Care Quality Commission

Estateband Limited

The Old Vicarage

Inspection report

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Ratings

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

Overall summary

The inspection took place on 30 October and 11 November 2014 and was unannounced.

Our last inspection of this service was on 14 July 2014 and followed up concerns from previous inspections. We found that there were continued breaches of legal requirements for care and welfare of people using the service. There were also breaches of legal requirements for infection control, safety and suitability of premises and assessing and monitoring the quality of the service.

The provider met with us on 1 September 2014 and told us how they were going to improve. At this inspection, we checked to see whether improvements had been made and found that they had not.

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

Summary of findings

and associated Regulations about how the service is run. We took action to cancel the registration of the former manager in September 2014 because improvements had not been made to comply with regulations. At present there is a manager in post who is not registered.

The Old Vicarage provides accommodation and personal care for up to 24 older people. On the first day of this inspection there were seven people living in the home. On the second day, there were four people in residence.

People's safety was compromised in a number of areas. Staff knew that they needed to report any concerns about abuse. However, allegations were not always properly responded to and there had been instances of neglect. People's safety was also compromised because of hazards in the environment and poor infection control. Their medicines were not always stored securely and administered properly.

There were enough staff on duty to meet people's needs and to respond promptly to people's requests for assistance.

People did not always receive care which met their needs. Action was not taken promptly to secure advice when people's needs changed significantly and care plans were unclear about specific individual needs. People did not always receive sufficient nutrition and hydration for their needs.

Long standing staff had access to training including in the Mental Capacity Act (MCA) 2005. The manager understood the need to make an application under the MCA Deprivation of Liberty Safeguards where someone's liberty had been restricted. However, staff were not receiving supervision or regular assessments of their competence to support people effectively and safely. New staff did not receive proper induction training to support them in their roles.

People or their relatives were not encouraged to express their views about care and treatment. Although people felt that staff were caring we received mixed views about this from relatives. Half of them felt that some staff were not patient with people. We saw some interactions that were caring and compassionate and others where staff did not engage with people. We found that people's privacy was respected.

The service was not responsive. It did not respond to changes in people's needs promptly and people's social interests and hobbies were not taken into account. One person said they got bored and relatives said that there was nothing going on for people. People and their relatives were not clear about how to make a complaint. Two relatives felt that concerns were not properly addressed with staff being defensive if they raised anything.

Leadership of the home was poor. There were no effective systems in place to monitor the quality of the service and identify where improvements were needed. There had been a lack of action to address shortfalls identified at previous inspections.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what these are at the back of the full version of this report. Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). We have taken action to cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Although staff knew they needed to report concerns, people were at risk of abuse. The provider had not always reported allegations passed on by relatives or taken action to investigate. External investigations indicated that there were occasions when people had experienced neglect. Prompt action was not taken when risks to people increased because their health deteriorated.

People were exposed to risks inside and outside the home because of trip hazards and a fire exit being obscured. The measures in place to prevent and control infection were inadequate so people's health was at risk.

People's medicines were not always secured and administered safely in line with the GP's instructions.

There were sufficient staff on duty to ensure they were able to respond to requests for assistance promptly.

Is the service effective?

Inadequate

The service was not effective. People's health and welfare was compromised because staff did not always seek medical advice promptly. People did not always have enough to eat and drink.

Staff were not supported to meet people's needs effectively. There was a lack of regular monitoring of competence and support through supervision. New staff did not receive prompt training relevant to enable them to understand their roles and support people properly.

CQC monitors the Deprivation of Liberty Safeguards (DoLS). The manager had sought and acted on advice where they thought a person's freedom was being restricted. Staff understood aspects of the Mental Capacity Act 2005. However, assessments were not consistent with the principles of the guidance.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People were not supported to be involved in planning their care and understanding the options open to them. Relatives were not consulted so that they could support people to understand the options open to them.

People living in the home were satisfied with the way staff supported them. However, relatives had mixed views. Two felt that staff understood and respected their family member's wishes and knew them well. However, two relatives described some staff as impatient and said that they would not recommend the home.

We saw that staff did offer explanation, comfort and reassurance when it was required and respected people's privacy.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive. People's plans of care did not reflect their current needs and set out how staff were to meet those needs appropriately. People's hobbies and interests were not taken into account in planning activities with them.

Three out of four relatives were not confident that their complaints or concerns were listened to and acted upon. One described staff as defensive if they made any suggestions. Another was concerned that staff might take it out on the person living in the home if they complained so they were frightened to raise issues.

