St Philips Care Limited

Pine Trees Care Centre

Inspection report

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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

Pine Trees is a 'care home' that provides care for a maximum of 35 adults some of whom live with dementia. 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.

The service was last inspected in January 2018 and was rated as 'Requires Improvement'. Before this inspection we received whistleblowing concerns about the management of the medicines system, and concerns raised about support people received with personal and health care. The inspection was currently brought forward.

This comprehensive inspection took place on 25, 26 and 27 June 2018 and was unannounced. At the time of the inspection there were 28 people living at the service.

The service had a registered manager. A registered manager is registered with the Care Quality Commission to manage the service. Like providers, they 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 registered manager was on long term sick leave, at the time of the inspection, but the registered provider had arranged for a general manager to manage the service. The general manager was supported by an acting regional manager. Both managers had been recently employed to oversee this service.

We had significant concerns about the management of the medicines system. For example there had been a failure of the service to obtain satisfactory supplies of medicines for at least eleven people who subsequently did not have prescribed medicines for several days. The management of the service said the failure was due to inadequate communication between GP's and the pharmacy. However we were concerned there did not appear appropriate action taken by the management of the service to resolve the problems, and ensure people had their medicines. Medicines which were not given included medicines which prevented blood clotting, blood pressure, pain relief, asthma, anti-depressants, medicines to treat thyroid conditions and diabetes. We were also concerned about the recording of the administration of creams which did not satisfactorily give us assurance that prescribed creams and ointments were administered when they were needed.

We were concerned there was not satisfactory evidence that people always received timely support to see a GP or other health professionals when they needed to. This included when people had stomach problems; the lack of appropriate support for one person with attendance to a hospital appointment; the lack of timely and regular liaison with medical professionals when people had lost a significant amount of weight, and the lack of suitable medical records, for example when people saw an optician, chiropodist or dentist, to demonstrate people received suitable medical check-ups when these were required.

People did not receive satisfactory opportunities to have a bath, shower and have their hair washed. There

was no record some people had a bath or a shower, or had their hair washed, over a period of several weeks. Some of these people had been regularly incontinent, and although they had been washed there was no evidence they had been offered a bath or shower. The majority of people we spoke with said they only were provided with a wash rather than the opportunity to have a bath or a shower.

Although there were a range of quality assurance procedures in place these were not effective based upon the findings of the inspection. The registered persons were able to demonstrate there was a range of systems in place to check the service. However we would question the effectiveness of these systems as they had failed to detect the problems found at this inspection, and ensure suitable action was then taken to bring about improvements to the operation of the service.
As part of this comprehensive inspection we also checked to see if the provider had made the improvements required following the inspection of January 2018. In January 2018 we found that care was not always person centred, for example we had concerns about the support people received getting up and going to bed; there was unsatisfactory responsiveness of staff to call bells; support people received at meal times was not satisfactory; and records to show staff recruitment procedures were not satisfactory; records to show staff received induction, training and supervision were not satisfactory. The service was at that time rated 'Requires Improvement.' Subsequent to the publication of the report the provider submitted an action plan about what steps they would take to improve the service.

At this inspection we found there had been some improvement in these areas. For example recruitment checks were satisfactory. The meal times in the dining room we observed were pleasant and supportive occasions, although we still had concerns about meal time arrangements for some people who spent their time in their bedrooms and were more dependent. Not everyone was happy about the arrangements for assisting them to get up and go to bed. Some people reported significant delays and staff not being able to assist them at a time of their choosing. There were some concerns raised by people, their representatives and staff about staffing levels and staff responsiveness for example to call bells. Many people said call bells were answered promptly, but we did receive on-going concerns from others about responsiveness. For example some people said they had to wait unreasonable amounts of time for help if they pressed the call bell. We have recommended staffing levels, call bell responsiveness and staff sickness be monitored and reviewed.
In respect of induction, training and supervision; we did see evidence that a check list was completed with new staff when they initially started at the service. However there was limited evidence that new staff were completing the care certificate, and there was limited evidence provided about staff completing shadow shifts. There were also gaps in new staff receiving practical training for example in first aid, although completion of eLearning was generally satisfactory. Records to confirm staff members received one to one supervision with a manager were variable, although day to day supervisory arrangements were satisfactory. For example there was always a senior member of staff on duty. We have however given recommendations to improve delivery of induction, training and formal supervision.
We received some positive reports about care staff and care practice. For example people told us: "Staff on the whole are very kind and pleasant," "Staff are very nice," "Some are extremely kind. Some are extraordinarily nice," "They are not rushed, they are all fine." However some people raised concerns about the attitudes of a minority of staff. People were involved in making decisions about their day to day lives, and to some extent about care planning. We observed staff working in a manner which was caring and kind.

The service provided ground floor accommodation, some bedrooms had en-suite toilets and wash hand basins. There was a large lounge, and a sun lounge leading to a patio area with tables and chairs. The building was well maintained and decorated, with good quality furnishings.

There were suitable safeguarding processes in place. For example the staff we spoke with knew what action

to take if they suspected abuse was occurring. The majority of staff had also received satisfactory training. The registered provider could demonstrate, where they had concerns, safeguarding referrals had been made to the local authority. When the service had been subject to safeguarding enquiries, the registered persons had fully co-operative. The service had suitable whistle blowing procedures. However, following this inspection, CQC judged we had concerns about the care of some people who used the service. As a consequence we submitted a safeguarding referral to the local authority to highlight these concerns.

Record keeping was generally satisfactory. Each person had a care plan, and regular records were kept about their care. However some care records were not comprehensive and lacked relevant detail. The service had suitable risk assessment processes in place and people had suitable risk assessments on their files, which were regularly reviewed.

Suitable health and safety systems were in place. The service also had suitable equipment (for example to assist moving and handling). Suitable checks were completed and documented. However the registered provider was not able to locate all relevant records for us to inspect.

The service was generally clean, and suitable infection control procedures were in place. However there was a smell of urine in places. Most people said the laundry system was effective and reliable, although some people said some clothing had gone missing.

