JK Health Care Limited

Weald Hall Residential Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 27 and 28 January 2015. We last inspected the service in August 2014 in response to information received. At that time we looked at staffing and care and welfare of people. We found the service did not have adequate arrangements in place that ensured people were engaged in stimulating activities that were meaningful to them and promoted their wellbeing. We received an action plan in October 2014 from the registered manager telling us of the improvements they were making to address this. At this inspection we found further improvement was needed in this and other areas.

Weald Hall residential home provides accommodation and personal care for up to 39 older people. The service mainly provides care to people living with dementia. There were a total of 37 people using the service at the time of our inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Summary of findings

The registered manager was unable to demonstrate an understanding of the importance of robust quality assurance systems and consequently the systems in place were not effective. There were no systems in place to develop solutions to reduce risk and protect people or drive improvement to the quality of the service being delivered.

Staff did not always know about or understand how to use or check that equipment was being used safely.

Staff had received some element of training in dementia care but not all staff demonstrated an understanding of dementia and how this affected people in their day to day living. People were not always treated with respect and their dignity, privacy, choice and independence were not always promoted.

At mealtimes people's dignity was not always maintained and choice was not always promoted. People did not always receive the encouragement they needed to eat and drink well.

Induction, training, supervision and support were not effective to ensure staff had the right knowledge and skills to carry out their roles and responsibilities.

There were enough staff to meet people's needs but we found that the delegation and organisation of their duties did not always mean people received the support they needed consistently and in a timely way. People were not provided with regular access to meaningful activities and stimulation, appropriate to their needs, to protect them from social isolation, and promote their wellbeing.

Deprivation of Liberty safeguards (DoLs) had not been appropriately applied. These safeguards protect the rights of adults using services who do not have capacity to make their own decisions and require some element of supervision. Applications had not been made for appropriate assessment and authorisation by professionals for a best interest decision on any restriction on their freedom and liberty.

Improvement was needed to the governance and leadership of the service to ensure the care and support provided to people was appropriate and in keeping with best practice.

We found that there were a number of breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010 and you can see what action we have told the provider to take at the back of the full version of the 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.

Premises and equipment were not suitably maintained to keep people safe.

Parts of the environment were unclean.

Delegation and organisation of staff duties was not managed effectively, little time was spent on providing social and emotional support to people and many were left to their own devices.

The provider had systems in place to manage safeguarding concerns and people's medicines safely.

Inadequate

Is the service effective?
The service was not consistently effective.

Staff did not have the appropriate skills needed to meet the needs of people living with dementia, effectively.

People did not receive adequate support with access to food and fluids, sufficient to meet their needs. The service was not monitoring the risks of malnutrition effectively.

Inadequate

Is the service caring?
The service was not consistently caring.

People were not always treated with dignity and respect and their privacy and independence was not always promoted.

Inadequate

Is the service responsive?
The service was not responsive to people's needs.

People did not receive personalised care that was responsive to their diverse needs.

People did not have regular access to meaningful activities or stimulation to promote their independence, autonomy, choice and wellbeing.

Inadequate

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

The providers systems for assessing the quality and safety of the service were not effective and had failed to identify the shortfalls identified during this inspection.

Management and staff did not have a clear vision of the service they were providing and the culture was not focused on improving for the benefit of those living there. Care in the main was task orientated rather than person centred.

Inadequate

Weald Hall 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 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 27 and 28 January 2015 and was unannounced. The inspection team consisted of three inspectors, two specialist professional advisors and an Expert-by-Experience. This is a person who has had personal experience of caring for older people and people living with dementia.

As many of the people who live in the service had dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views and experiences with us.

Prior to our inspection we requested a Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. We also looked at information we had received from other professionals including commissioners of care from the local authority and clinical commissioning groups.

We spoke with five people, four visitors and one healthcare professional. We also spoke with two senior care staff, five care staff and the registered manager. We looked at seven people's care records, 16 people's medication records, four staff records; staffing rota's and records relating to how the safety and quality of the service was being monitored.

Inadequate

Is the service safe?