Is the service well-led?

Inadequate 

The service was not well-led. The provider failed to check and monitor the quality of the service and to consult people living in the home and their relatives about quality.

We had repeatedly found concerns during our inspections which had not been identified by the provider or the former manager. This showed a lack of robust quality assurance systems. Where issues had been identified in either our reports or reports by external professionals, action had not been taken.

The Old Vicarage

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 October and 11 November 2014 and was unannounced.

The team consisted of a lead inspector and two other inspectors on the first day of the inspection. An inspection manager and one inspector completed the second day of the inspection. Before the inspection we reviewed the information we held about the service, including notifications. The provider is required by law to make notifications about some events happening in the home, such as serious accidents, abuse and deaths. We also received information from the council's quality monitoring team, infection control team and safeguarding team in east Norfolk.

During the inspection we looked around the home, talked to four people using the service and four of their relatives. We spoke with two staff, the manager and the provider of the service.

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

We checked how people were supported at each stage of their care and treatment. We reviewed four people's care records, medication records, records relating to the premises, training records and recruitment records for two staff.

Inadequate

Is the service safe?

Our findings

People who lived at the home were not safe. Risks to their safety had not been assessed properly. They were not protected from unsafe premises, from the spread of infection or from abuse. Medicines were not managed in a way that ensured people's safety.

We noted that one person had allergies to two medicines recorded in hospital notes contained in their care plan file. A further allergy to latex products was recorded on a body chart within their file. We discussed this with the manager who confirmed that the person did have these allergies. They were also prescribed medication for epilepsy but their care plan did not mention that they were epileptic. The 'care plan action plan' for the person, summarising their care needs, did not have this information entered in the box provided for recording 'other alerts e.g. allergies, diabetes'. This presented a risk that the person would not receive care in a way that promoted their safety.

We observed that one person's mobility had deteriorated significantly between our two inspection visits. We found that the risk assessment for the person developing pressure ulcers showed that their risk of these was low despite the changes in their mobility. Additional precautions, such as regular repositioning of the person to ensure their skin integrity, had not been incorporated into their care. This meant that the person's safety and welfare was at risk.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed hazards in the environment where people lived, making it unsafe for them. There were trailing electrical wires in the dining room and conservatory, causing a potential trip hazard. Some flooring was uneven and changes in level had not been signposted clearly to warn people. We saw that one person struggled to use their walking frame on the uneven surface in the ground floor corridor. The linoleum in one upstairs toilet was bubbling up and uneven, causing another hazard to people living in the home.

One of the home's fire exit doors on the ground floor corridor had been hidden behind a curtain making it difficult to see, causing a serious obstruction if people needed to get out of the home quickly in the event of a fire.

Although work had started to provide a safe and secure garden area, the pathway to the outside garden was uneven making it a trip hazard. In the back garden we saw an abandoned car, a large disused clinical waste bin, an old toilet bowl and a large pile of rubbish, making the grounds dangerous for people to use.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us they were happy with the cleanliness of the home. One relative told us, "I can't complain about the cleanliness, mum's room is clean and she wears smart clean clothes."

We noted some good practice in relation to infection control. We saw that mops and buckets were colour coded to ensure they were only used to clean designated areas. This helped to reduce the risk of cross infection. Antibacterial hand gel was available and gloves and aprons were easily accessible for staff to use when they assisted people to use the toilet for example. This meant that staff had some protection from infection.

However, the provider had failed to implement the findings of an infection control audit carried out in January 2014 by an NHS infection control nurse. The audit identified what the provider needed to do to minimise the risks to older people if an infection broke out and to ensure control measures were robust.

The laundry where people's clean clothes were stored was dusty and unhygienic. The pedal on the bin for clinical waste was broken. This meant that staff had to use their hands to open it, increasing their risk of exposure to infection. The hand washing sink contained a build-up of lime scale in the plug hole, creating an uneven surface where bacteria could accrue. The light switch was grubby and shelving was chipped making it difficult to clean. Used commode pots were washed in the laundry, near to where people's clean clothing and linen was stored. The floor covering in the laundry was torn making it difficult to clean. We requested the cleaning schedules for the laundry but staff told us there were none.

Paper towels and toilet tissue were not dispensed from enclosed containers in any of the toilets and bathrooms we viewed and so risked being contaminated when people used the toilets.

Inadequate

Is the service safe?