The service had taken suitable steps to ensure people's legal rights were protected in line with the Mental Capacity Act 2005. Staff received training about this. Visiting hours at the service were flexible, and visitors said they always felt welcome.

The service had a comprehensive activities programme. People enjoyed the activities available. The activities included entertainers visiting. Some external trips were organised although we were told the service's minibus was currently not working. An activities co-ordinator was employed.

We had mixed responses about the operation of the complaints system. Some people and their relatives told us they would feel confident making a complaint and it being responded to appropriately. Other people said, for example, although they were given assurances improvements would occur, these were not acted upon or improvement sustained. The complaints record was incomplete and did not comprehensively list all the complaints which we were aware had been made to the service, which meant themes and trends could not be easily identified, to help minimise re-occurrences.

The service had a satisfactory approach to end of life care. Suitable records were kept. Some staff had received training about end of life care.
We made recommendations relating to staffing and the supervision arrangements for staff.

We found breaches of regulations. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 unsafe.

The medicines were not managed safely and in June, some people had not received their prescribed medicines for a significant period of time.

People and staff did not always think there was enough staff, and call bells were not always responded to as quickly as they should be.

Recruitment procedures were satisfactory.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and training. However induction records were not always comprehensive. Staff had not all received regular formal supervision.

Although we witnessed good support for people at mealtimes, we received reports that people did not always receive suitable support to eat and drink.

The building was designed, decorated, furnished and maintained to a good standard.

Is the service caring?

Requires Improvement

The service was not always caring.

People viewed care staff as mostly caring and supportive, although there were some instances where people reported that staff did not act in a professional manner.

People did not always receive a timely response when they wanted to get up, or when they used the call bell.

Relatives said they could visit at any time and they always felt welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Everyone had a care plan and daily records were completed but these were not always detailed. This meant people were at risk of inconsistent care

The complaints procedure was not effective. Complaints records were incomplete.

People had the opportunity to join in with a range of activities including in house activities and visiting entertainers. An activities co-ordinator was employed.

Is the service well-led?

Inadequate

The service was not well led.

Instability in the management team had not helped to ensure the service was management effectively.

Although there was a comprehensive system of quality assurance and audit, the systems in place had failed to detect and bring about improvement to the issues of concern raised found at our inspection.

On going improvement has not been sustained.

Pine Trees Care Centre

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 25, 26 and 27 June 2018 and was unannounced. The inspection was arranged following serious concerns being received by the Care Quality Commission. These concerns were in relation to care standards and the operation of the medicines system. The inspection team consisted of two inspectors (two inspectors present on one day, and one inspector on two days.)

Before the inspection we reviewed information we kept about the service and previous inspection reports. This included notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. We also emailed professionals and relatives of people who used the service to find out what they thought about the service. Where feedback was received it has been included within the report.

During the inspection we used a range of methods to help us make our judgements. This included talking to nine people using the service, eight relatives and friends or other visitors of people, four staff, the manager of the service and the regional manager, and four external professionals including GP's and district nurses . We also inspected people's records, observed care, and reviewed records relating to how the service was managed.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in January 2018 we rated the key question service 'Requires Improvement' in this area. Before the inspection we received concerns that some people had not had enough medicines, and there had been periods in June 2018 when some people had not been administered essential medicines prescribed to them by their GP. As a consequence to this and other concerns, we brought forward this inspection as we were concerned about people's safety.
We have had concerns previously about the operation of the medicines system. Following our inspection in June 2017 we took enforcement action and issued a warning notice about the management of the system. These issues had been resolved and at our January 2018 inspection medicines were managed safely.

At this inspection we found significant issues with the management of medicines had occurred, which had resulted in some people not receiving medicines due to lack of supply. In June 2018 we found 11 people had not received their prescribed medicines for periods of between three and eighteen days. Some people were prescribed to have up to three doses of medicines a day for which they were not provided with. Medicines which had not given included medicines which prevented blood clotting, blood pressure, pain relief, asthma, anti-depressants, medicines to treat thyroid conditions and diabetes. For many of the medicines which had not been given, there could have been significant side effects of stopping these without any tapering off period, particularly if people suffered from acute health conditions.

At the time of the inspection we found there was an adequate supply of medicines. However, stock levels for some people were low (for example under a week's supply); although we were told a new stock of medicines had arrived during the inspection. There was subsequently a risk the problem could have occurred again if there was another supply error. After the inspection the manager confirmed that all required medicines had been delivered and there should not be any shortages in the next few weeks.

The manager told us the medicines had been ordered by the staff but that as a result of communication breakdown between the GPs and the pharmacy, the medicines ordered had not been supplied. The manager said they planned to have a meeting with the pharmacist and the GP's to discuss this incident ensure the problem did not occur again.

Medicines had allegedly been ordered by a senior care assistant, and it was not clear if the manager or deputy manager were involved in the ordering process. Although a medicines communication book had been introduced to ensure all discussions were recorded, when there were problems, there were not detailed records about this significant event. For example, there was no record to state there was a need for urgent action and there was limited action taken when medicines had not been received.

From discussions with the manager, we were not assured that everything possible had been done to ensure missing medicines were obtained sooner than they were. For example, we were not told that there had been an attempt to get urgent prescriptions for missing medicines and go to another surgery, if the usual supplier was unable to fulfil the required prescriptions. We spoke with the director of care about this who did not disagree with this judgement. The manager and regional manager also provided us with verbal assurance

that in future, the manager and deputy manager would check any medicines orders, and be actively involved in liaising with other stakeholders if there was a shortage of medicines.