Our findings

Premises and equipment were not suitably maintained to keep people safe. Many people had limited mobility and required equipment to assist them in their daily activities. Management and staff had limited understanding of their responsibilities in relation to checking equipment and identifying hazards that may potentially pose a risk to people's safety. Staff told us they did not visually inspect equipment before use and did not report any potential hazards. We found the rubber on the handles of a standing hoist were splitting and the foot plate was worn and not clean. A hoisting sling being used to move people was worn and had the potential to fray posing a serious risk of falling. Staff spoken with, although they had received training in moving and handling, were not aware the hoisting slings were part of the equipment that also needed inspection to ensure safety. Staff were not checking that hoist slings were suitable for purpose and safe to use. The registered manager was unaware of the condition of the hoists or slings.

Only one walking frame was labelled with the name of the person it belonged to. Throughout the inspection we observed walking frames in general use by several people. These frames had not been assessed as suitable for the person who was using them and they may well have been using a frame that was not suitable to their needs. A walking frame is a medical device and must meet applicable standards of safety, quality and effectiveness. We found the rubber feet on the base of some frames were worn and in one case the metal had worn through. This posed a risk of falling to people using them. When we pointed this out to the registered manager they replaced the feet on the walking frame where the feet had worn through but did not inspect the other frames.

We saw that four people were having breakfast in the dining room seated in wheelchairs that had either one or both footplates missing. This was unsafe and could have caused injury to people's feet by trapping them under the wheelchair during transportation. Staff were aware of this poor practice as a short time after our arrival to the dining room a member of staff went and fetched a number of footplates and began to attach them where possible.

The fire exit by the main staircase was not accessible in the event of a fire as it was blocked by a wheelchair and a large box of activities material. We also found toilet frames with an integral seat in two toilets were rusty and required replacement. They could no longer be cleaned properly and were a source of infection.

A slope in the centre of the floor in the main lounge, covered in carpet, posed a trip hazard for people as it could not be seen. During our inspection a person sustained a fall in this vicinity. Although the slope may not have been contributory in this instance the risk had not been identified or addressed. We saw that call bells were tied up in the ensuite bathrooms in the bedrooms of four people which meant if they fell to the floor they would not be able to reach them to call for assistance.

There was a strong smell of urine in one of the corridors and some of the bedrooms on the ground floor. The registered manager told us that they made daily inspections of the environment however the communal areas of the home were not clean. The dining room floor was very sticky underfoot throughout the two days we were there and was unclean. Armchairs were covered in spillages and food. Tea was served in large vacuum jugs which were heavily stained.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Accident reports were completed and detailed but the service did not demonstrate falls prevention awareness. Staff had not received any training in this subject area. Falls and incidents were not fully analysed to identify any trends or themes where action could be taken to minimise incidents of falls.

Risk assessments were not always effective or in place; there were no risk assessments carried out for the use of bed rails. Capacity and understanding of the purpose for bed rails had not been considered for people living with dementia. This meant that the decision for their use may not have been in the individual's best interest and could place them at risk of injury. Staff had not recognised the potential impact on people or explored alternative and more suitable options.

Staff spoken with felt that there were sufficient numbers of staff to meet people's needs. The registered manager told us that staffing levels were based on people's needs and that they would be increased if necessary and that this would be supported by the provider. However we saw that staff were not deployed sufficiently to ensure people were

Inadequate

Is the service safe?

adequately supervised and occupied. For example during the period following breakfast and leading up to lunchtime the activity coordinator was facilitating a game of cards in the main lounge, other care staff were writing up care records, at a key time of the day, when people needed support. There were nineteen people in the lounge and only four people were actively participating in the game. The remainder were unoccupied, some were distressed and calling out for help; others were left to their own devices and wandering in and out.

Staff were aware and understood the providers safeguarding policies and procedures and were able to give a good account of what they were; how they would raise an issue or escalate a concern if necessary. They said that they would be happy to raise issues with the manager.