The home's infection control policy was out of date and made reference to guidance that was 18 years old. This meant it did not reflect current best practice. It was also inaccurate as it stated that linen was laundered off site, when in fact it was washed in the home. This meant it did not reflect how infection risk was being effectively managed.

These shortfalls meant that, should there be an outbreak of infection in the home people would be at risk of infection adversely affecting their safety and welfare. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed two recent investigations completed by the local safeguarding team. Both of these resulted in findings of neglect. For one person, staff failed to seek medical advice promptly when the person had an adverse reaction to food on two consecutive days. The other investigation concluded that staff had left the building unattended, either to put out rubbish or to go out for a cigarette. During that time one person sustained a head injury as a result of a fall when attempting to leave by the same door. A relative also commented to us that they had turned up at the home, couldn't find staff, but then saw both staff on duty outside having a cigarette. This was supported by another visitor who said, "I come sometimes and all of the staff are having a fag outside the back door."

Two relatives told us that they had reported concerns about missing jewellery to the former manager. One told us they had also reported missing money. They said they were not confident that the manager at the time had referred their concerns to the police or that any other investigation had been made.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff confirmed to us that they had training to enable them to recognise and respond to suspicions of abuse. They told us about the sorts of things that could constitute abuse and that they would have no problem reporting issues to the manager. We asked what they would do if the concerns involved the manager. Both staff members said that they would raise concerns with the Care Quality Commission or the local safeguarding team if this was the case.

People's medicines were stored in a locked room and the controlled drugs cabinet met legislative requirements. However, the security of all medicines was compromised on the second day of our inspection. We observed that the keys were left unattended in the corridor outside the treatment room and the cupboard containing blister packs of medicine was not locked at all.

We found that the GP had completed notes within one file to recommend a change in medicines dosages for a drug used in agitation. The notes made on 31 October 2014, showed that the person was prescribed Risperidone tablets for twice daily administration. The GP went on to record that if the person was too sleepy staff should give one tablet a day or give the night dose and assess whether the person needed to have the morning dose. We reviewed the medication administration record (MAR) chart and found that staff continued to give the medicine twice daily for a period of four days after the GP had made the change. The person's daily notes showed that they were drowsy throughout the period and gave no indication that the second dose was required because they were agitated. This meant that the medicine was not administered as intended by the prescriber and the person received more of the drug than they needed to promote their welfare and safety.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us they received their medicines when they needed them and that staff had never forgotten to administer them. One person said, "I get my tablets and eye drops regular, staff are pretty good." A relative told us, "There's never been any problems with mum's meds; staff have always dealt with that well." Staff told us they had received training in administering medicines to people. However, there was no evidence that their competency to do it safely and correctly had been regularly assessed.

We checked the records for two recently recruited members of staff. Each contained proof of the staff member's identity, two suitable references and a disclosure and barring check to ensure they were suitable to work with vulnerable adults. However notes of the employment interview were not kept to ensure it was conducted in line with good employment practices.

On the first day of our inspection there were three care staff and the manager on the premises throughout our inspection. One staff member was engaged in preparing lunch for people. However, this still left two staff and the manager to support the seven people living there. Staffing levels had also been maintained on the second day of our

Inadequate

Is the service safe?

inspection when there were four people living in the home. Staff responded promptly to call bells during both visits indicating staffing levels were sufficient to meet people's needs safely.

Inadequate

Is the service effective?

Our findings

The service was not effective. Advice was not always sought promptly in response to changes in people's health and the support people needed was not appropriately reflected in their plans of care. People did not always receive sufficient food and drink to meet their needs and staff were not consistently trained and supervised to support people well.

Although a relative told us that they felt staff were good at getting the doctor out when the person needed it, we had concerns about the way people's health and welfare was promoted.

We observed that one person was very drowsy and difficult to rouse. On the first day of our inspection we asked two staff about the person's condition. They said that the person did have occasional days where they were sleepy but both confirmed the person's drowsiness was uncharacteristic. On the second day of our inspection we reviewed the person's records to ensure that they had seen their GP. The records showed that concerns about the person being drowsy or sleepy had been noted on a regular basis since they had sustained a head injury on 17 October. We found that the GP had been contacted about this but not until 31 October and after we had raised concerns about the person's welfare at our inspection on 30 October.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the first day of our inspection we observed the main meal being served. One person required assistance and prompting to eat and was at high risk of poor nutrition and hydration. We saw that staff encouraged the person by telling them what they had and how much they had left, in line with their plan of care. However, no snacks or finger foods were offered to try and boost the calorie intake of this person who had not eaten much of their lunch.

