Mr Olu Femiola

Pentrich Residential Home

Inspection report

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East Yorkshire
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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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Pentrich Residential Home provides accommodation and support to a maximum of 13 people over the age of 18 who have a mental health condition. The service is situated in a residential area of the coastal town of Bridlington in East Yorkshire.

Pentrich is conveniently located for all of the main community facilities including the public transport network. Parking is available to the front of the building. The property has three floors. The accommodation consists of two shared bedrooms and nine single rooms, two of which have en-suite facilities. Bathing / toilet facilities are available on each floor of the property. A dining room and two lounges, one designated for the use of people who smoke, are located on the ground floor. The property does not have a passenger lift so is only suitable for people who are able to use the stairs.

This inspection was announced and took place on 29 January 2015. We notified the person in charge of the service, of the visit on 27 January 2015. The reason for this was that we were aware that the manager of the service was on sick leave. As we knew the inspection

Summary of findings

would impact on the staff on duty it was reasoned that short notice of the inspection would give the senior care staff the opportunity to arrange cover for the day so they could focus on the inspection.

There has not been a registered manager at this service since July 2014. 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.

The last inspection took place on 28 February 2014. At that inspection we found the provider was meeting all the essential standards that we assessed.

During this inspection we spoke with seven people who used the service, three members of staff, one relative and the registered provider. At the time of the inspection on 29 January 2015, we were told by the registered provider and senior care staff that there were nine people living in the service, all of whom had been diagnosed with a mental health condition and some had additional physical health problems. Three people also had a dual diagnosis of a Learning Disability. The people living at Pentrich Residential Home had a wide range of needs including prompts and support with personal care, nutrition and hydration, emotional and mental health, medication and behaviours that challenge the service. This meant they were extremely vulnerable and reliant on care to be provided in accordance with their mental, physical, emotional and social needs.

The home was not safe as people were not protected against the risks of unsafe or inappropriate delivery of care and treatment as there was no detailed assessment of their mental, social and physical health needs completed.

We found there was no evidence that any safeguarding alerts were made to the local authority or to the Care Quality Commission during 2014, even when there was clear documented evidence of incidents taking place. We found that the registered provider did not have systems in place to monitor and manage the prevention and control of infection and where people did acquire infections the staff failed to provide appropriate treatment. The registered provider also failed to maintain appropriate standards of cleanliness and hygiene in relation to equipment used within the service.

The registered provider failed to protect people who used the service against the risks associated with the unsafe use and management of medicines. Staff were not trained to administer medicines and this put people at risk of harm or actual harm by being given the wrong medication or by medicines being administered incorrectly by staff.

We saw that the premises had not been made safe in all areas of the service, despite the registered provider being aware of maintenance issues raised by the staff over the last two years and highlighted in the service's weekly building maintenance records. Poorly fitting fire doors, poor maintenance of equipment and a lack of staff training in fire safety meant that the registered provider failed to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005.

There were insufficient numbers of suitably qualified, skilled and experienced persons employed in the service to enable people to take part in outings and activities in the community. Care staff were expected to cover any vacant duty shifts, including kitchen, domestic and laundry duties, in addition to one to one support for service users. This meant people were isolated in the home and staff worked long hours.

Staff did not receive appropriate induction, supervision and training. We found there was a lack of training relevant to mental health, safeguarding of vulnerable adults from abuse and the Mental Capacity Act 2005 (MCA) and staff displayed a lack of knowledge in respect of Deprivation of Liberty Safeguards (DoLS), capacity assessments and Best Interest meetings. This meant that staff who were in charge of managing the service did not have the necessary skills and knowledge to assess if people had capacity to consent to care and treatment. People who used the service were put at risk of harm as staff failed to ensure people had comprehensive assessments for their mental and physical health needs. Individuals were not well supported with eating and drinking so their state of health deteriorated.

Summary of findings

People were not always spoken with respectfully by staff. Staff had made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions. People were not consistently treated the way they wanted to be treated.

Some people told us they were concerned about speaking to us for fear of reprisals, which indicated that there was not an open culture within the service that actively sought out people's views about the service and their care.

We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information to help meet people's needs. The complaint procedure was not readily available to people and cooperation with other organisations, such as health care professionals, was inadequate so that people did not always receive the care and treatment they required in a timely manner.

We found that the quality monitoring system was ineffective and had not been used to ensure the safety of people who used the service and staff. We asked the registered provider and the senior care staff for evidence of how quality monitoring and assessing of the service was carried out. We were told that this was not formally documented. Staff reported that the service had been running for long stretches of time without a manager. This lack of leadership had an impact on staff. Staff told us they were not confident of speaking up at supervisions meetings as their conversations were not kept confidential by the management team.

We found that the registered provider was breaching 14 of the essential standards of quality and safety (the regulations) relating to care from regulations 9 to 26, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These included: Care and Welfare; Assessing & Monitoring the quality of the service provision; Safeguarding people who use services from abuse; Cleanliness and infection control; Management of medicines; Meeting nutritional needs; Safety and suitability of premises; Respecting and involving people who use services; Consent; Complaints; Records; Staffing; Supporting workers and; Cooperating with other providers. You can see what action we asked the registered 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?
The service was not safe.

The premises were not properly maintained and did not meet health, safety and fire regulations. Some areas of the service were not cleaned to a hygienic standard.

Minimum staffing levels meant people's needs were not always met.