At previous inspections we raised concerns about the recording of the administration of prescribed creams and /or lotions. We were concerned that when creams were applied suitable medicine administration records (MARs) were not completed. Instead staff entered on the electronic care planning system a single entry for example 'cream applied' for each person where applications had been administered. However, this recording did not differentiate between different prescribed creams items (if the person was prescribed more than one lotion or cream). At this inspection there were still no accurate records about the application of which creams and lotions were applied. We were provided with print offs from the electronic care planning system, for several people, who were prescribed creams and other lotions. The records were varied in accuracy. For some people the record differentiated between different prescribed items, however for other people entries were listed as either 'cream' or 'medication'. There were a significant number of gaps on the sheets provided to us. Many of the items were prescribed as 'as required' medicines (although this was not detailed on the records provided), so it was not clear if the gaps were because application was not required, or whether there had been an unintentional omission.

To help ensure the safety of the medicines system, the provider had an audit system in place to help identify when improvements were required. For example an audit had been completed on 23 June 2018. There had also been an external audit which had been completed by the pharmacist which was dated 18 June 2018. However, we could not see the audits had highlighted any concerns in relation to when there was a lack of medicines available for people. Further copies of audits were supplied after the inspection. Some of these highlighted stock had run out and stated medicines had been ordered, and staff were chasing up prescriptions. No urgent action was highlighted. A monthly audit, returned to the registered provider, did not highlight any concerns. We were concerned therefore about the effectiveness of the audits completed. We were also shown records of stock control checks but the records showed to us did not seem to highlight the problem of stock running low and then running out. It was concerning that CQC was informed by the manager, through our statutory notification system, that an audit which had been carried out by the provider's management team on 08 June 2018. This highlighted some issues for example the lack of MAR sheets not provided by the pharmacy for two people; stock totals not carried forward on to new MAR sheets and two items of medicines arriving late but subsequently supplied within a satisfactory time period. However the audit did not pick up the lack of supply of other medicines. CQC found on the inspection that from 06 June there were at least eight people where there was a record that they were not being administered prescribed medicines for several days as these had not been supplied. CQC was not notified of this matter.

These failures to ensure prescribed medicines were available when required is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found storage of medicines was tidy and it was easy to find medicines in stock which people were prescribed. Administration records were completed to a good standard. There was a system for the return of medicines which were no longer required, and a record was kept of these. Medicines requiring refrigeration, or additional security were stored appropriately. At the time of the inspection nobody self-administered their own medicines. The service had suitable procedures about the covert administration of medicines (medicines disguised in food or drink). There was a clear risk assessment in place for one person, and a letter on the person's file from medical professionals confirming the appropriateness of administrating medicines covertly. People's behaviour was not controlled by excessive or inappropriate medicines. Some people did have some prescribed medicines to help them manage distress or confusion, (for example as a consequence of dementia or mental health issues) but these medicines were prescribed and reviewed by

external medical professionals. The provider has a suitable policy regarding the operation of the medicines system based on current guidance such as issued by the Royal Pharmaceutical Society and National Institute of Clinical Excellence (NICE). Senior staff and the manager were responsible for the administration of medicines. These staff had received suitable training about the operation of the medicines' system.

People we spoke with said they felt safe at Pine Trees Care Centre For example we were told: "I feel safe. I am quite happy here," "I feel quite safe, I have never lost anything," and "If I was not happy here I would not be here. Of course I feel safe."

Staff we spoke with were generally happy with care standards although one member of staff said (who was otherwise generally happy with standards and the new manager), "I don't think people are always safe here. The medication is not right yet. There is repeated sickness by some staff over and over (which does not seem acted upon). I raise concerns about this but I am not sure what is done."

The service had a satisfactory safeguarding adult's policy. Staff had received training in safeguarding adults. The manager said safeguarding processes were discussed with staff at team meetings. The staff we spoke with demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and action taken to ensure people were safe. The manager had made some referrals to the local authority because they were concerned about some care practices, and informed the local authority of actions being taken to safeguard people. The CQC received concerning information, before this inspection, which was referred to the local authority, under multi agency safeguarding procedures. This information was provided by a whistle-blower which related to allegations of poor care, and the management of the medicines system. Following the inspection we put in a further safeguarding referral due to concerns we found about the care of some people received during the inspection.

The service had satisfactory risk assessment procedures. This assisted the service to ensure it was aware of people's needs, and they could meet these, before the person moved in to the service. Each person had a risk assessment on their file. Risk assessments assist staff to be aware of any potential concerns or risks relating to the person, and how the service is working to minimise those risks. There were risk assessments about pressure ulcer prevention, the prevention of malnutrition, moving and handling, falls, eating and drinking, general dependency, continence and pain. Risk assessments were last reviewed in June 2018. We were told health and safety risk assessments were completed for all areas of the building, as well as tasks which may present a risk. We asked to see copies of these documents but they were not provided.

The manager said if people had any behaviours which the service found challenging, these would be recorded in individuals' care plans. We have been told the service would discuss any concerns about people's behaviour (for example as a consequence of dementia) with relevant professionals such as community psychiatric nurses. At the time of the inspection none of the people who lived at the service had any significant behaviours which challenged others.

At the last inspection, in January 2018, we were concerned that recruitment procedures were not satisfactorily implemented. For example two references were not obtained for some recently recruited staff. At this inspection we checked the recruitment records for some of the staff recruited since the last inspection. Records we inspected were satisfactory. Each file now included a fully completed application form, a record of the person's interview, identification to validate the person's identity, a disclosure and barring check (which checks with authorities such as the police to ensure the person is suitable to work with vulnerable people), and two references. (Although one person only had one reference on their file which was in breach of the registered provider's recruitment policy.)

The manager said people who lived at the service had capacity and consequently the service minimised restrictions as much as possible. This was evident at the inspection. For example, we saw people walking around the building, spending time in their bedrooms and encouraged to make a range of choices such as what to wear, what to eat and how to spend their time.

We were told there were formal handovers in the morning and in the evening. The manager said a 'Flash Meeting' occurred each day at 11am. At this meeting senior care staff, heads of cleaning, maintenance and catering got together for ten minutes to discuss any key issues, and take further action if necessary. Along with staff handovers, this process enabled staff to share information and concerns about the care of people. We saw records of these meetings. The service also had a communication book so any relevant information could be shared between staff.