On the second day of our inspection we found that the same person had a flavoured nutrition supplement on a table behind them which they could neither see nor reach. A staff member brought them a cup of tea between 9.40 and 9.45am. It was 10am when we saw a staff member come in and offer some assistance and prompting with the nutrition supplement. We observed that they had a two or three sips, and said, "Oh, that's lovely." However, the staff member then offered them assistance to go to the toilet leaving the rest of that drink and their tea untouched. We reviewed their fluid monitoring charts in relation to these two drinks. Their records showed their nutrition drink had been given at 9am and their tea at 9.45am. The records showed that they had drunk 200mls of both of these, which would represent a full cup. This was not the case and so we could not be sure that people received adequate hydration or nutrition.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two long standing members of staff told they felt the training they received was relevant to the needs of people living in the home. However, one staff member said that recent dementia training had not helped them to improve their knowledge about how to support people more effectively. We observed that some of the interaction between staff and people living with dementia showed a lack of skills in this area. For example, we saw that one person living with dementia became distressed about their spouse. Their distress increased when a staff member re-affirmed that their spouse had passed away.

The records for two new members of staff did not show that they had received appropriate induction training to make sure that they understood how to support people properly. We asked staff how their competence was monitored to ensure that the training they had received was put into practice. They were not able to confirm that their everyday practice was observed formally to assess how well they supported people.

The manager was able to find supervision and appraisal records for only two staff members. This meant that the provider could not show they had sustained the improvements in this area we saw at inspection in July 2014. The former manager was closely related to many of the staff working at the home, making it difficult to ensure that staff supervision, appraisal and disciplinary procedures could be conducted fairly and objectively. The current manager had been in post for approximately five weeks when we started our inspection. Staff said that the manager was supportive. However, they had not yet received supervision to talk about the standard of their work and any training needs.

This was a renewed breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Staff told us they had received training in the Mental Capacity Act 2005 (MCA). On the first day of our inspection, staff told us that two people living in the home were able to make decisions for themselves. We found that they had signed their notes to say they had been involved in discussion about their care plans. They also signed that they gave consent for health professionals or inspectors to look at their records.

Staff were able to identify people for whom decision making was difficult because they were living with dementia. They told us how people were encouraged with choices such as what they wanted to eat or wear and whether they wanted to have a bath or wash. We could see from daily records that people's decisions to refuse assistance with personal care were respected and that staff would approach them later on or on a different day to see if they wished for support in these areas. For one of the people staff spoke to us about, their records just showed that they lacked capacity to make decisions without detail about the specific aspect of care or treatment under consideration.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards require that providers submit applications to a 'supervisory body' for authorisation to deprive someone of their liberty. This is needed if providers feel that it is necessary in the person's best interests. We found that one person living in the home had been subject to regular checks on their whereabouts because of concerns for their safety if they left the building. They had been assessed as not able to make an informed decision about the risks to which they would be exposed if they went out alone. An appropriate application had been made to the local authority as the 'supervisory body' in line with these safeguards. The application had been made and granted because of the extent of the risk if the person left the home, because they were unaware of these risks and they were subject to regular checks and supervision to ensure they remained within the home.

Requires Improvement

Is the service caring?

Our findings

The service was not consistently caring. People were not always involved in making decisions regarding their care. People we spoke with told us they had not been involved in reviews of their care plan. One relative told us that they were kept informed about their loved one's welfare. However, none of the relatives we spoke with were able to confirm they were involved to support people in decisions about their care. One relative went on to say that they had never seen their family member's care plan despite visiting the home regularly.

We asked staff who might have difficulties being involved in making decisions about their care. They identified people to us and told us this was because they were living with dementia. We found that there was a lack of information within those people's records to show how staff had tried to explain aspects of their care or treatment to support them in making specific decisions about their care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received mixed views from relatives about how caring staff were. A relative said, "Mum's very slow with her walking frame and I once saw a member of staff become really impatient as they couldn't pass her to get into the lounge. Instead of just waiting, the staff member passed a heavy tea tray right over mum's head. I thought that was dangerous and disrespectful to mum." Another relative commented that some staff were less patient than others and a third said, "If I'm honest the care is not what I want for mum. Staff never go in to chat or spend time with her." Two of the four relatives we spoke with told us that they would not recommend the home. We observed that there were times when there were no staff in the lounge to engage with people. We also saw that some staff came into the room without speaking to or acknowledging the people who were present.