Staff failed to respond appropriately to safeguarding incidents and there was a lack of reporting to the local authority and the Commission. Medicines were not handled appropriately and inadequate risk assessments meant people who used the service were put at risk of harm.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive effective induction, training or supervision and displayed a lack of knowledge around MCA, DoLS and Best Interest meetings. This meant some people were being deprived of their liberty unlawfully.

People's rights to be independent and autonomous were not always upheld and people were not fully included in the decisions about their care and treatment.

People's mental health and nutritional needs had not always been satisfactorily addressed.

Inadequate

Is the service caring?
The service was not caring.

People were not always spoken with respectfully by staff. Staff had made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions. People were not consistently treated the way they wanted to be treated.

Staff did not always treat people who used the service with dignity, consideration and respect. We saw that some staff were abrupt with people.

Inadequate

Is the service responsive?
The service was not responsive.

We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information they required to help them meet people's needs.

The complaint procedure was not readily available to people and this meant that people were not certain how to make a complaint or express a concern.

Cooperation with other organisations was inadequate so that people did not always receive the care and treatment they required in a timely manner.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The registered provider's quality monitoring system was ineffective and had not been used to measure or ensure the safety of people who used the service and staff.

The service had been without a registered manager since July 2014 and the lack of leadership had an impact on staff. Staff lacked confidence in the leadership of the home. They told us that they felt unable to express their viewpoints as information was not kept confidential by the management team.

Pentrich Residential 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 registered 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 29 January 2015 and was announced.

The registered provider was given 48 hours' notice because we were aware that the manager of the service was on sick leave. As we knew the inspection would impact on the staff on duty it was reasoned that short notice of the inspection would give the senior care staff the opportunity to arrange cover for the day so they could focus on the inspection.

The inspection team consisted of an adult social care inspector, a specialist advisor in mental health and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection was knowledgeable about the use of mental health services.

We had not requested a 'provider information return' (PIR) as the service was inspected at short notice due to identified risks. We had received whistle blowing information in November 2014 about the service and we also had concerns raised with us in December 2014 from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and Safeguarding Team.

During the inspection on 29 January 2015 we spoke to the registered provider and the senior care staff. The expert-by-experience spoke with seven people who used the service, two members of staff and one relative. The inspector also spoke with two members of staff. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes.

We observed care and support in communal areas, spoke with people in private and looked at the care records for three people who lived in the service, three staff recruitment records and records relating to the management of the service. We looked at induction and training records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the service. We also spoke with staff about their experience of the induction training and on-going training sessions.

Inadequate

Is the service safe?

Our findings

The service was not safe. During our inspection on 29 January 2015 we found significant breaches of regulations with regard to safeguarding people who used the service from abuse, cleanliness and infection control, management of medicines, staffing and safety and suitability of premises.

We looked at the safeguarding of vulnerable adults policy and procedure given to us by the senior care staff. This policy was the local authority multi agency document and was dated 2009. We found no evidence to show that the registered provider had updated the policy and procedure since 2009 and therefore it did not reflect new ways of working and new thresholds introduced by East Riding of Yorkshire Council (ERYC) in 2014. The policy and procedure for making notifications to the regulatory body referred to CSCI (the Care Quality Commission's predecessor organization) and included old notification forms. This did not meet current regulations and did not give staff up to date and correct guidance in ways of working, which meant people who used the service were left at risk of abuse.

We looked at an accident report dated 28 January 2015. The report described a situation where one person had verbally abused and intimidated another, and care records evidenced that this person had been verbally abused and intimidated for the last 12 months, but there was nothing recorded to say that staff had done anything to prevent this re-occurring. This meant one person had experienced constant abuse over the last year that staff had not recognized or taken action to prevent.

We looked at one person's care file and found that in the daily notes written by staff during 2014 it was recorded that this individual had numerous incidents documented about episodes of distressed and anxious behaviours and verbal abuse towards staff and others. We found no evidence that staff had contacted any health or social care professionals in response to these concerns or submitted a safeguarding alert to ERYC. This meant that this person and other people had not been safeguarded from the risk of abuse.

As part of the inspection we checked the registered provider's safeguarding file and found the registered provider and their staff had not assessed any of the above incidents as safeguarding and there was no record of them in the file. This was confirmed by the ERYC safeguarding team when we contacted them on 30 January 2015. There had also not been any safeguarding notifications sent in to the Care Quality Commission (CQC) during 2014. This meant that people were not safeguarded against the risk of abuse as the registered provider had failed to take reasonable steps to identify the possibility of abuse and prevent it before it occurred and had not responded appropriately to allegations of abuse.

We were given a copy of the staff meeting that the registered provider held on 10 November 2014. In this meeting staff were told that the registered provider was aware that some staff were "…really shouting and being nasty to people who used the service." Two people who used the service spoke with us and said there was one member of staff who had now left the service who wasn't very nice to people. They said "He was a bit nasty sometimes." We were also told that there was a current staff member who "Shouts at people sometimes." There was no evidence that the staff had been reported to the ERYC safeguarding team or that the registered provider had investigated the allegations and referred the member of staff to the Disclosure and Barring Service. This meant the member of staff would be able to work elsewhere with vulnerable adults which meant other people who used services could be put at risk of harm.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

When we asked people if they felt safe in the home one person said, "It's difficult to say because it's so close knit. Twenty-four / seven we're altogether. There's always problems." The other six people we spoke with all said they felt safe. Comments included, "Yes it's alright, not too bad." "I am safe here. Yes" and "I'm safe in the building." When we asked about whether staff kept people safe from other people in the home one person said, "One resident struck me last year. It was unwitnessed. A male resident" and three other people said "Yes."