The service had a whistleblowing policy so if staff had concerns they could report these without feeling they would be subject to subsequent unreasonable action for making valid criticisms of the service. Where concerns had been expressed about the service; for example if complaints have been made, or there have been safeguarding investigations; the registered persons had carried out, or co-operated fully with these.

Equipment owned or used by the provider, such as specialist chairs, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced, and repaired as necessary.

We were informed health and safety checks on the premises and other equipment were carried out. We were provided with a summary of when some checks, from external contractors, had been completed. This verified that manual handling equipment, gas appliances, the nurse call system, fire safety equipment, a legionnaires' water sample test, and electrical testing had all been completed, at appropriate frequencies required by law. However, not all documentation was available for inspection. For example, the electrical hardwire and gas safety certificate.

The service aimed to provide five care staff on duty in the morning from 8am until 2pm, four care staff from 2pm until 8pm, and three care assistants on waking night duty between 8pm and 8am. In addition to these staff, the manager worked during the day, Monday to Friday. There was also a deputy manager. In addition, the service employed cleaning, kitchen, administration, laundry and maintenance to help ensure the service ran effectively.

The manager said if staff were off sick they always ensured, where possible, bank or agency staff were employed, to avoid staff shortages.

Staff views were variable about staffing levels. We were told: "We have been short sometimes. But agency is used. Before it was horrendous." Another member of staff said, "It is up and down. There can be a lot of sickness. New bank staff have been interviewed. (In respect of staff sickness) It is the same offenders. There is a clear pattern."

People told us call bells were kept accessible to them either when they sat in armchairs or when they were in bed. However, we received mixed views about whether staff responded appropriately to call bells. One person said call bell responses were variable. Staff would sometimes come immediately, but there could be delays of up to 15 minutes if staff were busy; for example we were told; "Sometimes they come quickly and sometimes they take ages." One relative said they had, had to raise concerns on two occasions about the call bell not being in reach for their relative to summon assistance. Another person said responses, "Depend(ed) on the number of staff and the demand." However, some people said there were no problems.

One person said; "I have the call bell to hand. I rang it by mistake and staff came quickly." We observed the staff response to one person. The person rang the call bell and staff responded to the alarm within one minute. In respect of another person we checked their call bell and it did not work. This was due to a kink in the wire so when it was adjusted, it worked. One person said, "They are fairly quick, depending on the time of day."

We recommend staffing levels are reviewed, call bell responses are monitored and as necessary recorded, and robust arrangements are put in place to monitor staff sickness and absence, and take suitable action where this is necessary.

Overall, the service had arrangements in place to ensure the home was kept clean and hygienic. However, we noted there was a smell of urine in some areas of the building. Domestic and a laundry assistants were employed each morning, seven days a week. Staff had clear routines to follow. The service had suitable policies about infection control which referenced national guidance. Senior staff understood who they needed to contact if they needed advice or assistance with infection control issues. Staff understood the need to wear protective clothing such as aprons and gloves, where this was necessary. Most people said the laundry service was good, although some people reported some items had gone missing.

Catering staff were on duty from 7am to 6.30pm. Suitable procedures were in place to ensure food preparation and storage met national guidance. The local authority environmental health department had judged standards to be satisfactory.

We were concerned the registered provider had not practically demonstrated they had learned from incidents and events when things had previously gone wrong. For example recent previous CQC inspections have raised concerns about the management of medicines and care practices, as detailed in previous inspection reports. After the previous inspections the registered provider provided assurance about service improvement, which included significant input from the organisation to address the identified problems. However effective support and improvement was not sustained. One consequence had been the significant concerns identified within this report for example about the management of medicines and care practices. This has resulted in the service being subject to investigation through multi-agency safeguarding procedures, by the local authority.

The failure to learn from past mistakes, and develop appropriate and effective systems to minimise mistakes occurring contributes to the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service kept some monies and valuables on behalf of people, for when people needed to purchase items such as for toiletries and hairdressing items. Some people's finances were handled solely by the person's representatives. Records of expenditure were kept, including receipts, where this was necessary. The registered persons did not act as appointee for any people who used the service, and staff did not have any access to people's financial accounts which assisted people's monies to be kept securely.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in January 2018 we rated the service 'Requires Improvement' in this area. Before the inspection we received reports that several people were regularly having loose bowel movements and no investigation was being conducted into why this was occurring. We checked the records for four people. There was no record of the GP being consulted about this concern. Where people were suffering from this condition there was no record they had been given any medicine to minimise the symptoms or any action to change people's diet from what was usually offered to the other people at the service.

Another concern had been raised by a relative when they discovered a severe rash on a person's back. There was a delay in getting assistance from the GP, and the relative was concerned that before they had discovered the rash no timely action by staff had appeared to have occurred. The relative showed us a photograph of what the person's back had been like, and the rash was quite severe. Records showed the person had rashes elsewhere on their body in the past. The same relative raised a current concern that blood had been found in their relative's urine. They were concerned it took three days between when the matter was reported and staff obtaining a urine sample to go to the GP.

Another person, who is completely physically dependent had to attend a hospital check-up, by ambulance without staff support, and the service did not inform relatives of the appointment. We were told this was due to an administrative mix up. We are concerned the person was not suitably supported to go to an important hospital appointment and was put in a very vulnerable, unsupported situation. There was also a failure to communicate appropriately with the person's family and hospital staff.

Care plans showed three people had lost significant amounts of weight. For example one person weighed 65 kilos in January 2018 and 52 kilos in June 2018. The GP, when approached by the local authority, said there had been 'poor communication' between the home and the GP regarding this matter. We were concerned there was no or limited records of what actions staff had, or were, taking to address these concerns. However, for other people, we did see evidence where appropriate help was provided for example food and fluid charts were in place.

We were told people had access to see a chiropodist, optician or dentist. There was a record in people's care plans if they were registered with a dentist. However, we were not provided with comprehensive records which showed that people had seen a chiropodist, optician or the dentist.
Records we did see about any visits from medical professionals were mostly limited to GP's and district nurses. We saw a record that three people, in the sample group, had seen an optician.
There was a section regarding oral care, within people's care plans, but this did not detail when the person last saw, or next needed to see a dentist. In records seen specific details about who and how to contact opticians and dentists was not provided.