Medicines were stored safely for the protection of people who used the service. There were suitable arrangements in place that were followed by staff to ensure all medicines were managed safely. People's medication administration records and associated records showed that they received their medicines as prescribed and in a safe way. Where people were prescribed medicines on a "when required" basis, for example for pain relief, we found there was not always sufficient guidance for staff on the circumstances these medicines were to be used. Staff were aware of the importance of people receiving particular medicines at specific times of the day in order to manage their health condition effectively and we observed staff to administer these on time. People were given their medicines by suitably trained and competent staff. Those authorised to handle medicines had received appropriate training and had been assessed as competent to do so. We observed a senior carer try several times to administer medication to someone who refused, on the basis that sometimes if they tried again later they would often take the medicines, rather than omitting the medication on the first attempt.

Inadequate

Is the service effective?

Our findings

Staff were not adequately trained and this was demonstrated in their practice and approach to the care and support people received. People using the service were at various stages of their dementia condition ranging from early onset to advanced stages; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and in keeping with best practice.

Staff had a limited understanding of how dementia affected people in their day to day living; they did not know about best practice and did not always recognise poor practice. They were unable to tell us how they could support people to reduce their anxieties. After breakfast we saw four people had been left in the dining room for as long as 30 minutes. They had nothing to do, required support and had become increasingly agitated and frustrated. When we mentioned this to one staff member they said, "These are our more awkward clients who can be uncooperative" and so they were left until last.

Some staff lacked knowledge about people's backgrounds and past lives which would have enabled them to explore different ways of communicating and understand more about the person they were supporting.

Support for staff learning and development was inconsistent. Staff told us that they did not have a personalised development plan which reflected professional development or specialisms linked to the needs of people they cared for. The provider's statement of purpose, dated April 2014, stated that, 'Staff were trained to a high standard' and the service was 'committed to training staff' and 'the majority of staff had completed dementia training.' We found that this was not the case. Records showed that only half of the staff team had received a basic level of dementia awareness training and only ten out of 33 staff had received a further level of training in this area. The registered manager told us that staff were completing assessment workbooks, in their own time, to develop their skills in dementia care. We observed an individual calling out four times, "Help me, help me, help me." Despite staff coming in and out of the dining room they did not respond to them at that time. When they did attend, to put footplates on their wheelchair; they approached without warning or explanation and did not provide any verbal reassurance when they moved the individual and the wheelchair. This resulted in the individual hitting out at the staff members. A staff member responded, "Why are you doing that? Behave nicely." A more substantial training was needed to enable staff to develop the skills and expertise needed to carry out their roles and responsibilities effectively such as communication skills, person centred care, diversity and engaging with people in purposeful activity.

Staff told us that they had an induction when they commenced work at the service and this involved orientation to the service and shadowing senior staff. The registered manager told us that the senior person provided new staff with basic knowledge and information with regards to their responsibilities, policies and procedures. Staff did not complete a robust induction programme that satisfied the learning outcomes as advised by Skills for Care, the employer led authority on training standards and development needs of social care staff.

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

Management and staff demonstrated a lack of understanding in relation to Mental Capacity Act (MCA) 2005 Code of practice and Deprivation of Liberty Safeguards (DoLS); one staff member said that they had attended some training recently about this but were unable to tell us what it was about except for, "One bit mentioned Court of Protection." Care records showed that people's ability to make a decision in everyday matters such as receiving personal care and nutritional or medication assistance had not been assessed within their care planning arrangements. The provider did not have robust policies and procedures for obtaining people's consent to care that reflected current legislation and guidance, and followed by staff at all times.

The principles of Deprivation of Liberty Safeguards (DoLS) had not been fully considered for people living in the service. The service was a locked environment and key pads were used for the entrance and exits of the floors and building. The registered provider was not aware of and had not taken appropriate steps in line with recent amendments in the DoLS legislation and applications had not been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe.

Inadequate

Is the service effective?

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People we spoke with and relatives told us that the food was variable. People did not have access to cold drinks throughout the day; there were no drinks available to people in the lounges until the hot drinks trolley came round in the morning and afternoon. There were no snacks or fruit available for people. During the morning we saw that individuals were given a packet of crisps as a prize for winning a game. On one occasion a staff member told the person as they ate the crisps, "They will last you until dinner." Other people watched as the person was eating them but nobody else was offered crisps. Poor nutrition and dehydration can quickly exacerbate some of the symptoms of dementia, making individuals feel agitated and more confused, as well as having a significant impact on their overall physical health and wellbeing.