We looked at risk assessments and premises safety. We had a number of concerns about fire safety, which were raised with the senior care staff on duty both during the inspection and at our feedback at the end of the inspection.

Inadequate

Is the service safe?

During our inspection we walked around the service accompanied by the senior care staff. We saw that a fire door near the kitchen area was wedged open by the staff. We also noted that fire doors to two bedrooms did not shut properly. In one bedroom on the ground floor we saw that four oxygen cylinders were stored there for use by the person who lived in that room. However, there was no 'Oxygen in use' sign on the bedroom door which would have alerted the emergency services in the event of a fire. We asked the senior care staff for the fire records relating to maintenance and safety in the service and a copy of the staff training plan. We saw on the training plan that only four out of the ten staff working in the service had completed fire safety training. One member of staff had completed fire safety training in 2010, two other staff completed fire safety training in 2011 and 2013 respectively and the forth member of staff completed the training in 2013. When we asked the senior care staff for the evacuation plans for the building in the event of a fire we were told these were not in place.

We saw that the fire records showed the last fire drill carried out at the service was documented as 14 November 2013. There was also a note in the records to say that in 2013 the fire alarm had gone off (false alarm) during the night. The person making the record noted that the people who used the service did not respond to this alarm and no one made any attempt to leave their rooms, which could have had serious risks to people's health and safety if it had been a real emergency. There was no evidence in the fire records or staff training plan to indicate that the registered provider took any action to ensure fire drills and staff training were brought up to date and completed regularly following this incident.

This meant you failed to identify the risk to service users and others working in or visiting the premises and failed to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005. Following our inspection we contacted the Humberside Fire and Rescue service and raised our concerns with the Technical Fire Safety Officer who told us they would visit the service in February 2015 to follow up our concerns.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

During our inspection we looked at the levels of staff on duty within the service. We were given a copy of the staff rota by the senior care staff for the four weeks leading up to our inspection on 29 January 2015. This showed that there were two care staff on duty each day between the hours of 08:00 and 21:00. At night there was one member of care staff on duty and the senior care staff told us that another member of staff was usually on call in an emergency. The rota showed that there was one domestic staff and one cook on duty from Monday to Friday, but care staff had to take on these additional duties on a weekend and after 13:00 Monday to Friday. Care staff were also responsible for laundry tasks every day. This meant there was very little free time for care staff to take people who needed support out into the community on a weekend and in an afternoon / evening.

We asked people who used the service if they felt there was enough staff on duty. One person who was not able to go out unaccompanied told us "Sometimes I can't go out for my shopping." Another person said "No, not enough staff." A third individual said "I think we are getting some more staff. We could do with some more." We had been told by the senior care staff that three people could not leave the premises without support from staff. Given the additional duties care staff had to carry out, this meant that these three people were not being supported appropriately and when they wanted to they were unable to go out. This effectively isolated them from involvement in the community. We asked the senior care staff for any records they had about activities and trips out for service users. We were told there were none available. One person told us that as they could not leave the service without a member of staff to escort them then their only entertainment was bingo and the television. They told us that they were bored for most of the day.

One member of staff who spoke with us said that since the New Year they had worked on nights, finishing at 08:00 and were then scheduled back in at 16:00 hours the same day. We checked the staff rota and confirmed that on 5 January 2015 this had taken place. This meant the member of staff had only had a break of eight hours between shifts and this did not meet The Working Times Regulation 1998.

There were insufficient numbers of suitably qualified, skilled and experienced persons employed in the service to enable people to take part in outings and activities in the community. Care staff were expected to fill in any gaps in

the rota and cover kitchen, domestic and laundry duties in addition to one to one support for service users. This meant people were isolated in the home and staff worked long hours.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

During our inspection on 29 January 2015 we looked at the medicine records, stock levels, storage and staff practices regarding management of medicines. We were told that all staff had completed the on line training course from a high street pharmacy company. However, when we looked at three staff files and the training plan provided by the senior care staff we saw that only four out of the ten staff were recorded as having completed medicines training. The training plan showed that the cook had this training in 2012, the senior care staff completed the training the day of our visit and two care staff completed the training in 2011 and 2014 respectively.

We looked at the staff rota for the last four weeks up to our inspection on 29 January 2015. We saw that three staff who covered night duty had not had medicine training. As there was only one member of staff on duty at night this meant people requiring medicines between 21:00 and 08:00 could be given medicines by untrained staff. Also, until the day of our inspection when the senior care staff had completed their medicine training, there were numerous dates when untrained staff had administered medicines. This meant that people who used the service were at risk from unsafe medicine management.

We looked at the medication administration records for seven people who used the service. We found that there were recording errors on five people's medication administration sheets. For example, we found that two people had hand written entries on their medicine administration records for paracetamol. We found that staff had not double signed these entries to show that two staff had checked that what was recorded on the medication administration record was the same as on the prescription label on the medicine packet. We checked both medicine packets against the entries and found that staff had not recorded the strength of the medicine or how often it was to be given on the medication administration record for one person. Both hand written entries completed by the staff said that the medicine was to be given 'PRN' (as and when required), but we found the dispensing labels on the packets said the medicine was to be given four times a day. This meant these two people may not have received their medicines as prescribed by their GP and could have been left in pain.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

When we asked people who used the service if the home was clean and hygienic, one person said "Yes, it's a nice home" and another told us "It's a good home, always clean and tidy." When asked if they were happy with the cleanliness of their room and the laundry service one person said, "Yes, I'm happy with it."