People's care was not always designed to meet their needs effectively or safely which is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We received reports that two people ran out of essential medical supplies to assist with management of their continence. One person had run out of convenes (a medical device to assist with urinary incontinence) and another person ran out of essential supplies relating to a catheter.
In respect of the convene, relatives had warned staff that a new supply needed to be ordered, but it appeared no action was taken. The relatives informed us of a number of errors which had occurred previously such as the incorrect size of convene being ordered. The family said, they, rather than the care home, had had to resolve the problem. The person concerned told us the convene had regularly been fitted incorrectly due to staff not knowing what to do. We were also told that when the convene supply had run out this had resulted in the person having a wet bed and there had been delays in staff responding to help the person to change. This was described as "Very distressing," for the person concerned. There had been another occasion when the person had been wet. Staff had stripped the person's bed, and had allegedly left the person, naked, while they had gone away to attend to another person who had rang the call bell. A complaint had been made about this incident and the manager had dealt with the issue satisfactorily.

The failure to ensure medical devices were available when required is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We spoke to the team leader of the district nurse team, and also to a district nurse. They raised no concerns about pressure care, hydration issues and said there was no problems with skin care. We were told there had been concerns about pressure areas and dermatitis (possibly due to people not being supported effectively with their continence) in the past, but these were not current concerns for the team.

At the last inspection we were concerned that personnel records did not demonstrate staff had suitable induction, training and supervision to assist them with the correct skills and knowledge to complete their jobs.

At this inspection, the manager said when staff start working at the service they received a full induction, which lasted three days. In addition, new staff were also required to complete all on-line training in fourteen subjects such as safeguarding, mental capacity act, dementia and fire safety during their first few days of service. An orientation checklist was also completed which outlined who was responsible for what in the organisation, and issues relating to the building, basic care issues, staffing, health and safety and quality assurance. The new member of staff also completed shadow shifts. One recently recruited member of staff said they had shadowed more experienced colleagues for a two week period. They told us, "I was bit nervous to start but I was alright. I am happy here."

The registered provider was aware of the Care Certificate, which is an identified set of national standards that health and social care workers should follow when starting work in care. The manager said staff were required to complete the organisation's on-line training as part of evidencing the member of staff had the knowledge to achieve the Care Certificate. It was confirmed new staff were currently completing the Care Certificate. The process was said to last up to six months.

We inspected staff files for six staff all of who started working at the service since January 2018. All of the staff files inspected contained a completed orientation checklist. We were informed the staff had begun to complete the Care Certificate. We asked to see work books to confirm this but these were not available for inspection. The orientation checklist did not outline when staff completed shadow shifts, or when they started to complete modules of the Care Certificate. We saw a copy of a certificate which verified one of the staff members had completed this course.

The service had a comprehensive training programme to assist them to carry out their roles. The training

staff were required to complete included: first aid, fire safety, infection control, moving and handling, first aid, safeguarding and dementia awareness. Staff also received training about diet and nutrition, health and safety, medication awareness, and equality and diversity. The majority of training which staff had to complete was on-line based. However, there were also 'practical' elements to training for moving and handling, first aid and fire safety.

According to records we assessed five of the six staff assessed had completed the majority of the training they required. However, one staff member appointed in April 2018 had completed less than a third of the courses identified as necessary for staff employed at the service.

The staff we spoke with were positive about the provision of training. We were told, "I have done loads of training. I have done all 13 courses." Some of the staff we spoke with felt there was too much e-learning, and preferred practical face to face training. The manager informed us that for some training, such as the Mental Capacity Act 2005 some face to face training had been arranged.

We recommend the registered provider reviews details of the training which individual staff have not completed, and develops individual action plans with the staff concerned to ensure required training is completed within a satisfactory timeframe.

Staff told us they felt supported in their roles by colleagues and senior staff, telling us that there was always a senior member of staff on duty who staff could approach if they needed help. Senior carers, and the team leaders, were also responsible for leading shifts and ensuring the effective day to day management of the service, particularly if the manager and deputy manager were absent from the service.

We found that only one of the six staff we assessed had a record of supervision within the files we requested. Supervision is a process where members of staff sit down with a supervisor to discuss their performance, any goals for the future, and training and development needs. All of the staff had started working at the service from January 2018, with the majority starting work there since April 2018. However, it is important that staff new to their roles receive suitable coaching and guidance, particularly if they are new to the care industry. Records did not demonstrate this formally occurred once the initial formal induction period had been completed. A member of staff who had worked at the service for several years said in respect to supervision, "I think I have this every six months with a manager…I have never had an appraisal." Similar concerns were outlined in the last inspection report.

We recommend the registered provider monitors that all staff receive regular formal supervision, and records are maintained of this on staff files.

At the last inspection we were concerned about the support people received at meal times. Although we did witness and hear about good practice with how people were assisted, we also witnessed and heard about poor practice. We also witnessed poor organisation at meal times for example, people not having satisfactory support available to them.

At this inspection we observed four meal times in the dining room: three lunch times and one breakfast. All the occasions were positive experiences for people. On three of the four occasions staff provided timely support to people. People were not rushed. The choice of food looked good and smelt appetizing and most people appeared to enjoy the dining experience.

At breakfast time people had the option of a full cooked breakfast. Staff spoke with people while they were providing assistance. Where people required assistance with mobility, staff did so in a safe and gentle way.

Generally there were between two and four staff present to provide assistance. When people asked for assistance from staff this was provided. However, at the lunch time on the second day of the inspection, there was at times only one member of staff present. Although the member of staff did their best to provide good support, there was not enough staff around, and this resulted in some delays for people with help they needed. During this meal time one person came to the meal time late. However, despite being under quite a lot of pressure, the member of staff asked them which of the two options they wanted, and when they said they wanted egg and chips instead this was willingly provided. It was very good that despite the staff member being stretched, they still provided the person genuinely person centred support and choice. The commitment to the person's wishes seemed authentic and it seemed irrelevant that an inspector was sitting in the room.