People left to eat independently had little interaction with staff which did not encourage or promote practical help to eat more either independently or with support. As a result some people ate very little of what they were served and staff did not explore this further. For example one person had been assessed as being at high risk of malnutrition and dehydration. They had been referred to a dietician on three occasions. Nutritional supplements had been prescribed and they required high calorific and enriched foods. Their care plan instructed staff to offer choices, ensure prescribed supplements were given, to offer small amounts and offer fluids. We saw that they ate only three mouthfuls of their meal. Three different staff interacted with them during the mealtime but none provided any support or encouragement to eat more. The remainder of their meal was taken away uneaten. They were not offered a choice and no supplements or drinks were offered or encouraged.

People's food and fluid consumption was not monitored effectively to provide an accurate picture of any changes in people's nutritional needs and ensure planned care and support was effective. One staff member had the responsibility for completing nutritional records for everybody and relied on information passed on by other staff. One staff member said that this was difficult because, "You have to ask the other carers what people have eaten and chase around a bit to find it all out."

The cook and the kitchen assistant told us that nobody had specific dietary requirements however we found at least three people had diabetes. They were not provided with low sugar or sugar free desserts.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A new initiative had been introduced whereby weekly clinics were held in the service by the community matron to review any concerns identified in people's changing needs such as increasing falls and confusion. This enabled people to have prompt access to healthcare services. The community matron also saw new people to the home following their admission to review their healthcare needs. A visiting district nurse told us that they had no concerns with the service and staff knew people using the service well. They said that people were referred promptly to them where there were concerns and staff usually followed their instructions fully.

The provider had taken steps to promote a dementia friendly environment however further improvement was needed. Corridors were painted in different colours to assist people to orientate themselves in the service and some corridor walls were themed for example, a London theme and Elvis, which stimulated interest. The carpet colours and patterns did not provide differentiation for people with visual impairment or dementia related needs and we saw one person continually turning back and not wanting to go any further when needing to turn a corner. There were no distinguishable features such as different coloured doorframes to enable people to recognise toilets and bathrooms and signage was not consistent around the service. We saw people looking for the toilet. There were memory boxes outside people's bedroom doors which helped to establish a familiar landmark for individuals to recognise their bedroom. The boxes contained personal items and old photographs.

We recommend that the service seek advice and guidance from a reputable source about the design of dementia specific settings to maximise the safety and suitability of the environment for the benefit of people with dementia using the service.

The service was in urgent need of redecoration. Although we saw a long term maintenance plan for 2015 which identified larger projects such as a wheelchair ramp, replacement of shower rooms and overhaul of heating

Inadequate

Is the service effective?

system; there were areas of the home that lacked general maintenance and repair for example a broken toilet flush. We found some carpets were heavily soiled and required renewal. There was no form of shade in place in the communal areas to protect people from the light and reduce heat. People were seated in direct sunlight in one lounge with only heavy curtains to pull which placed the room in darkness. One person seated next to a window was pulling a curtain around them to protect them from the light.

Inadequate

Is the service caring?

Our findings

People were not always treated with kindness and compassion in their day to day care. There were some good interactions between staff and people using the service but there were some staffs that were disrespectful and demonstrated a lack of understanding of the needs of people they supported. As one person was assisted to sit in the dining room they said, "My legs are sore, I'm not having you on; they really are." The staff member did not respond to them. This person was very anxious and kept seeking reassurance from us. Another person constantly called out that they did not feel well. Staff did not validate this person's feelings and just kept telling them, "You are fine, there is nothing wrong with you." On another occasion an individual told us that they had been crying since they had awoken, they felt very low but did not know why. This had not been picked up by staff and despite us bringing this to their attention we did not see staff engage with them.