During our inspection on 29 January 2015 we found that the registered provider did not have systems in place to monitor and manage the prevention and control of infection. We asked the senior care staff for evidence of infection prevention and control records as required by The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

We found that there was no infection prevention and control lead to take responsibility for infection prevention and control and we saw on the training plan shown to us by the senior care staff that staff were not up to date with this training. Only five of the ten staff had completed this training, one staff did the training in 2010 and four staff did the training in 2013. One member of staff told us that they were doing a distance learning course at the time of our visit.

We were shown the cleaning schedules for the service which gave basic details of the daily, weekly and monthly cleaning tasks carried out by the domestic and care staff. We were told by the senior care staff that there was no risk assessment or infection prevention and control audit and no annual statement as required by Criterion 1 of the Code of Practice. We asked the senior care staff if we could look at the policies and procedures for infection prevention and control as asked for in Criterion 9 of the Code of Practice. We found that the policies were dated 2010 and did not meet the criteria for The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

Inadequate

Is the service safe?

We noted that one bed provided for a person who was incontinent was not fit for their needs. We saw that the base, mattress and head board for the bed were not impermeable and the head board especially was inset with dirt and stained. We found there was an unpleasant odour in the bedroom due to ineffective cleaning of the bed and carpet. We asked to see the cleaning schedule for carpets and the senior care staff told us that this was not recorded so we could not determine when or how often the bedroom carpet had been cleaned. This meant the registered provider had failed to risk assess and provide suitable equipment for people who used the service that would be hygienic and prevent the spread of infection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

We looked at the recruitment files of three care staff recently employed to work at the service. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). These measures ensured that people who used the service were not exposed to staff who were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and employment terms and conditions. This ensured they were aware of what was expected of them.

Inadequate

Is the service effective?

Our findings

The service was not effective. During our inspection on 29 January 2015 we found significant breaches of regulations with regard to staffing, supporting workers and meeting nutritional needs. We had concerns about the staff's understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, which put people at risk of abuse.

We asked the senior care staff about the induction process for new staff within the service. We were told by the senior care staff that new staff did not receive any training as part of their induction. New staff received a basic one day induction to the service, in that they were taken around the building and shown where paperwork was kept and where the fire exits were. We saw basic induction records to confirm this, in the employment files for three care staff.

We asked the senior care staff what support / supervision new employees received. We were told that new employees could shadow a more experienced worker for a couple of shifts and that they would receive a supervision session at the end of their three month probationary period. This meant that new employees did not receive appropriate training and supervision during their first three months of employment. This put people who used the service at risk of harm from staff who lacked the skills and knowledge to meet their needs.

We asked the senior care staff how often staff received supervision; these are meetings that take place between a member of staff and a more senior member of staff to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. We were told that these meetings took place every month. We looked at the staff supervision records for three staff members. In one staff file we found one supervision record dated 10 July 2014 and another 10 November 2014. In the second staff file we saw supervision records dated 20 July 2012, 21 February 2013, 24 October 2013 and 28 July 2014. In the third staff file we saw no evidence of any supervision records. This meant that staff were not being appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people who used the service safely and to an appropriate standard.

We asked the senior care staff for a copy of the staff training plan for 2014 / 2015. The plan showed us that of the ten staff on the training plan only three staff were up to date with moving and handling, four with first aid and two staff had completed fire safety training in the last two years. Only two staff had food hygiene certificates and neither of them carried out any cooking tasks. Four staff had completed infection control training in 2013, three staff had completed health and safety training in 2013 and two staff were up to date with medicine management training. No staff had completed safeguarding of vulnerable adults training in the last year.

When we checked the training plan we found that there was no evidence that any staff member had completed training on topics relating to mental health. Only one member of staff had done training on the Mental Capacity Act 2005 and deprivation of liberty safeguards; this training was done in 2009 and 2012 so would not have included any recent changes brought in by the Supreme Court Judgment from April 2014. Four staff had completed training in behaviour that challenged the service; the most recent date for this was January 2013.

We found that people who used the service were not protected from the risk of harm or actual harm, because staff did not receive appropriate induction, supervision and training.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests.

During our inspection on 29 January 2015 the registered provider told us that they had to prevent one person who used the service from leaving the building late at night on 28 January 2015. This person had said they were going to walk around the streets of Bridlington and staff were concerned about this person's health as it was a particularly cold night. We were told that this was not the first time this had happened. However, we found no evidence in the records shown to us to indicate that the registered provider or staff had sought advice from the

person's social worker or the safeguarding team about their capacity to make decisions. Discussion with the registered provider and the senior care staff indicated no one had considered the need for an assessment of the person's capacity for this particular circumstance.

We looked at four care plans during our inspection. We were told by the senior care staff that one person had a deprivation of liberty authorization in place. On checking the paperwork we found that an application had been made in January 2015 but this had not yet been authorised. This indicated that the senior care staff did not understand the difference between making an application and having a valid authorization under deprivation of liberty safeguards. This could have resulted in this person being deprived of their liberty when this had not been authorised.

During our inspection we were given a copy of the staff training plan by the senior care staff. This showed that only one of the ten staff employed by the registered provider had completed Mental Capacity Act 2005 training and that was on 16 February 2012. Staff that the registered provider had put in charge of the home (the acting manager and the senior care staff) were not recorded on the plan as having attended this training. The training plan also showed that only one member of staff had completed training on deprivation of liberty safeguards. This meant that staff who were in charge of managing the service did not have the necessary skills and knowledge to assess if people had capacity to consent to care and treatment.

