Lowmoor Nursing Home Limited

Lowmoor Carehome

Inspection report

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Date of inspection visit:
25 June 2018
27 June 2018

Date of publication:
13 September 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 25 and 27 June 2018, and the first day was unannounced. Lowmoor Carehome is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nursing care is provided at this service.

Accommodation for up to 42 people is provided over two floors in three separate units. There were 41 people using the service at the time of our inspection. Lowmoor Carehome is designed to meet the needs of older people living with or without dementia.

This is the first time the service has been rated Requires Improvement.

The service did not have a registered manager at the time of our inspection visit. Lowmoor Carehome had not had a registered manager since 31 March 2017. 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 provider had appointed a manager in December 2017, but the provider confirmed the manager had now left the service.

People were not consistently kept safe from the risk of abuse. The systems in place to identify and deal with concerns had not worked to safeguard people from abuse. The provider had not consistently ensured staff were of good character and were fit to carry out their work. Risks associated with the service environment had not always been assessed and mitigated. There was no comprehensive system to enable the provider to review accidents and incidents. People's medicines were not always managed safely.

People were at risk from receiving care from staff whose skills and knowledge was not assessed or monitored. The provider had not consistently ensured that staff had undertaken training to enable them to meet people's needs effectively. People and relatives were not consistently supported to participate in planning or reviewing their care. People who needed support to communicate were not always able to meaningfully participate in making decisions about their care.

Staff we spoke with were knowledgeable about people's individual preferences and lifestyle choices, but this information was not consistently available to all staff. There was a risk people's views and information about their lives were not available to support staff in providing care. People and relatives knew how to raise concerns or make a complaint. However, concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed. People experienced varying levels of support to maintain interests and hobbies.

The service was not well-led. There was a lack of consistent management at the service, which had affected people's quality of care. The provider had not always notified CQC of significant events as they are legally

required to do.

People and relatives spoke positively about the skills and knowledge of staff. There were enough staff to provide the care and support people needed. Risks associated with people's health conditions were assessed and mitigated. Risks associated with infections were minimised, and the premises were clean. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink. People were supported by staff to access healthcare services when required. The provider had taken steps to ensure the environment was suitable for people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider was working in accordance with the Mental Capacity Act 2005 (MCA), and people had their rights respected in this regard. People and relatives spoke positively about the caring approach from staff, and throughout our inspection visit, we saw people were treated in a dignified way. People's right to private and family lives were respected. People and relatives were supported to discuss their end of life care, and staff knew how to support people and their relatives in the way they wanted.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not consistently kept safe from the risk of abuse. People's medicines were not consistently managed safely. The provider had not consistently ensured staff were of good character and were fit to carry out their work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were at risk from receiving care from staff whose skills and knowledge was not assessed or monitored. The provider had not consistently ensured that staff had undertaken training to enable them to meet people's needs effectively. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not given information about their care plans or reviews of care in ways that were meaningful to them. People and relatives were not consistently supported to participate in planning or reviewing their care. People and relatives spoke positively about the caring approach from staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Information about people's views, wishes and lifestyle choices was not consistently available to all staff. People experienced varying levels of support to maintain interests and hobbies. Concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of consistent management at the service, which had affected people's quality of care. Checks and audits on the quality of care had not been consistently undertaken. The provider could not assure themselves all staff had training, skills and support needed to provide personal and nursing care to people safely and effectively.

Lowmoor Carehome

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 27 June 2018, and the first day was unannounced. The inspection was prompted by information about allegations of abuse shared with us by the local authority. These allegations are subject to investigation by the local authority and police, and this inspection did not examine the circumstances of the allegations. However, the information shared with CQC about the allegations of abuse indicated potential concerns about how the provider ensured people were protected from the risk of abuse. This inspection examined those risks.

At the time of our inspection, eight safeguarding investigations were being carried out by the local authority. Seven of the allegations of abuse were referred to the police. In relation to the eighth allegation, the local authority made a referral to the Nursing and Midwifery Council (NMC) in relation to an agency nurse. This NMC referral was made as a result of concerns about the fitness to practice of the agency nurse.