Staff spoken with gave good accounts of how they respected and promoted people's privacy and dignity; however we saw times when this was not put into practice. People were dressed in dirty and stained clothing. On one occasion a person was being supported from the dining room to the lounge, after their breakfast. Their jumper and trousers were badly stained with food and drink. The staff member did not notice and walked them past their bedroom without suggesting a change of clothes. They remained in the stained clothing for the remainder of the day. We also noted that some people were dressed in clothing that was either too small or too large for them. One person was wearing trousers that were very big and falling down, a staff member told us it was because they had lost so much weight, however the trousers were also too long and had to be rolled up to avoid them tripping.

On both days of our inspection we saw that people were unshaven. One person told us that they always used to shave but this did not happen very often now. Another person's care plan stated that they took pride in their appearance and liked to have a shave every day. There was a notice on the staff noticeboard which said, 'Shave all men' but this was not evident.

There were no curtains to cover the two windows in the bedroom of one individual; staff told us this was because they pulled them down. Consideration had not been given to how they could promote their privacy and dignity and find alternative arrangements for them such as roller blinds, Velcro curtains that could be reattached or window film.

We observed mealtimes. Plate guards or assisted cutlery were not offered or in use which would have benefited some people in maintaining their independence. One relative told us that their family member was unable to hold routine cutlery and therefore it was necessary for them to be fed. Two people were being fed simultaneously by one staff member. They stood behind and between them, wearing plastic gloves. They approached each person from behind, to feed them, using a spoon, which was full of food and potentially placed them at risk of choking. Because the spoon was so full they held their hand under one person's chin to prevent food from dropping onto the person's lap. The staff member did not talk to the people they were feeding. This task led approach was not safe, discreet or dignified and showed no respect for the people being assisted to eat.

People were not always enabled to express choice. Mid-morning tea and coffee was served with a selection of biscuits available however the staff member picked the biscuits out of the box and gave them to each individual on a plate. In contrast people were offered a choice of biscuit with their afternoon tea. At the start of lunch a choice was offered, verbally and visually to people at one or two tables but then staff reverted to giving out food without choice.

People were not consistently supported to express their views and be actively involved in making decisions about their care and support. Not all care plans evidenced that people or their representatives had been consulted about their needs, wishes and preferences regarding how they would like their care or support to be given. The registered manager told us that resident meetings were not frequent. They said, "We speak to people to find out their views, we always communicate, people are very vocal here and we encourage it because it is their home." There was no evidence of this.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service responsive?

Our findings

At our last inspection in August 2014 we found the service did not have adequate arrangements in place that ensured people were engaged in stimulating activities that were meaningful to them and promoted their wellbeing. Although steps had been taken to identify a staff member to carry out group activities with people we found that a task approach was taken irrespective of the need of the individual and further improvements were needed. Throughout our inspection we saw some activities taking place however we remained concerned that those provided were relevant to people and in accordance with their wishes, preferences and abilities. The staff member was facilitating a game of cards, however only four out of nineteen people had cards in front of them. One person did not participate at all and had a visual impairment; the cards were removed at the end of the game. Some people were quite vocal and were trying to participate in the game but they did not have any cards. Other activities included skittles and ball throwing which people were not really engaged with.

We found people were not being protected from the social isolation and loneliness. Staff did not support people with individual interests or hobbies and there was no system to ensure that people who spent time alone had this explored through individual care planning to ensure their needs were met. One person told us about their very interesting life and work, they were very chatty, easy to talk to and responsive to us. However they repeated at every opportunity, “I pray every night to be taken and not wake up.” They told us that they were lonely and had nothing to live for. Another person told us, “I feel like I am always doing nothing – and then one day I will be dead. I am wasting time and I am fed up to the back teeth, I have never felt so unhappy, I have no wish to live.”

We heard a staff member saying to one person, “This is a retirement home, you have retired, you don’t have to do anything, no washing, no cooking, no ironing, no cleaning.”

We saw another person following and chatting to the cleaner. When we asked if people were given the opportunity to help such as dusting or laying the tables they told us that this used to happen but not for a long time. This demonstrated a lack of understanding how people with dementia need to be involved in activities of daily living to provide them with a purpose and promote emotional wellbeing.

None of the care plans we looked at contained a care plan that adequately demonstrated how the service responded to individual’s differing needs in terms of interests, social activities, types of dementia and the varying stage of dementia they were at. We observed people being left largely to their own devices on the days of our inspection which resulted in anxiety levels, distress and social isolation escalating.