We were told by the care management team on 22 December 2014 that the East Riding of Yorkshire Council had corporate appointeeship for six of the people who used the service at Pentrich Residential Home. It was also confirmed to us by the care management team on 30 January 2015 that these people had been reassessed in January 2015 and had been found to lack capacity to manage their finances.

The senior care staff had confirmed to the care management team, in December 2014, that staff from the service had taken people who used the service to the bank to access their personal allowances. This was because previous arrangements, set up by the registered provider, to access personal allowance funds had become unsustainable. However, there were no capacity assessments or best interest decisions in place to support the service in doing this. Further concerns were identified because the senior care staff did not have a clear understanding about why they could not take people to the bank and did not appear to understand their responsibilities in relation to the Mental Capacity Act 2005.

Alternative arrangements were put into place by the care management team for people to access their personal allowances until the registered provider sorted out the problems in accessing the funds in the 'residents' account. At the time of our inspection on 29 January 2015 those problems had still not been resolved. When asked if staff responded to requests quickly, one resident said that "I didn't always get my money on time."

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

During our inspection on 29 January 2015 we were told by two members of staff that people who used the service did not have any access to the kitchen area in Pentrich Residential Home. We looked around the premises and found no evidence that people had any independent means of making themselves a hot drink or snacks. The two staff members told us that people would have to ask staff if they needed anything from the kitchen. This meant the registered provider did not support people who used the service in relation to maintaining life skills around eating and drinking.

One relative who spoke with us was concerned that the hot food in the evening was limited to things like beans on toast. They said that the food could be better, that there should be more choice and that sometimes there was not enough food in the fridge. When asked about the food provided to them, people told us it was, "Not too bad. Getting better", "It's alright. I like the sausages", "Alright" , "Good" and "It's good, yeah."

We asked senior care staff if we could look at the food and fluid charts for one person whose care file contained a care plan for eating and drinking that identified them as being underweight and for whom a nutritional risk assessment tool had been completed. Our examination of the tool found that it had not been completed correctly and the last time it was reviewed was on 28 November 2013. This meant the risk assessment would have been ineffective. The senior care staff told us that food and fluid charts were not

completed for this person. Notes in the person's care file dated 28 January 2015 said this individual had "Refused breakfast, drinking a lot and at lunch time collapsed." This individual was admitted the hospital on 28 January 2015.

This meant the staff were not monitoring and reviewing the nutritional and hydration needs of this person, despite there being a significant risk to their health.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

As part of our inspection we assessed how well the staff were meeting the health needs of the people who used the service. We found there was nothing recorded in the four care files we looked at to evidence that health needs had been assessed, identified and were being met. In discussion with staff we were told that people went to the doctors when they were ill. However, this was not being recorded, monitored and outcomes considered. It was a reactive approach and not a planned approach to good health.

One visitor told us that senior staff were sometimes "Not on the ball with things". They mentioned a health problem with their relative and said that staff were "Not chasing it up." They said they had to "Get onto staff to follow it through." One person told us that they would like to see a doctor about a pain in the chest. We mentioned this person's request to the senior care staff, who told us "(The person) has a history of chest problems, they will be okay." When asked whether he could get to see the doctor quickly, another person was positive. They said, "One week I had a bad throat. I got some tablets from the doctor and it improved in a week."

The relative we spoke with said that the home had no car to take people to hospital and that people who used the service were having to pay a lot of money to pay for taxis to get there. This was confirmed to us by a member of staff who said one person had to pay 50 pounds for their last trip to hospital. We passed our concerns about this onto the local authority who funded this person's placement at the service.

In one care file we looked at, records evidenced the person had behaviours that were difficult to manage, but there was no detailed plan for staff to follow on the management of this behaviour. The risk assessment stated "Staff to intervene if (the person) is getting too close to another resident in anger and remind them of the consequences". There was no plan as to how staff should intervene and no detail of what the consequences were. We asked the senior care staff if there were any formal assessments from health and social care professionals, but was told these were not available.

There was a behaviour management chart in one person's care file that listed a number of incidents throughout 2014 and January 2015. There was a review held on 19 January 2015 with the placing authority representative in attendance. The notes of the review were very basic and documented that everything was fine and there were no issues,. It was clear, none of the issues from the behaviour management chart had been discussed, therefore the local authority were not made aware of the difficulties and dangers that the home were having in meeting the needs of the person and keeping them and the other people in home safe. This meant that the person who used the service was not protected against the risks of unsafe or inappropriate delivery of care and treatment as the registered provider did not have a detailed assessment of their mental and physical health needs in place.

We discussed our concerns about people's health and wellbeing with the senior care staff during our inspection and also with the local authority the day after our inspection.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

As part of our inspection we walked around the building with the senior care staff and looked at the communal areas and some people's bedrooms. The relative we spoke with said that the bedrooms were dark and dingy and could do with some decoration. This was echoed by one person who used the service who said, "It just wants painting again." Another person who used the service told us that the sink in their room was blocked. They had brought it up with staff, but were still waiting for a response

We saw that throughout the premises there were a number of areas that required repair and maintenance. For example, we saw the décor and furnishings in the smoking lounge were very basic; the radiator cover was dirty and stained with nicotine and one of the windows had a double

Is the service effective?

glazing pane that was 'blown' so that condensation had built up between the panes of glass. The downstairs communal toilet had water around its base, which indicated it may be leaking. This facility also lacked a toilet roll holder, the light shade was torn and the new wood boxing in the pipe work, required painting to seal the surface and make it easy to clean. Tiling in this toilet area also needed sealing near the skirting board level as it was open to water / fluids running down the wall, which meant it was difficult to clean.