People we spoke with were satisfied with the way they were treated by staff. One person commented, "Staff are all pretty decent." They went on to say that staff treated them in the way they liked. One relative told us the person they visited liked to spend all day in bed and that staff were happy to let them do that. Another told us that, "Staff are friendly." They felt that staff knew the person's "…little ways well".

Staff were able to give us examples of how they protected people's privacy and dignity. They told us how they would make sure doors were properly closed when they were delivering care for people. We saw that they did this when they assisted people to use the toilet.

We observed that one person became distressed. Although staff did not at first respond in an appropriate manner they did then recognise the need to offer comfort and reassurance. They sat with the person, holding their hand and distracted them by talking with them about their family.

We heard staff explaining to people what was going on. For example, staff explained to someone that it was time for their lunch, what the food was and encouraged them with eating it. Another person said they were not hungry at lunchtime. A staff member gently reassured them that they would keep something back for them in case they changed their mind later.

We saw two people laughing and chatting with a staff member and we also heard staff speaking with people politely and with respect. One person was asked if they wanted a blanket and staff made sure they were comfortable. We also heard someone telling a staff member, "You're a good girl." This was when they had been asked quietly whether they would like help to go to the toilet.

Inadequate

Is the service responsive?

Our findings

Improvements had been made with regard to recording people's life histories and interests, so that staff had information about what had been important to them in the past and what they enjoyed. However, this was not used to plan how the service would support people with their hobbies, interests or to socialise inside and out of the home. One person told us, "I spend all my time sitting here, it do get a bit boring".

Two relatives also raised this with us as a concern. One commented, "There's no games, nothing, residents just sit there, there's no stimulation". Another relative told us about a suggestion they had made that the television in the main lounge could be set to use subtitles. They thought this might encourage the person to come downstairs and watch television with others so that they were not isolated in their room. The relative told us they felt that staff were dismissive of the idea and not prepared to try it. This meant the person continued to spend most of their time alone in their room.

Because we observed that staff did not spend much time with people other than for care tasks, we asked the provider what opportunities there were for people to engage in social activities. They told us that the activities record was, "…a bit thin." However, no action had been taken to increase the opportunities open to people. We also reviewed records to see how people were supported with their interests and hobbies. We found that there was little on offer to people on a regular basis. For example, on the 11 November when we visited for the second time, one person's record did not show they had been offered any activities, stimulation or conversation since 24 October when a staff member recorded they had a laugh with the person about the weather.

We found that people's needs had been assessed but assessments were not kept up to date so that changes in their needs were recognised and responded to promptly. Records showed that parts of one person's assessment and care plan were entirely inconsistent with what we observed. We found that their care plan for mobility was dated as reviewed on 28 October and their moving and handling plan was dated 29 October. The moving and handling plan recorded that the person walked independently. However, their daily records showed that they had spent significant amounts of time in bed for over a week leading up to our second visit and they remained in bed throughout that visit. The manager told us the person was currently unable to walk due to their swollen legs. Their care plan for mobility, their moving and handling plan and their risk assessment for developing pressure ulcers had not been updated. This meant that care had not been planned in a way that met the person's changed needs so that their care and welfare was promoted.

A relative told us that a person's eyesight had deteriorated so they were not able to do the things they used to do. We observed that the person concerned leafed through a newspaper but was not reading it. When we asked them about it they told us that they could see the pictures but not read it properly unless they held it really close to their eyes. We asked staff what the person's vision was like and they told us it was good. The person's assessment and care plan also showed that their eyesight was good. This conflicted with what the person and their relative told us and what we had observed. There was no evidence of a recent referral or follow up for an eye test to show that staff were aware of any change in the person's needs.

These concerns represented a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked a staff member how people would raise complaints and concerns if they needed to. They told us that one person had no difficulty expressing their views but generally preferred not to escalate them. They gave us an example of how another person had asked the staff member to get the manager so that they could talk about something that was concerning them. None of the people we spoke with were aware of the home's complaints procedure and where to find the information. We concluded from our discussions that most people would need support to make a complaint.