On many occasions throughout our inspection we saw an individual getting increasingly distressed and calling out “where is my baby?” “Oh, oh, oh I want to go home”, and “Mum where are you, I want my mum.” Their care plan described them as often upset and needed constant re-assuring and comforting. This level of support was not provided from staff.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although there was a complaints system, we received mixed views from relatives that concerns may not always be taken on board and managed in a positive way. This did not promote an open culture in which anyone would feel able to raise a concern and, where they feel they need to, raise it further as a complaint. The complaints log contained only one complaint received in 2012. The registered manager told us that concerns or complaints received verbally were acted on at the time and not recorded formally. Therefore they were unable to demonstrate that changes had been made as a result of any failures identified.

Inadequate

Is the service well-led?

Our findings

We found widespread and significant shortfalls in the way the service was led with regulations not being met. Leadership was not proactive and there were limited processes in place to assess and monitor the quality of the service and if it was operating safely and effectively. Prior to our inspection the provider submitted information telling us that the premises were risk assessed for safety; risks were minimised and equipment was well maintained. We found this was not to be the case. Systems in place to help identify risks were not robust. Audits undertaken in relation to health and safety, first impression environment, cleaning and infection control had not been carried out routinely since October 2014. The provider conducted monitoring visits to the service every two weeks and findings were recorded in a book. The monitoring visits and audits failed to identify the issues found at this inspection.

There were no other audits to measure and review the quality of the service and care provided. The registered manager was unable to demonstrate how they identified any trends and themes in incidents and accidents across the service and where improvements were needed in order to minimise risks of similar incidents happening again. The provider was failing to continuously assess the quality of the service to drive improvement or identify where lapses had occurred.

The culture of the service was not focused on improving for the benefit of those living there and the management and staff did not have a clear vision of the service they were providing. None of the staff spoken with were able to tell us what the aims and values of the service were. The service provides care and support for people at various stages of dementia. The service advertises that it participates in My Home Life which is a national movement to improve the quality of care of everyone residing in a residential care home, promoting best practice but there was no plan about how the service kept up to date with developments in dementia care to ensure the care provided was appropriate and in accordance with best practice. The registered manager was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted. There were no arrangements in place to show how comments or concerns received from people using the service or their representatives were considered or managed to drive improvement. There were no arrangements in place to help people who had no one acting on their behalf to access advocacy services to enable them to voice any concerns if they needed to.

Staff generally felt supported by their colleagues and the registered manager, however not all staff understood their roles and responsibilities. The registered manager told us, “I believe I am open and approachable for my staff, and as well as their manager, I like to think I am also their friend.” The registered manager said that staff were supported through one to one supervision meetings, staff meetings and by working alongside them. We found there were no records of staff meetings dated from 2013. However we noted that one record, which was not dated, made references reminding staff about people’s personal appearance and care, footplates to be put on wheelchairs when transporting people and to complete monitoring records and care plans. We brought this to the registered manager’s attention as we were concerned that these areas were still not being addressed. They did not demonstrate a good understanding of quality monitoring and assurance and was not able to show us how they were driving improvement.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not ensured the premises and equipment used to deliver care was safe, properly maintained and clean. This was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have an effective operation of systems or processes designed to enable them to regularly assess and monitor the quality of service provided and to identify, assess and manage risks relating to the health, welfare and safety of people using the service. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not protected from the risks of inadequate nutrition and hydration.

This section is primarily information for the provider

Action we have told the provider to take

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that staff received appropriate support, training, professional development and supervision as is necessary to enable them to appropriately perform the duties required of their role. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10(1)(2)(a)(b) People did not have their dignity, privacy and independence ensured and were not always treated with consideration and respect and enabled to make, or participate in making decisions about their care and support or express their views. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a)(b)(c), (3)(b) We found that people did not receive care and support that was personalised specifically for them, appropriate to and meeting their needs and reflecting their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person did not have appropriate arrangements in place for obtaining people's consent and acting in accordance with current legislation and guidance when people did not have the capacity to consent. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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.