We saw that three bedrooms had furniture that required repair. In one room the door of the under sink unit had fallen off, a double room had two wardrobes sectioning the room into two areas and we saw that the back of one wardrobe was coming away from the main framework. The third room had a chest of drawers with the drawer fronts missing..

We saw that there was a large pile of rubbish / old furniture stored in the outdoor space at the rear of the premises. The senior care staff told us that a contractor had been arranged to collect the rubbish on the day of the inspection, but had not turned up. The siting of the rubbish at the rear of the property meant that people who used the service did not have safe access to their outdoor space. As three people could not leave the home without an escort this area was their only means of fresh air unless staff were available to take them out into the community. We were contacted by the registered provider soon after our inspection and they confirmed the rubbish had been removed.

We were given a copy of a "Weekly record of building inspection" by the senior care staff. We were told this was a record of building maintenance carried out by the handyman. The records were dated from 2 November 2013 to 22 December 2014. The record showed that on 2 November 2013 a member of staff had recorded that the first floor bathroom had an on-going leak from the roof. On 16 December 2013 another staff member recorded that the first floor bathroom ceiling was leaking when raining. This was documented as an urgent repair. At our inspection on 29 January 2015 we saw that there was an 'out of order notice' on the door of the first floor bathroom. We asked the senior care staff why the notice was there and was told that the bathroom was not used because of a leaking roof. We asked to see the bathroom and observed that the wood panelling on the ceiling of the bathroom was water damaged and tiles on the walls of the bathroom were missing. However, we also observed that there were towels and a bath mat in the room and we asked the senior care staff if the room was in use. The senior care staff confirmed that it was and said that people who used the service particularly liked to use this facility so it was in regular use unless it rained as the roof continued to leak. We asked the senior care staff why there was a notice on the door if the bathroom was still in use and was told that it had been put there because the inspection was taking place.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

We contacted the health and safety officer at East Riding of Yorkshire Council on 30 January 2015 to discuss our concerns about the environment at Pentrich Residential Home. The health and safety enforcement officer visited the premises on 2 February 2015 and made a number of recommendations and action points that they will be following up after one month.

Inadequate

Is the service caring?

Our findings

The service was not caring. People were not always spoken with respectfully by staff. Staff had made efforts to offer people choice, but people were not enabled to be fully independent in their actions or decisions. People were not consistently treated the way they wanted to be treated.

We observed some good interactions between staff and people living in the service. However, we also observed one member of staff being abrupt with one individual. This experience was echoed by a relative who said that "[Staff member] could be a bit abrupt sometimes." This indicated that staff did not always treat people who used the service with dignity, consideration and respect.

When we asked about the staff people said they were, "In general, satisfactory. Most of the time. A staff member who's left used to shout a lot", "Perfect", "Alright, I think" and "The staff's alright here." When we asked how they were treated by staff people told us, "Pretty good", "Alright", "Some of them are alright", "Alright, thank you" and "One or two can rush me." One person said, "My favourite staff member is (name). They give me clothes." When asked if their privacy and dignity was respected by staff, one person said "No." However, they did not wish to expand on this.

When asked if staff listened to their views, one person said: "Yes, mostly. There's only so much they can do. They can please some people some of the time, but they can't please all the people all of the time." When asked if staff knew people who used the service well, one person said: "No. They don't know me at all." We asked what the individual meant by their remark, but they declined to talk further with us at that point.

We asked people about their experiences within the service and if they felt staff treated them equally. One person said: "One or two don't treat me equally." When asked if they had the confidence to speak their minds, one person said: "No I don't speak my mind", but again we could not get them to expand on this point. We were told by one person that they were very concerned about being overheard talking to us and another person said "How do we know there won't be reprisals?" This showed that people who used the service were nervous about expressing their views to others.

We asked people what they liked about the service and three people told us "I can go out on my own", "I am a free spirit here" and "I have freedom. I can go out when I want to." However, one person said they felt lonely as they could not leave the home without a member of staff and there was rarely anyone available to go out with them. This person told us they spent a lot of time in their room alone. Two other people also said there were not enough staff to enable them to be as independent as they would like. This meant the registered provider did not provide appropriate opportunities and support to people to promote their independence and community involvement. For three people this meant they were at risk of being isolated within the service.

We asked people what they would change about the service if they had the opportunity. People told us, "I think the activities need working on", "I wouldn't - nothing really" and "I don't want to leave. This is my home and I'm staying here." People talked to us about what the day to day atmosphere was like in the service and said, "It's pandemonium sometimes. It's quiet today", "Alright" and "Not bad. Not a bad home this. I wouldn't leave here. I would not."

We asked the senior care staff for evidence of any 'resident' meetings and any feedback from individuals about the service. We saw meeting records that indicated people had attended a meeting on 15 May 2013 and 7 November 2014. The meeting minutes were brief and there was no evidence to show that any action was taken about the issues raised by the people who attended the meetings. We were given two satisfaction questionnaires one completed by visitors in 2012 and one completed by people who used the service in 2013. There was no analysis of the comments and feedback given by the participants and no action plan to show if any action had been taken by the registered provider as a result of receiving people's views and feedback of the service. This meant the registered provider did not assist people who used the service to express their views about their care and treatment and when people did give the registered provider feedback the registered provider did not accommodate those views.