The dining room was well presented. Tables were laid, and people were provided with a choice of cold drink, and tea or coffee at the end of the meal. However despite us reporting on this matter, on several occasions, tea and coffee were still served in teacups but without saucers.

We spoke to people about the food. People said they were given a choice and were provided with plenty of regular drinks. We were told, "The food is very good here," "I love the food, I eat all of it," and, "Food is good, there is a choice."

We were told the service's menu was regularly discussed in residents' meetings, and this was evident in the copies of the meeting minutes we inspected. We were told no people who used the service had specific cultural or religious preferences about the food they ate, or how it was prepared. There were currently no vegetarian or vegans who used the service. The meals at lunchtime were displayed on a white board in the dining room. People had a choice, which they did not have to make in advance which is very good as people could make a choice about what they wanted at the time of the meal, rather than have to make it in advance. For example, once seated staff would ask them which of the options they wanted, and their choice was subsequently provided.

Some people had special diets due to their health needs, and some of these people needed to have their fluid and food intake monitored to prevent the risk of dehydration and malnutrition

Some concerns were expressed by the relatives of people who had their meals in their bedrooms. One person's relatives complained to us there could be a significant variation when a person was served their breakfast. Records for the person covering late May 2018 until the time of the inspection recorded the person ate their breakfast from anytime between 9am until 11am. A concern was raised that when the person had their breakfast particularly late this meant they did not want to eat lunch. The lunch was recorded, in the person's records, as served between12.30pm and 1.30pm. The manager said the delay in serving breakfast was due to the person often going back to sleep after they had been washed. It is concerning however though that the person could often not have anything to eat, not even a slice of toast, despite being administered medicines at about 8am. It was not clear if medicines administered should be given before, with or after food, but it was a concern that medicines were given to a person on an empty stomach and food was then not provided for a significant period of time. The manager had a meeting with the family concerned, on the last day of the inspection, and told us a satisfactory way forward had been agreed to minimize delays.

We assessed the records of other people. Records showed the times when people had their breakfast varied considerably. This could be down to personal choice, and the service not operating in a regimented manner. However it was concerning that there could be a gap of up to an hour from when people were recorded as being assisted with washing and dressing, and then having their breakfast. Based upon what we observed,

and what people and their relatives told us we were concerned that people did not always receive their meals in a timely manner.

Failure to provide people with suitable support with eating and drinking contributes to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People said they were regularly offered cups of tea or coffee in their bedrooms. We were concerned that when we met with several people in their bedrooms there was not a jug of water there. This was despite it being a warm day. We asked one person if they were offered a jug of water and they told us, "Some times they will bring it in, and sometimes they don't. Personally I drink a lot."

The service had suitable processes to holistically assess people's needs and choices. We were told the assessment process followed involved the manager going out to assess the person to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Completed assessments subsequently assisted staff to develop a care plan for the person, so care was delivered in line with people's wishes and preferences, as well as current legislation, standards and guidance.

Nobody we spoke with said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability or age. The registered provider had an anti-discrimination policy which covered staff and people who used the service.

External doors, at the service, were locked for security reasons. People who lived at the service could either ask staff to open the front door, or alternatively were given the code to the key pad. People we spoke with, who were physically able, or had mobility aids, said they could move around the building as they wished. There was a decking area, where people could sit outside, particularly when the weather was pleasant, as well as lawned areas around the building. It was disappointing that we witnessed the door to the decking area was locked during at least one afternoon when the weather was very pleasant and people may have enjoyed the opportunity to sit outside. We did however witness that people had supervised access to the garden on other occasions during the inspection.

The Mental Capacity Act 2005 (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 as least restrictive as possible.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Some limited information was provided in people's care plans about their mental capacity, but this varied in the level of detail depending on which file was assessed. Where appropriate the manager had submitted applications to the local authority requesting assessments are completed for people who the manager thought may lack mental capacity. No physical restraint was used at the service. The manager said staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and this was evident in training records we inspected.

Requires Improvement

Is the service caring?

Our findings

When we inspected the service in January 2018 we rated the service 'Requires Improvement' in this area. People and their relatives were either positive or had mixed feelings about the care received from staff.

People told us: "Staff on the whole are very kind and pleasant," "Staff are very nice," "Some are extremely kind. Some are extraordinarily nice," "They are not rushed, they are all fine." However some people reported that some staff said some staff were good, others could just provide rudimentary support, and in a minority of cases people had concerns about some staff attitudes. For example we were told, "One member of staff was very rude. When I wanted to go to the toilet she said I had already been. I have a problem with my stomach." This matter was reported to the registered provider. Staff told us, "I think people are well cared for." A relative told us, "I visit regularly. I have no concerns at all. There are always staff around. Everyone seems happy."

There were mixed views whether people could get up and go to bed when they wished. For example, one person, who was totally physically dependent for support said staff would vary when they came to assist them to get up from 8.30am to 10.00am. This person told us they did not have any breakfast until they were washed and dressed. The person said they would get "quite annoyed," if help did not arrive by 10.00am. The person said staff would assist them to go to bed from 7pm onwards which, if early, was not their choice, but they had not objected. The person told us they did not go to sleep but laid in their bed. They could not see the television due to its positioning.

There was limited information, in the care plans we reviewed, about people's life history. In the majority of care plans we inspected this was limited to a maximum of one or two sentences. This information is useful as it assists staff to know something about the person's life before they lived at the service.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. We were told where possible staff involved people in care planning and review. We were told consultation also occurred with people's representatives such as their relatives about their care plans. However, we did not see any documentation of how people were involved. We were told people and their relatives were provided with information about external bodies (such as the local authority, community organisations and advocacy services), in the service user guide, which was issued when people moved to the service. The service had 'resident's meetings' where there was discussions about the menu, activities and people invited to give their views about the service.

