one person reported they had had cream applied daily, however records did not support this as the last entry was recorded on 13 December 2014. Another person had cream applied every time their incontinence pad was changed however; the last recorded entries were 15 December 2014, 21 January 2015 and 28 January 2015. Records were not reflective of the care given. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating records.

Inadequate

Is the service responsive?

A craft session took place in the morning and people sat round a table colouring, drawing or looking at magazines. The home was situated in close proximity to the local church and volunteers from the church escorted those who wanted to, across the street to attend church services and coffee mornings. One person told us their religious beliefs were met, because they had access to support whenever they wanted and a representative from their religion would visit when required. Staff told us a good selection of activities, events and outings were provided. The home had its own mini bus and 'dial a ride' was also used to facilitate trips out. Destinations included shops, garden centres, restaurants and cinemas, although staff told us that people were becoming more dependent and it was difficult to facilitate as many people on trips as before because more people needed wheelchairs and there were fewer staff to help them.

Focussed inspection 24 March 2015

People did not receive personalised care that was responsive to their needs. One person had been admitted to the home straight from hospital, where they had been treated for aspiration pneumonia. The home completed a dysphagia risk assessment. **Dysphagia** is the medical term for **swallowing** difficulties. Aspiration occurs when fluid is taken into the lungs. This is linked to dysphagia as the person is unable to swallow easily and sometimes fluid can enter the lungs. Chronic aspiration will lead to chest infections and sometimes pneumonia. Acute aspiration can lead to pneumonia or choking. Choking is a life threatening emergency situation. The home failed to identify that the person had a history of aspiration pneumonia and therefore completed the risk assessment incorrectly. The incorrect risk assessment concluded that the person was a medium risk of dysphagia when they were in fact at high risk. The home did not manage the risk appropriately and did not put a dysphagia care plan in place which provided guidance for staff on how to meet the person's needs. The person was at a higher risk of dysphagia as they had made the decision not to drink the thickened fluids prescribed for them. This higher risk was also not identified and a care plan put in place to address the risk.

A visitor had raised a concern about how often their relative's hair was washed. On the 9 March 2015 records showed that the relative had communicated to the home that their family member preferred to have a bath than a shower. Following that communication, records showed that the person had received a shower on 10, 17 and 24 March. There were no records that the person had had a bath. The person was unable to tell us whether they had had a bath. The home had not taken account of the person's preferences about how their care was to be delivered.

During our visit on 7 January 2015 we identified a person who had severe difficulty swallowing. The person did not have a dysphagia care plan in place and had not been referred to a speech and language therapist (SALT) for assessment. Records showed that the person was referred to a SALT on 17 March 2015. This was ten weeks after our initial visit and four days after the home were required to be compliant.

Another person spent time walking around the home on the day of the inspection. They were known to have a urinary tract infection (UTI) and displayed signs of confusion and distress. The person's care plan did not contain a short term urinary tract infection care plan. Although the person had a history of UTI's, there was no preventative care plan in place which may have reduced future occurrences of infections. . We noticed an unpleasant odour which remained throughout the day. Records showed that the person had a catheter in situ and therefore there should have been no detectable odour. Despite the unpleasantness of the odour, no member of staff took any action to address this during the day. Records showed that the person had not received a bath or a shower since being admitted the home on 10 February 2015. Staff did not take action to address the person's needs.

During our visit on 7 January 2015 we identified that required topical medicines were not being consistently applied or applied as directed. We found this practice continued on 24 March 2015. For one person their care plan stated that cream should be applied each time their incontinence pad was changed and each time they were washed. The topical medicines administration record (TMAR) showed that between 7 March 2015 and 23 March 2015 the cream had been applied seven times in the morning and twice in the evening. The meant the person was not receiving the skin care they required. We looked at TMARs in relation to seven people and they were all completed in this inconsistent way. It was not possible to

Inadequate

Is the service responsive?

ascertain whether the creams had been applied but not recorded or had not been applied at all. Most people were not aware of when their creams should be applied and did not recall whether they had been.