Of the five people who spoke with us about their health and care needs, only one person knew that they had a 'care plan' where staff recorded their care needs. One person said the new manager had sat with them and talked about their daily life. We were told by staff there were no arrangements for advocacy services to be involved in anyone's care, as people all spoke up for themselves or had

Inadequate

Is the service caring?

family who could support or represent them. This indicated that people were not encouraged to be involved in their care and treatment and their rights to make or influence decisions was not always respected.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. We found that people's care plans and risk assessments did not always represent their needs or ensure staff had the information to help meet people's needs. The complaint procedure was not readily available to people and cooperation with other organisations was inadequate so that people did not always receive the care and treatment they required in a timely manner.

We looked at three care files for people who used the service. We found that all the files were untidy, not in good order and information within them was patchy and inconsistent. There was no evidence of comprehensive assessments and there was a lack of a person centred planning approach. One member of care staff told us that there were problems with the paperwork. They said that staff "Never knew what they were doing" in relation to paperwork and that they were not confident that "It was right, that it was up to date and that it contained what it should contain."

There was nothing in the files to evidence that health needs had been assessed, identified and were being met. The senior care staff told us that "People go to the doctors when they are ill." However, this was not being recorded, monitored and outcomes considered. This meant people's health and welfare were put at risk as staff were not able to check a person's history of medical appointments as part of their health assessment.

We saw that risk assessments in the care files for three people were old and out of date. In one person's file we saw one risk assessment for deteriorating mental health that was dated 20 February 2012 and another for physical aggression that was dated 6 April 2013. The file stated that these had been replaced by a newer risk assessment, but there was no evidence of a new one in the file. This person's file also recorded behaviour that was difficult to manage, but there was no detailed plan for staff to follow on the management of this behaviour.

We observed that another person required oxygen, which was stored in their room. However, there was no care plan in their file for the use of oxygen. We also found that this person's care file stated they were significantly underweight. We saw that there was a nutritional tool, but that it had been poorly completed and the last review had been on 28 November 2013, indicating that the risk assessment tool was ineffective. On the 28 January 2015 this person collapsed at the service and was admitted to hospital. This meant people's health and safety were put at risk as staff did not assess and monitor people's mental and physical care needs effectively.

During our inspection we saw little evidence of activities taking place within the service. Most activities undertaken by people who used the service were carried out in the community. There was little evidence of activities to keep people occupied in the service. We spoke with one relative who said that they felt that "There should be more activities in the home."

When asked about activities people who used the service said, "I do country dancing, make pictures, write, watch television. I read the Radio Times, the Television Times and listening to radio. There's a big television. I like television", "Bingo, watching television"; "I go shopping or to a coffee bar" "Watch television" and "I go out walking sometimes. Sometimes go to Scarborough for the day. What could be better than that?"

One person told us "There's supposed to be an Indian craft afternoon and an Indian night. They've not got round to it. I don't know when it's supposed to be. There are games in the lounge. And I've brought in a scrabble board. It's not been used before." A common theme during the inspection was that various things were in the pipeline, but had not materialised as yet such as the Indian themed evening and a 'residents' meeting.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

We did not see evidence of a complaints policy or procedure on display within the service. People who spoke with us during our inspection had expressed concerns that there might be repercussions for them if they were seen talking to us. This indicated that there was not an open culture within the service.

We asked the senior care staff for the record of complaints kept in the service. We were told by them that there had been no complaints reported apart from a number raised by one person who used the service. We saw an example of this person's written complaints as they were stored in their care file. We asked if these were recorded formally in the

Inadequate

Is the service responsive?

complaints folder and the senior care staff told us that they were not, as the person made a lot of complaints about staff which they then later retracted. We found no evidence to indicate the registered provider or the senior care staff had investigated this person's complaints or even taken them seriously. This meant the person could have been at risk of harm.

We found evidence in one staff file that they had made a written complaint to the registered provider in 2015 about the behaviour of a member of staff who was shouting at people who used the service. We saw that the registered provider had noted on the letter of complaint that they had told the member of staff making the complaint, that this would be dealt with. We also saw that the registered provider had noted on the letter that the other member of staff's employment was terminated the same day. We saw on the duty rota given to us by the senior care staff that the staff members' last working day was on 7 January 2015.

We found that the registered provider did not have an effective complaints system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by people who used the service, or persons acting on their behalf. This meant the registered provider had failed to assess and prevent or reduce the impact of unsafe or inappropriate care or treatment for people who used the service.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

During the inspection on 29 January 2015 we spoke with the registered provider and the senior care staff. We were told about the difficult behaviours of one person who used the service and how staff struggled to meet their needs. We also saw documentation of a number of incidents between this person and another person who used the service. However, we found that when staff were given the opportunity to discuss these problems at the care review held with this person's social worker on 19 January 2015, the record states that staff told the social worker that everything was fine and there were no issues.

This meant that you failed to work in cooperation with the local authority and that the local authority were not aware of this person's specific care needs, which put the health, safety and welfare of them and other service users at risk. We raised our concerns about the health, safety and welfare of people who used the service with the safeguarding team and commissioning team at East Riding of Yorkshire Council on 30 January 2015. At the time of writing this report there were on-going safeguarding investigations into the care and welfare of people who lived at the service.

We looked at three people's care files and found there was no evidence in the files of comprehensive assessments being carried out for health and welfare. We were told that people went to the doctors when they were unwell, but there was no evidence in the files that this was recorded, monitored and outcomes considered. This meant that staff would not have been able to share up to date information with other services about the person's needs.