The inspection visit was carried out by two inspectors, a specialist advisor with experience in providing nursing for older people and people with dementia, 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 second day of our inspection was carried out by one inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about specific events which the service is required to send us by law. We sought the views of Healthwatch Nottinghamshire, who are an independent organisation that represents people using health and social care services. We also sought the views of commissioners from the local authority and clinical commissioning group. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. Commissioners also undertake monitoring of the quality of services.

During the inspection visit we spoke with nine people who used the service, and seven relatives. We spoke with two nurses and five care staff. We also spoke with the activity coordinator, one member of kitchen staff, one maintenance staff, two office staff, and two of the directors of Lowmoor Nursing Home Limited. We sought the views of five external health and social care staff. We looked at a range of records related to how the service was managed. These included four people's care records and we looked at how medicines were managed. We also looked at four staff recruitment and training files, and the provider's quality auditing system.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us. We asked the provider to send us information relating to the governance of the service, for example, policies and staff training information, and they send this to us when we asked for it.

Requires Improvement

Is the service safe?

Our findings

People were not consistently kept safe from the risk of abuse. Prior to our inspection visit, we were aware of abuse allegations in relation to staff care practices. Although the provider had now taken action to dismiss staff, the local authority and police were still investigating the allegations. Relatives and social care professionals told us they had concerns about the high turnover of managers at Lowmoor Carehome. Two relatives spoke with us about allegations of abuse in relation to their family members. They felt things had improved since the provider had taken action. However, one relative said they were unhappy that staff had either not raised concerns, or had not been listened to when they spoke up. Social care professionals felt the internal investigations undertaken by the provider in relation to allegations of abuse were not investigated fully, and that information requested during safeguarding investigations were not made in a timely manner. Evidence from staff and records showed that although staff received training in recognising and alerting concerns about poor or abusive care, they had not always felt confident to speak up and report their concerns. The provider agreed that the culture in the service had not always supported staff to report concerns, or for those concerns to be acted on. They said that since April 2018, management staff at Lowmoor Carehome had been working to address all the issues raised in relation to safeguarding people from the risk of abuse. However, the provider's action plan, updated on 5 June 2018 did not have any detail on how the culture care practices within the service would be improved to reduce the risk of abuse occurring. The provider acknowledged that a high turnover of managers in the service since March 2017 had an impact on how staff care practices were monitored and managed. The systems in place to identify and deal with concerns had not worked to safeguard people from abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. However, evidence we saw demonstrated these checks were not consistently thorough. For example, a recent safeguarding investigation identified that the provider had not checked with an agency that staff had completed DBS checks. The provider had taken action to rectify this. We found evidence that two staff had obtained references from colleagues at Lowmoor Carehome, rather than from previous employers or external character references. There was no evidence that gaps or discrepancies in prospective staff applications were followed up to assess whether this presented a risk. The provider told us, and we saw evidence they had now taken steps to ensure recruitment checks were robust. However, evidence showed the provider had not consistently ensured staff were of good character and were fit to carry out their work.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the service environment had not always been assessed and mitigated. Prior to

January 2018, there was inconsistent evidence of a clear system to check the building for hazards. Staff told us they reported any issues in the maintenance folder, and we saw action was then taken to reduce risk. However, there had been no system of auditing and checking the risks had been addressed . Since January 2018, the provider's maintenance team had rectified this, and now had comprehensive daily, weekly and monthly checks in place to ensure all aspects of the service environment were safe.

People's medicines were not consistently managed safely. A relative expressed concern that their family member's prescribed creams were not being applied as they should be. We spoke with staff about this and looked at records relating to how people's topical medicines (e.g. creams or gels) were managed. Staff told us there used to be a system in place to ensure they recorded when people had topical medicines applied, but they no longer used this. Nursing staff confirmed there were currently no records kept of when and where people had their topical medicines applied. This meant people were at risk of not having their topical medicines as prescribed. On the first day of our inspection, the provider took action to ensure accurate records were put in place. With regard to other prescribed medicines, staff told us and evidence showed these were stored, documented, administered and disposed of in accordance with current guidance and legislation.

There was no comprehensive system to enable the provider to review accidents and incidents. Staff told us, and we saw records where individual incidents were documented; these showed any action taken to reduce immediate risks and ensure people were safe. However, there was no analysis to enable the provider to identify themes or trends in poor or unsafe care provision, or to demonstrate that lessons were learnt.