Guidance for administration of the creams was recorded in most cases on the TMAR as 'as directed.' A nurse told us that care staff applied the creams and were able to judge whether a person required cream or not. This is a medical decision and care staff had not received appropriate training.

This evidence represented a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to care and welfare.

Improvements in other aspects of care were apparent. The handover process ran smoothly, with night staff remaining 'on the floor' for 15 minutes so that day staff could be part of the handover. Care staff and nurses were involved in the handover and the records of handover were more detailed and accurate than previously noted.

Action had been taken to address the risk of pressure ulcers. People who were immobile or being nursed in bed had risk assessments and care plans in place. A pain assessment tool was now being used to assess whether, people who were unable to communicate, were in pain and required pain relief. This meant that people could have pain relief administered appropriately.

Inadequate

Is the service well-led?

Our findings

Comprehensive inspection 7 January 2015 and 2 February 2015

Staff morale was low and staff were not actively involved in developing the service. The home was not well organised, care was not provided in a consistent way, staff didn't feel listened to and we found errors in people's medicines and care plans which should have been detected through routine audits. Some aspects of the service were unsafe, such as the storage of medicines in the hairdressing salon for up to a month. Staff training was not up to date and staff competencies had never been checked. People said they didn't know who the registered manager was, but they would like to know. Staff were not well managed and lacked organisation, support and motivation. One member of staff said "I am so tired, we are so busy, there is no time to do anything properly. I know I cannot keep up and feel awful for the residents." Another member of staff described how there were meant to be extra staff on shift over Christmas, but at the last minute the extra staff had been cancelled by the registered manager who told staff they could manage. They went on to say "There is never any thanks for the hard work from management, only the family members." Staff told us that the registered manager was rarely seen 'out on the floor' and when they did see him there was little interaction. There was a 'disconnect' between nurses and care staff resulting in a lack of team work. People were aware of low staff morale and were worried that their favourite care staff would leave as a result.

The culture in the home was of demotivated staff, who felt they were not listened and responded to. The lack of leadership and teamwork impacted directly on the care that people received. People were at risk of not receiving appropriate care. The registered manager told us about 'flash meetings' which were held for a few minutes at a time to organise care and obtain feedback about what was happening in the home. These meetings did not happen very often. Records showed that four meetings had been held in November 2014 and two in December 2014. Discussions at these meetings included information about fire doors and asking staff to tidy the hair dressing salon. Records in relation to the last staff meeting held in October 2014 showed that staff had been informed there was concern around the non-answering of call bells. No questions or discussions were recorded. This meant that either staff had not been offered the opportunity to discuss their concerns or they had not felt able to raise concerns in an open forum. Staff were not able to discuss concerns during supervision meetings because these were rarely held. The registered manager and the provider were not receiving accurate feedback about the home and when concerns were raised they were not responded to. Concerns were raised in a relatives meeting in October 2014 that staff were not working as a team, no action had been taken since the October meeting to improve teamwork.

Audits were carried out but were not effective in detecting and responding to concerns. For example medication audits recorded discrepancies but no explanation in relation to missing or additional medication recorded. We were shown a catering audit which asked people if they found the food too dry, sweet or salty however the audit was not dated, it did not record the type of food that people were asked to comment on and there were no recorded actions. An audit carried out in October 2014 entitled 'Dignity and dining' recorded that tables were laid correctly and that matching crockery and napkins were used however it did not record the actual dining experience people received. For example we observed that people were not consistently supported and that food was left to get cold and unappetising. People eating in their rooms told us that food often arrived cold and inedible.

The registered manager told us that the provider had a mission statement which put kindness at the heart of care. We found that whilst individual staff exhibited kind actions and people appreciated their kindness, the service as a whole was not kind because individual needs weren't met, people weren't safe and no one felt listened to. People and staff said they felt worried and frustrated. The registered manager told us that he wanted to be "Fully compliant with stakeholders," however stakeholders (staff, relatives and people), we spoke with, were not satisfied with the service. He went on to describe the key challenges to the service as being meeting stakeholder needs and meeting people's higher dependencies. He said that relationships were the key to success. It was evident that relationships had broken down across the board and that this had reflected in people's care, staff attitudes and motivation. The registered manager left on the 9 January 2015. The provider told us that a relief manager was managing the home. The relief manager was in post at the time of our second visit on 2

Inadequate

Is the service well-led?