This meant that the registered provider failed to make suitable arrangements to protect the health, welfare and safety of people who used the service in circumstances where responsibility for the care and treatment of people was shared with, or transferred to, others. This put people who used the service at risk of harm or actual harm.

This was a breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

Inadequate

Is the service well-led?

Our findings

The service was not well led. During the inspection of the service on 29 January 2015, we found that the quality monitoring system was ineffective and had not been used to ensure the safety of people who used the service and staff. We asked the registered provider and the senior care staff for evidence of how quality monitoring and assessing of the service was carried out. We were told that this was not formally documented.

Staff reported that the service had been running for long stretches of time without a manager. This lack of leadership had an impact on staff. The service last had a registered manager in July 2014 and failure to have a registered manager after six months could lead to CQC taking enforcement action. We wrote to the registered provider on 30 January 2015 about this matter, informing them that continuing without a registered manager would be a breach of a condition of their registration. We have received a response from the registered provider and we continue to monitor this situation.

We asked the senior care staff for the quality assurance records. We were given a set of policies and procedures dated 2009 with no evidence that these had been updated since that time. The policies and procedures looked as though they had been developed or downloaded from other services as they had the names of other services on them and one had a NHS Trust name as the author of the policy. This meant that staff did not have any documents that gave them clear guidance on best practice or the procedures to follow at Pentrich Residential Home, which put staff and service users at risk of harm.

Through the inspection process we found numerous failings within the service. These included: Care practices that did not meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A lack of training relevant to mental health, safeguarding and MCA; care plans were not person centred and lacked accuracy; a lack of knowledge in respect of DoLS, capacity assessments and Best Interest Meetings; poor reporting of safeguarding incidents and a lack of appropriate referring to / seeking support from relevant agencies; poor maintenance of the environment and an overall lack of effective leadership. We found that the registered provider was breaching 14 of the essential standards of quality and safety (the regulations) relating to care from regulations 9 to 26, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The evidence in this report showed that the registered provider failed to identify, assess 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 regulated activity. It also showed the registered provider failed to observe their obligation under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, to notify us of certain incidents.

We spoke with seven people who used the service and three members of staff during our inspection on 29 January 2015. We were told by two members of staff that they did not raise issues or concerns about care / practice during their supervision meetings as issues brought up were not kept confidential and because of this they were reluctant to disclose information again. We were told by one person who used the service that they were very concerned about being overheard talking to us and another person said “How do we know there won’t be reprisals?”

We found from this that the culture in the service was not open and honest or one where people who used the service and staff felt able to voice their concerns and issues about the service. This meant the registered provider failed to establish effective mechanisms to enable them to have an informed view in relation to the standard of care and treatment provided to people who used the service.

The registered provider’s failure to observe the requirements of Regulation 10 has resulted in inappropriate treatment being delivered to service users, in that their environment is not properly maintained, their welfare not safeguarded through appropriate notifications and referrals being made, and their views about the way the service is delivered are not taken into account.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the registered provider to take at the end of the full version of the report.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person failed to protect the welfare and safety of service users against the risks of receiving unsafe or inappropriate care or treatment as proper steps had not been taken to assess, plan and deliver appropriate care and treatment to meet service users individual needs. 9 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. Regulation 10 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who used the service were not protected against the risk of abuse because of inadequate arrangements to take reasonable steps to identify the possibility of abuse and prevent it before it occurs and responding appropriately to any allegation of abuse. Also the failure to protect people from unlawful control or restraint in relation to deprivation of their liberty. Regulation 11 (1) (2) (3)

Regulated activity	Regulation

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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used the service were not protected against the risks associated with acquired infections because of inadequate maintenance of appropriate standards of cleanliness and hygiene in relation to the premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person failed to protect service users against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for obtaining, recording, handling, using, safe keeping 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 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person failed to ensure service users were protected from the risks of inadequate nutrition and dehydration through inadequate monitoring of service users intake, and insufficient staff support to enable service users to eat and drink sufficient amounts to meet their needs. Regulation 14 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c)

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	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had inadequate arrangements in place to ensure service users dignity and independence were maintained. The registered person also failed to encourage service users to be involved in their care and treatment and their rights to make or influence decisions was not always respected. Service users were not able to express their views as to what was important to them and their autonomy and access to community involvement was restricted. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had unsuitable arrangements in place which failed to obtain, and act in accordance with, the consent of service users in relation to the care and treatment provided to them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person failed to notify the Commission of incidents which occurred whilst services were being provided in the carrying of the regulated activity, or as a consequence of the carrying on of the regulated activity. Regulation 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person had an ineffective complaints system in place for identifying, receiving, handling and responding appropriately to complaints and comments

This section is primarily information for the provider

Action we have told the provider to take

made by service users, or persons acting on their behalf. This meant the registered person failed to assess and prevent or reduce the impact of, unsafe or inappropriate care or treatment for service users. Regulation 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person failed to ensure that appropriate records were maintained. The lack of detailed and up to date care plans and risk assessments meant service users were at risk of receiving unsafe and inappropriate care and treatment. Regulation 20 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person failed to take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes for carrying on the regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person failed to ensure that service users were protected from the risk of harm or actual harm, because staff did not receive appropriate induction, supervision and training. Regulation 23 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers

This section is primarily information for the provider

Action we have told the provider to take

The registered person failed to make suitable arrangements to protect the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with, or transferred to, others. Regulation 24 (1)