We observed staff making sure people's privacy and dignity needs were understood and always respected. Most of the time we saw staff mixing with people appropriately in a caring and kind manner. Where people needed physical and intimate care, for example if somebody needed to change their clothes, help was provided in a discreet and dignified manner. When people were provided with help in their bedrooms or the bathroom this assistance was always provided behind closed doors. When people were experiencing discomfort or emotional distress we observed staff providing suitable support to comfort people. Staff worked with people to encourage and / or respect people's right to be as independent as possible.

The relatives we spoke with said they could visit the service at any time. Visitors said they always felt welcome and were offered a drink. Relatives said staff always answered any questions they had. Visitors said they felt managers were helpful if they had any queries or concerns.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in January 2018 we rated the service 'Requires Improvement' in this area.

Everyone who used the service had a care plan. All care records were electronically based, with the ability to print out relevant documents such as care plans and risk assessments as necessary, for people, their relatives and staff. The manager said where possible people, and their representatives, were consulted about people's care plans and their review.

The manager had implemented a key worker system. This is where specific staff members are allocated to have a particular focus on one or a small group of people. This may involve developing care plans with people, and ensuring they have enough clothing, toiletries and so on. Senior care assistants, team leaders and the deputy manager were responsible for reviewing care plans. Staff told us it was difficult to find the time to do this, as they were also expected to supervise and provide direct care. Some key workers only worked nights so this meant they could not build up a relationship with the person concerned to holistically know what their needs were.

The care planning system had the potential comprehensive and useful. For example there were sections about people's physical and mental health care needs for each person. Specific care plans were provided for areas such as communication, continence, daily life, emotional support, physical safety, mobility, nutrition and hydration, personal care, skin integrity and sleeping. However current care plans did not always provide staff with sufficient guidance and information. For example under the relevant sections relating to people's care, there was limited detail about people's specific needs, and how staff were working to address these. An example of this is that one care plan stated "I have poor vision or hearing," but there was no specific detail about whether this related to both issues, or just one. Similarly the care plan did not outline what actions had been taken to assist the person, or what planned actions would occur to improve the situation.

All staff were able to access people's care plans which were stored electronically, and accessible to staff through laptops and mobile devices. Staff, were responsible for keeping records up to date by using the electronic device. However, not all records were accurately completed, for example some care interventions had been recorded twice and some had not been recorded at all. There was also little narrative description of what the person did or how they were. In addition, there was minimal records of activities the person was involved in.

People did not always receive effective support relating to their personal care. For example, three sets of relatives raised concerns that people did not receive a bath or a shower. Two relatives said they did not think people's hair was ever washed. One relative commented, "I don't know when (they) last had a shower," and another said, "They are not washing [...] hair. They say they cannot do it. They were meant to be getting a specialist bowl but they didn't." We assessed both people's records for the period covering late May 2018 to the time of the inspection. There was no record these people had a bath or a shower, or had their hair washed.
Concerns were expressed to us that one of these people had not had their incontinence pad checked and

changed as frequently as it should have been. Care notes showed people's skin integrity was satisfactory although two people suffered from ongoing problems with soreness, and redness, and there was a record that both people had previously had pressure areas on their bottoms. These people were regularly incontinent, one of the people had suffered from loose bowel movements, although records showed both people were regularly changed.

It had been agreed that another person had a regular shower at a specific time following concerns raised by a relative. We received a report that the plan was not always adhered to. There was also an incidence when concerns were raised that the person was not washed properly.

The majority of people we spoke with said they only were provided with a wash rather than a bath or a shower. However two people told us "I have a shower when I ask for it. Sometimes they are too busy and other times they give me one," and "I have a shower sometimes when they come for me." We checked the records of four other people. These showed that apart from giving people a wash in the morning, there was very limited records people had a bath or a shower. For example, from 17 May 2018 to 31 May 2018 one person had one shower and from 25 May 2018 to 25 June 2018 two other people had no baths or showers. There was no record these people had been offered bathing opportunities and no record in their care plans to state they refused any offer of a bath or a shower. All of these people were dependant on staff for support with washing, and suffered from incontinence and needed to use incontinent pads.

People's personal care was not being met in line with their wishes and preferences, which is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

An activity organiser was employed. The activity organiser provided activities between Monday to Friday, in the morning until mid-afternoon. Activities available included arts and crafts, quizzes, bingo, baking and reminiscence. Some external activities providers were also used, such as singers and musicians. These included singers from the chapel. External trips had previously been organised. However, we were told the service's minibus had not been working which meant trips had not happened recently.

Some concerns had been expressed to us about the provision of activities to people who preferred not to spend time in the communal areas of the service. However, the manager told us the activities organiser did spend time with people who preferred to spend time on their own, and tried to engage them into the entertainments or put on one to one activities such as painting people's finger nails and providing people with books to read. We were told there currently was not a library service although we understand Cornwall Council and the Royal Voluntary Service provided a service to people who cannot visit the library.

Some of the people at the service had limited skills understanding correspondence due to their dementia. When people received correspondence staff would read this to people. We did not see any documentation in for example audio or easy read formats although because we were told staff would spend time with people to read through relevant documentation. We judged the service was able to provide people with limited literacy skills, or sight impairments, with information which was accessible to them.

We have previously had concerns about the effectiveness of the complaints procedure. At the last inspection there had been improvements about the recording of any complaints received. We had previously been told the complaints procedure was issued to people, and their relatives, when they moved into the service, as part of the service's service user guide.

At this inspection people again told us they had mixed feelings whether concerns and complaints would be responded to appropriately. Some people said they were, whereas others had not had positive experiences.

For example, one person had raised ongoing concerns about support they received to get up and have meals without significant delay, but this issue had not been resolved. Two other people had ongoing concerns about the appropriateness of the personal care they had received. Although relatives told us their complaints had been satisfactorily responded to, complaints had not been used to effect positive change within the service, for example concerns relating to the management of people's care continued.