Risk assessments were tailored to each person's needs, and staff knew what action to take to reduce risks associated with people's health conditions. For example, one person was at risk of choking. An assessment and associated care plans had been completed, and staff knew what action to take to support them. Risk assessments and associated care plans were reviewed with people regularly and updated to ensure staff knew how to support people safely.

There were enough staff to provide the care and support people needed. People, relatives and staff said staffing levels were sufficient and our observations supported this. The provider reviewed people's care needs and adjusted staffing levels to ensure people received the care they required.

Lowmoor Carehome was kept clean, which minimised the risk of people acquiring an infection. Staff described and understood infection control procedures, and followed these, using personal protective equipment when required. Staff carried out a range of regular tasks to ensure the service was clean. This included cleaning activity in all parts of the service, for example, in food preparation areas, communal areas and in people's own bedrooms. The provider carried out checks in relation to cleanliness and infection prevention and control to ensure this was effective. This ensured the risks associated with infections were minimised, and the premises were clean.

Requires Improvement

Is the service effective?

Our findings

Staff told us, and records confirmed they did not have appropriate meetings (or supervision) with their manager to discuss their individual work performance, training or development. The provider had recently started to carry out checks on staff undertaking key care tasks. This was so staff could be given feedback on their skill, and where needed, be given training and support to improve their care practices. The staff handbook stated, "Our policy is to monitor your work performance on a continuous basis so that we can maximise your strengths, and help you overcome any possible weaknesses." However, there was no evidence that the provider had been providing regular supervision, appraisal or support for individual staff prior to February 2018. The provider's supervision records showed 30 staff as not having had any supervision. For staff who had received supervision, there were no records to show whether any action had been taken to improve their skills or knowledge. This put people at risk from receiving care from staff whose skills and knowledge was not assessed or monitored.

The provider had not consistently ensured that staff had undertaken training to enable them to meet people's needs effectively. For example, 14 staff had not completed infection prevention and control training, 16 staff had not completed dementia training and 18 staff had not completed fire safety training. These were training courses the provider deemed mandatory for all staff. This meant people were supported by staff who did not always have appropriate training to meet their needs.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had a probationary period before being employed permanently. Staff told us they felt their induction gave them the skills to be able to meet people's needs. The provider had an induction for new staff which included training and shadowing colleagues. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensures nurses maintain their nursing practice and keep up to date with skills training. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse.

People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans. For example, people's needs in relation to any disability were identified, and staff were familiar with people's care plans and how to meet their needs.

People told us that the food was good. One person said, "The food is good to eat and it's nicely served as well." Records showed people had a varied menu, with options available for people with specific dietary requirements. Where people expressed views about wanting different options, or different times for their meals, their preferences were met. People who needed assistance or encouragement to eat were supported by staff. Staff knew who needed additional support to eat or special diets, for example, fortified diets or appropriately textured food and thickened drinks. People who were at risk of not having enough food or drinks were assessed and monitored, and where appropriate, advice was sought from external health

professionals. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

Staff told us and evidence showed they kept daily records of key events relating to people's care. Staff shared information with colleagues throughout the day and at shift handover. Key staff, including housekeeping, kitchen and maintenance staff met daily to share information about what was happening that day. This meant that staff knew what action was needed to ensure people received care they needed each day.

People were supported by staff to access healthcare services when required. For example, relatives said their family members were supported to see the GP when needed, and records confirmed this was the case. One person who had recently moved to Lowmoor Carehome was promptly referred to the local dementia outreach service for additional assessment and support in relation to their diagnosis. Staff we spoke with were familiar with people's health needs, as identified in their care records. Care plans detailed what people's health needs were, and said what staff should do to help people maintain their health. Staff kept daily notes regarding health concerns for people and action taken. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

People were encouraged to make choices about decorating their personal space, and their bedrooms were personalised. One relative told us they had supported their family member in choosing the colour of their bedroom when it was decorated. People had access to a garden patio area which was designed to give easy access to people using walking aids or wheelchairs. The provider had taken steps to ensure the environment was suitable for people's needs.