A relative told us that they were not aware of the home's complaints procedure and that they would worry about raising any concerns in case staff took this out on the person living in the home. Another relative told us how they had raised concerns that they had twice found other people's medicines on the floor of the person's room. They had not received any feedback about actions taken in response to this. They went on to tell us that they were reluctant to raise issues because of the defensive attitude of staff and did not feel their complaints were taken seriously.

Inadequate

Is the service responsive?

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home's complaint book contained no record of any complaints received despite family members telling us they had raised concerns with the former manager.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. There were no effective systems to assess and monitor the quality of the service. There was a failure to ensure that risks to people were identified and managed, including those described in this report in relation to unsafe care. We found problems in relation to the way people's care and welfare needs were assessed, planned for and met. We found continued failings in infection control and the safety of the environment. People or their representatives had not been asked for their views about the quality of the service. The provider had not had regard to a succession of reports compiled by the Care Quality Commission relating to the failure to comply with regulations. The provider had also not taken proper account of the audit of infection prevention and control measures compiled by a specialist in infection control.

The provider had not implemented the improvements that were set out in the action plan they had developed following the last inspection. This included for example, that there would be quarterly audits for infection control. There was no evidence that any audit had taken place and the provider was not aware of the unclean state of the laundry when we visited. There was no cleaning schedule in place to ensure that improvements in this area were made and sustained.

The action plan stated that regular supervisions of staff for their competence in manual handling were due to take place from 9 September. There was no evidence that these had happened to ensure that they were using equipment properly and safely when they were supporting people. The provider told us they would be daily monitoring checks to ensure people's call bells were functioning properly and 'walkarounds' to check for safety issues within the home. There was no evidence of these checks taking place to ensure action would be taken promptly to address any concerns for people's safety in the home.

We asked about the induction to the service that the manager had been given on their recruitment and about their supervision from the provider. The manager told us that nothing had been offered and that they had not been made aware of the extent of concerns within the service when they were recruited. The manager told us that the provider was not monitoring the progress being made with the action plan for improvements, other than being involved in the work which had started outside the home.

There was no evidence that relatives or other representatives had been asked for their views about the quality of the service so that the provider could respond to suggestions and make improvements. One relative told us they recalled being asked for their views once and told us they thought this was two or more years ago. Another told us that they had never been asked during the past seven years.

The provider did not take action to address issues with the former manager and agreed that they had not realised how bad things were despite inspections highlighting concerns and despite previous enforcement action.

We concluded that, from repeated breaches in regulations and the failure to fully respond to warning notices that the provider did not have regard to reports compiled by the Care Quality Commission about standards within the service.

These matters were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have effective systems in place to monitor the quality of service delivery and to identify and manage risks to people. The provider did not have regard to the content of reports compiled by the Commission and by other professionals. Regulation 10(1)(a), (b), (2)(b)(iv), (v) and (2)(e)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not ensured people were protected against risks associated with unsafe or unsuitable premises. Regulation 15(1)(c)(i) and (ii)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not ensured people using the service and staff were protected against the risk of infection. Systems to control infection were inadequate and appropriate standards of cleanliness were not maintained throughout the premises. Regulation 12(1)(a),(b), (2)(a) and (c)(i)

The enforcement action we took:
We have taken action to cancel the provider's registration.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure people were protected from abuse as they had not responded appropriately to allegations of abuse. Regulation 11(1)(b)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider had not protected people from the risks of unsafe use and management of medicines. Arrangements for safekeeping and safe administration were not appropriate. Regulation 13

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to protect people from the risks of unsafe or inappropriate care. The planning and delivery of care did not meet people's individual needs and ensure their welfare and safety. Regulation 9(1)(b)(i) and (ii)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person had not ensured that people were protected from the risks of inadequate nutrition and from dehydration. People did not always receive the support they needed to drink supplements and fluids sufficient for their needs. Regulation 14(1)(c)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained and supervised to deliver safe care and support to people. Regulation 23 (1)(a)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to encourage people to understand their care and treatment. Arrangements did not ensure that people, or those acting on their behalf, were encouraged to express their views in relation to their care and treatment. Regulation 17(1), (2)(c)(i) and (ii)

The enforcement action we took:
We have taken action to cancel the provider's registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

The registered person did not have and effective system for receiving and responding to complaints. The complaints system was not brought to people's attention or that of their representatives in a suitable manner and the provider failed to ensure complaints were fully investigated and resolved to the complainants satisfaction as far as practicable.

Regulation 19(1),(2)(a) and (c)

The enforcement action we took:
We have taken action to cancel the provider's registration.