The service had a system to record complaints made. There appeared to be two complaints systems in operation; a paper based system and an electronic system. Both systems did not contain the same information. From these records it was clear complaints had been investigated but there was no evidence this had led to improvements in the quality of support people received. Some but not all of the complaints we heard had been made had been recorded with a record of any actions taken by the service's management to resolve matters raised. For example one relative said they had made a complaint about the standard of personal care and this had been investigated. However there was no record of this in the records we were presented with. There was a record of three recent complaints which had been received since May 2018 to which the registered provider had investigated and responded to.

People's complaints were not effectively managed and used to help improve the service, which is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We were told people were supported at the end of their lives to have a comfortable, dignified and pain free death. At the time of the inspection nobody required end of life care. Where appropriate, people had an end of life care plan which outlined their preferences and choices for their end of life care. The service consulted with, where appropriate, the person and their representatives about the development and review of this care plan. Some staff had received training about end of life care, and the manager confirmed more staff would receive this training in the future.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in January 2018 we rated the service 'Requires Improvement' in this area. There have been several management changes since the last inspection. The registered manager had been on long term sick leave for nearly one year. In the registered manager's absence, a general manager was appointed. After the last inspection the general manager left, and an interim manager was appointed. The current manager, at the time of this inspection, had only worked at the service for a few weeks. At the time of the inspection the regional manager was no longer was involved with this service, and an external consultant had been appointed to oversee the service. The current deputy manager was working their notice period. This post was being advertised at the time of this inspection. There had been a lack of stable leadership at the service and the lack of consistent management meant it was difficult for improvements to me made and sustained. In addition, the provider's inspection history shows that since 2016 they have not been able to fully meet regulations and/ or sustain regulatory compliance.

Following our last inspection the provider had submitted an improvement plan to CQC to demonstrate what action they were going to take to ensure the service was safe and met with regulations. However, we found that action to improve the service was still required.

We were provided with a copy of an audit document which the manager of the service was required to complete, on a monthly basis, for the registered provider. This included self-assessment relating to areas such as meals and nutrition, care documentation, infection control, medication, the kitchen, personnel records, and health and safety. However, this process had not been effective as it had failed to identify improvements relating to medicines and complaint management, record keeping, staff training and supervision, and care practices.

The provider's regional manager had also completed audits of the service in December 2017, January 2018, June 2018, and July 2018. However, these audits had also been ineffective as they had failed to identify the failings identified during this inspection. In addition, we also saw a list of other quality assurance visits completed by other managers employed by the registered provider, which had failed to highlight deficiencies within the service.

The registered persons had ensured most relevant legal requirements, including registration, safety and public health related obligations. However, the Care Quality Commission had not been not been informed of medicines at the service not being available to people despite this being a significant event which put people at serious risk.

Record keeping and storage was not satisfactory. On the second day of the inspection we provided the manager with a list of records we needed to see. Although we were provided with most of the records on the list we had to repeatedly ask for the remaining records, which then followed in part. We did not receive some records requested such as health and safety risk assessments (for the building, staff and visitors), a copy of the most recent electrical hardwire certificate. Similarly, it took repeated requests to obtain other records such as staff and resident meetings which appeared respectively. These did not appear to be readily

accessible to staff members and people who used the service.

We were concerned about accessibility of information relating to people's care, and the level of detail in some of the records provided. All people's records were stored electronically. Staff were provided with a handheld electronic device to input and review information. This included a care plan and risk assessment for each person. Staff completed information about care they provided the person, generally after each care action using hand held electronic devices. However, when we reviewed care notes they were often basic and did not provide any detailed information. Sometimes important information was missing. For example, if people had a meal, and if they ate it, or details of what actions staff took if there was a concern about someone's health. We were provided with a lap top to access care records but either due to the service's internet connection, or the reliability of the hardware provided, it was extremely difficult to access records in a timely manner. As we were unable to access the information online we asked the staff to provide us with paper copies of the records we needed to see. The manager and other staff reported they had also experienced problems accessing information using laptops although we were told access using the handheld devices was better. The manager said she would discuss the problem with the registered provider.

The lack of appropriate governance arrangements, the effectiveness of quality assurance arrangements and the failure to keep satisfactory records is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

An annual survey was completed and the results of the last one had been positive. The manager had received 11 responses to a survey currently being completed with relatives. Responses were generally positive, although some concerns were raised about call bell response and laundry services. Regular residents' and staff meetings occurred.

Staff felt the new manager was making some improvements to the service's performance. Their comments included, "(The manager) is fantastic. Things have improved since I have been here," "The manager is good, wonderful. Better than before," and "She is very approachable and easy to speak with," An external professional said the new manager was "Really, really good. Very person centred...the most positive manager they have had in a long time."

Staff we spoke with said about the culture at the service "Colleagues practice could improve...some are better than others." Another member of staff however said, "It was not working. It is now calmer. (The current manager) is more structured. We are all trying to make it so we know what is going on."

The service had a management structure. In the absence of registered manager, the general manager reported to a regional manager who reported to the organisation's head of care. We were told the regional manager, and the head of care had been actively involved in managing the service and regularly visiting the service. A deputy manager reported to the acting general manager. The deputy manager assisted the manager with the day to day running of the service. There were team leaders, and senior care assistants led each shift. A senior took responsibility for the management of the medicines system on each shift.

The previous rating issued by CQC was displayed. The manager said issues relating to previous inspections had been communicated to staff. The manager said staff had a clear understanding of their roles and responsibilities. There were policies in relation to grievance and disciplinary processes.

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	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The complaints system was not effective

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 9 HSCA RA Regulations 2014 Person-centred care Arrangements for people to have personal care for example regular baths and showers, and a hair wash, were not satisfactory. Care records sometimes lacked sufficient detail

The enforcement action we took:

We imposed a condition on the service's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The medicines system was not effectively managed People were not always provided with effective personal care and health care support

The enforcement action we took:

We imposed a condition on the service's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of appropriate governance arrangements. Quality assurance systems were not effective. There was a failure to keep satisfactory records

The enforcement action we took:

We imposed a condition on the service's registration