The provider was working in accordance with the Mental Capacity Act 2005 (MCA), and people had their rights respected in this regard. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People and their relatives confirmed staff gained permission before offering care. Staff understood the principles of the MCA, including how to support people to make their own decisions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had assessed people as being at risk of being deprived of their liberty and had made applications for a number of people.

Staff told us, and training records confirmed, that they had training in techniques to reduce and diffuse people's behaviour when this presented a risk to others, and how to safely use restraint as a last resort. We saw staff use the techniques they described, for example, to divert one person which resulted in the person becoming calmer and less distressed. Evidence in people's care records showed that restrictions in people's care were reviewed by the provider to ensure they were less restrictive. This meant people had their rights upheld in relation to restrictive care practices.

Requires Improvement

Is the service caring?

Our findings

People who needed additional support to communicate were not consistently given this. They were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. One staff member said the service used to have pictures to help people make decisions at mealtimes, but that these were no longer used. Another staff member confirmed they used to use photographs to help people make choices about activities, but this did not currently happen. Staff we spoke with felt people would benefit from using communication aids, such as pictures. Although staff were familiar with people's verbal communication styles, the provider had not ensured people who required support with communication had their needs met. There was a risk people's own communication styles and needs were not understood, and therefore their ability to express themselves would be affected. This meant people who needed support to communicate were not able to meaningfully participate in making decisions about their care.

People and relatives spoke positively about the caring approach from staff. One person told us, "The staff are top class." One relative said, "The carers, in my opinion, are 99% fantastic." Throughout our inspection visit, we saw people were treated in a dignified way. For example, one person tried to remove items of their clothing. Staff acted quickly to ensure the person's dignity was not compromised, and this was done in a kind and discreet way. Staff also responded quickly to people's requests for support or reassurance. One relative told us their family member, who had recently moved to the service, was responding positively and calmly to staff. They said, "Staff are good. They bring themselves to [family member's] level and speak clearly to them."

People were supported to spend private time with their friends and family. One relative told us they could come and have meals with their family member, which they enjoyed. Another relative told us they regularly brought their dog when visiting their family member. They said this was what the person wanted, and staff were supportive of this. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right to private and family lives were respected.

Information about advocacy services was displayed in the service and we saw statutory advocates had been involved in supporting people to make decisions about their care and life choices. This meant people could be supported to understand their rights.

Staff respected people's right to confidentiality. Staff we spoke with understood when it was appropriate to share information about people's care. We saw staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care discreetly or in private. Records relating to people's care were stored securely, as were records relating to the management of the service.

Requires Improvement

Is the service responsive?

Our findings

Staff told us, and we saw people were supported to express their opinions about their daily lives, but this was not consistently evidenced in care records. For example, one person's care records had limited information about their individual views, wishes and aspirations. For people who were less able to communicate verbally, there was not always evidence how staff sought their views, wishes and aspirations. Although staff we spoke with were knowledgeable about people's individual preferences and lifestyle choices, this information was not always recorded. This meant important information about people was not consistently available to all staff. There was a risk people's views and information about their lives were not available to support staff in providing care.

People and relatives were not consistently supported to participate in planning or reviewing their care. Whilst one relative said they were involved in assessments of their family member needs, another relative told us they had been waiting three months for a meeting about their family member's care. Records showed not all people were involved in reviewing their care.

People had mixed views about the activity opportunities available at the service. One person said they were happy with what was offered, and said, "I never get bored." Another person told us, "I get bored with nothing to do," and said they would like the provider to have more meetings where people could be asked about activities. We did not find any evidence to demonstrate people were able to participate in meetings to discuss activities or the quality of the service. The provider employed staff to coordinate and facilitate activities, and staff we spoke with had good knowledge about people's interests and hobbies. Staff told us people could take part in both group and individual activities. One staff member said they did not always have enough resources to do the range of activities they felt people would benefit from. We saw staff took a flexible approach to planning activities, based on how people were feeling on the day. People experienced varying levels of support to maintain interests and hobbies.