February 2015. The above evidence was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to assessing and monitoring the quality of service provision.

Records in relation to infection control and health and safety audits showed that they had been carried out regularly and that actions had been taken in response to the findings.

In between our visits on 7 January 2015 and 2 February 2015, the provider undertook a medicines audit. They identified a number of issues such as record keeping around receipt of medicines and medicines security. As a result the provider took corrective action in respect of the highest risk concerns. The provider continued to address the remaining identified concerns but did not have a deadline completion of this or a scheduled re-audit date.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of carrying out an assessment of the needs of the service user and planning and delivering care in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1) (a) (b) (i) (ii). **Focussed inspection 24 March 2015** The provider continued to breach this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not protect service users, and other people who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the service provided in the carrying on of the activity against the requirements set out in this Part of these Regulations and identify and manage risks relating to the health welfare and safety of service users and others who may be at risk from the carrying on of the activity by having

This section is primarily information for the provider

Action we have told the provider to take

due regard to the complaints and comments made, and views expressed by service users and those acting on their behalf, appropriate professional and expert advice. Regulation 10 (1) (a) (b) (2) (b) (i) (iv)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person did not have suitable arrangements in place to protect service users against the risk of such control or restraint being unlawful or otherwise excessive. Regulation 11 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not protect service users against the risk associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, safe using, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable, nutritious food and hydration, in sufficient quantities to meet service users' needs and support where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (a) (c) **Focussed inspection 24 March 2015** The provider is now meeting this regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Comprehensive inspection 7 January 2015 and 2 February 2015**

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 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users or establishing and acting in accordance with the best interests of the service user. Section 4 of the Mental Capacity Act 2005 (best interests) applies for the purposes of this regulation as it applies for the purposes of that Act. Regulation 18 (1) (a) (b) (2) **Focussed inspection 24 March 2015** The provider continued to breach this regulation.
	How the regulation was not being met: The registered person did not, so far as is reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users and that service users are enabled to make, or participate in making, decision relating to their care or treatment. The registered person did not treat service users with consideration and respect, provider service users with appropriate information and support in relation to their care or treatment or encourage service users to understand the care or treatment choices available to the service user, and discuss with an appropriate health professional, the balance of risks and benefits involved in any particular care or treatment and express their views as to what is important to them in relation to their care or treatment. Regulation 17 (1) (a) (b) (2) (a) (b) (c) (i) (ii)

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 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Regulation 20 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of the carrying on of the regulated activity. Regulation 22

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers

Comprehensive inspection 7 January 2015 and 2 February 2015

How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of the carrying on of the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal. Where the regulated activity carried on involves the provision of health care, the registered person did not ensure that health care professionals employed for the purposes of the carrying on of the regulated activity were enabled to provide evidence to their relevant professional body demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition pf their ability to practice. Regulation 23 (1) (a) (2)

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of carrying out an assessment of the needs of the service user and planning and delivering care in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1) (a) (b) (i) (ii). **Focussed inspection 24 March 2015** The provider continued to breach this regulation.

The enforcement action we took:
A warning notice was served on the registered provider requiring them to become compliant by 13 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable, nutritious food and hydration, in sufficient quantities to meet

This section is primarily information for the provider

Enforcement actions

service users' needs and support where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (a) (c)

Focussed inspection 24 March 2015

The provider is now meeting this regulation.

The enforcement action we took:
A warning notice was served on the registered provider requiring them to become compliant by 13 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Comprehensive inspection 7 January 2015 and 2 February 2015** How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users or establishing and acting in accordance with the best interests of the service user. Section 4 of the Mental Capacity Act 2005 (best interests) applies for the purposes of this regulation as it applies for the purposes of that Act. Regulation 18 (1) (a) (b) (2) **Focussed inspection 24 March 2015** The provider continued to breach this regulation.

The enforcement action we took:
A warning notice was served on the registered provider requiring them to become compliant by 13 March 2015.