People and relatives knew how to raise concerns or make a complaint. Information about this was available in the home. However, records associated with managing concerns and complaints were not consistently completed. For example, a complaint made by a relative on 2 November 2017 was recorded, but there was no evidence that the provider had responded in accordance with their policy. Staff we spoke with could not say how the complaint had been resolved, or whether any action had been taken to improve the quality of care for the person. The provider complaints leaflet did not give information about the Local Government Ombudsman (LGO). The LGO is the final stage for complaints about all adult social care providers. The provider confirmed that, with the turnover of managers at the service, no real work had been done on regular surveys to get people, relatives and staff views on the quality of care. This meant that concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed. There was a risk that the views or people, relatives and staff were not used to drive improvements in the service.

No-one at Lowmoor Carehome was receiving care at the end of their lives at the time of our inspection. However, we looked at how end of life care was planned. People and their relatives were encouraged to talk

about their wishes regarding care towards the end of their lives. This included where people would like to be at the end of their lives, whether they would like to receive medical treatment if they became unwell, and in what circumstances. People had advance care plans in place which included, where appropriate, records of their wishes about resuscitation. Staff received training in end of life care, and further training was planned to ensure people received care that was responsive to their individual needs at the end of their lives. This meant people and relatives were supported to discuss their end of life care, and staff knew how to support people and their relatives in the way they wanted.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. Relatives and staff expressed concerns about the high turnover of managers at the service, and the lack of continuity this provided for people's care and staff support. One relative commented, "The managers don't appear to be here. There is always a turnover of staff." External social care professionals also expressed concerns about the frequent changes of managers, and told us they felt the governance of the service was not well-led. The provider confirmed their manager had recently left, and the head of operations had spent the majority of their time dealing with the day to day running of Lowmoor Carehome. The head of operations confirmed this, and said this had therefore taken them away from their role in reviewing and planning improvements in the governance of the service. On 25 June 2018 the provider's head of operations resigned, but following discussion with the provider, they withdrew this and remained in post. The deputy manager stepped up to provide full managerial support. There was a lack of consistent management at the service, which had affected people's quality of care.

The lack of consistent and stable management at the location meant the systems and processes in place to ensure personal and nursing care met legislative requirements were not always effective. For example, prior to January 2018, staff told us and records showed that checks and audits in relation to the service environment were not consistently carried out. Checks on staff skills and care practices and supervision had also not been completed. Checks and audits on the quality of care had not always been undertaken, so there was a lack of clear information about where improvements needed to be made. For example, staff told us a former manager directed them to stop recording topical medications given, and there was no clear rationale for this decision. Staff felt each manager made changes to the way the service was run without considering the impact on people, relatives and staff. The provider confirmed this, but had not taken any clear action to ensure people continued to receive a good service when there was a change of manager.

Staff understood their roles and responsibilities, but felt that concerns raised in the past would not always have been acted on. Although the provider had a whistleblowing policy in place, this had not been effective. The provider could not assure themselves all staff had training, skills and support needed to provide personal and nursing care to people safely and effectively.

The provider had not used feedback from external organisations to improve the quality of care for people living at Lowmoor Carehome. A local authority quality audit on 25 September 2017 identified a number of areas where the quality of care needed improvement. For example, staff supervision and training was not always up to date, and topical medication administration records were not always completed. On this inspection, we found improvements in these areas had not taken place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager at the time of our inspection visit. 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. Lowmoor Carehome had not had a registered manager in post since 31 March 2017.

The provider had not always notified CQC of significant events as they are legally required to do. For example, on 2 January 2018 one person had required medical attention following a choking incident. On 8 May 2018, the police attended an incident at the service. We confirmed with staff we had not received a notification for these events. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care. The provider gave us assurance that notifications would be made in future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems in place to identify and deal with concerns had not worked to safeguard people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not done checks to ensure prospective staff were suitable to work. DBS checks were not always undertaken. There was no evidence that gaps or discrepancies in prospective staff applications were followed up to assess whether this presented a risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not consistently ensured that staff had undertaken training to enable them to meet people's needs effectively. Staff did not receive regular supervision or checks on their skills.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's systems and processes in place to ensure personal and nursing care met legislative requirements were not always effective. The provider had not taken any clear action to ensure people continued to receive a good service when there was a change of manager. The provider had not ensured all staff had training, skills and support needed to provide personal and nursing care to people safely and effectively. The provider had not used feedback from external organisations to improve the quality of care for people living at the service.

The enforcement action we took:

We have issued the provider with a Warning Notice.