Tamaris Healthcare (England) Limited

Riverside Court Care Home

Inspection report

31 Irish Street
Salmoor Way
Maryport
Cumbria
CA15 8AZ
Tel: 01900 815323
Website: www.fshc.co.uk

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Ratings

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

Overall summary

This unannounced inspection took place on 23 & 24 February 2015 and a pharmacy inspector visited the home on the on the 9 March 2015. Riverside Court Care Home provides accommodation and nursing care for up to 60 people who have nursing needs or who are living with dementia. There were 53 people living at the home when we visited.

Tamaris Healthcare (England) Limited is a subsidiary of Four Seasons Healthcare and it is run using the staff and the systems of Four Seasons Healthcare. We will refer to the organisation running the home as Four Season Healthcare (FSHC) throughout this report.

During the visit, we spoke with 23 people living at the home, eight relatives, six nurses, ten care staff, the registered manager and the regional manager and the senior regional manager. A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us contradictory things about the service they received. While some people were happy, others were not. We received mixed views from relatives about the care. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us. Both health professionals and social services reported concerns about the standard of care in the home prior to our visit.

While some people told us they felt their privacy and dignity was respected and made positive comments about staff, they also told us that staff were often rushed. People told us that at times there were not enough staff available to answer their call bell and provide the support they needed. From our own observation we saw that care was mainly based around completing tasks and did not take account of people's preferences. Staff told us that they had little time to spend "just chatting to people."

People's safety was being compromised in a number of areas. This included how well equipment was provided and maintained, how well medicines were administered, and the support for people who had more complex healthcare needs.

We found that people's needs were not consistently assessed. This led to care plans and risk assessments that did not identify all the health and social care needs of people. For some people with behaviours that maybe challenging, or for those with mental health needs, there were no care plans or risk assessments to instruct staff on these needs, or how to meet them.

Staff members were not always following the Mental Capacity Act (2005) for people who lacked capacity to make decisions. For example some people's mental capacity was not assessed and other people's was assessed only once. Sometimes the decision on a person's capacity had been made by only one member of staff in the home, there were no details of who had been consulted or involved in this decision.

We saw inconsistent approaches from staff with some staff explaining to people before they undertook a care process. Other staff failed to give the person any information about the care and support they were about to deliver. We also noted unsafe moving and handling practice being carried out by staff that put people at risk. We saw that people were sat in wheelchairs for long periods.

People were not always supported to eat and drink enough to meet their nutrition and hydration needs. We saw that some people were losing weight and did not have appropriate monitoring and interventions in place to support them. Those people who needed little support with their meals told us that the food in the home was good and that they had plenty of choice.

We found that advice from outside agencies, such as healthcare professionals was not always routinely sought. When it was, it was often not recorded or followed by staff in the home. This had resulted in people receiving inappropriate and unsafe care and treatment. Such as people not having the right moving and handling equipment in place to move them safely.

We were concerned that some people living in the home felt isolated. We found people who had not been out of the home for a long time, these were people who with staff support would be able, and wish to do so. We found there was a lack of stimulation with people spending long periods in bedrooms alone. There were not enough meaningful activities for people either in a group or as individuals. The activities recorded for some people in their notes were described as having a shave or a shower.

Whilst the organisation had a programme of training available for staff we saw evidence that the learning was not always put into practice. We had concerns about how staff were recruited and found that this was not always carried out according to the organisation's policies on recruitment.

We also found staff lacked supervision and guidance from senior staff. Records in the home were of a poor quality, and some people's changing care and health needs were not always updated. This meant that staff were not always up to date with a person support needs. This placed vulnerable people at risk of receiving unsafe care and treatment.

A number of people living in the home, and their relatives told us that their complaints and concerns were not

Summary of findings

listened to, and not responded to in an open and positive way. People in the home, relatives and staff told us that there was not an open culture in the home and this made it difficult to make complaints or to raise concerns.

The system the provider had for monitoring the quality of the service had not identified the significant problems that we found on this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and this corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspectors had serious concerns regarding the health, safety and well-being of those people living at Riverside Court Care Home.

We informed the provider, Four Season Healthcare, that we were considering the use of the section 31 power under the Health and Social Act 2008. This is one of the most draconian enforcement powers it holds, that allows it to serve a Notice of Decision to remove a location condition, on the basis that unless the Notice is issued, persons will or may be exposed to the risk of harm. In effect it removes the registration of Riverside Court Care Home from the provider's certificate and the home would no longer be able to operate.

We set out all the areas of non-compliance with the regulations in a letter to the provider. We asked them to respond within 24 hours with an urgent action plan setting out how they intended to address the concerns the inspectors found in relation to the unsafe provision and risks to people in the home. The urgent action plan was received, within the timeframe, and we judged that it addressed the immediate concerns of safety and risk of harm.

We have since asked that the action plan be up dated on a weekly basis. We have visited the home to monitor progress towards meeting the action plan. This will be fully assessed at the next inspection of the home. Health professionals and social services have been carrying out reviews of all individuals in the home to ensure that people are receiving safe care and treatment.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed.

Incidents of potential abuse were not referred to the appropriate authorities for investigation under safeguarding adult's procedures. This meant that independent investigations of potential abuse did not take place.

Medication was not safely managed within the home. People did not always receive their medication on time or as prescribed. Care plans to ensure people receive their medication in an appropriate way were not in place. People who self-medicated were not monitored properly to ensure that this was safe.

Recruitment practices were not robust enough to ensure that staff in the home were suitable to work with adults who may be vulnerable.

At times there were insufficient staff available within the home to provide the support people needed with their health and personal care.

Is the service effective?

Inadequate

The service was not effective.

We found that care plans to make sure that people's health needs were managed were not individually reflective and as a result people did not always receive care that met their personal needs.

Whilst staff had some up-to-date training and supervision, it was not always put into practice.

People who had fluctuating capacity and were less able to make a decision did not have arrangements in place to assist them to make appropriate decisions.

Equipment people required for their health and personal care was not always available or managed in line with best practice guidance.

People did not always receive the support they needed to eat their meals safely and well. Those that were able to take their meals without staff support told us they enjoyed the meals provided.

Is the service caring?

Inadequate

The service was not caring.

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about individual staff. However, we found staff interactions were often task-focused and not all staff demonstrated a caring attitude.

There was a lack of consistency in the approach of staff, and the kind and compassionate care in the home could be attributed to the skills and efforts of individual members of staff.

Summary of findings

Information for people less able to communicate was not in a format that assisted them.

People reported that their visitors were welcomed into the service. A number of relatives reported that the communication from the home was poor and that they didn't feel listened to.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that care plans did not always reflect up to date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not consistently recorded. As a result some of the people had not received care that met their individual needs.

We found differences between a person's care records, staff knowledge and what we observed. This had led to people not getting safe care.

The service did not manage complaints that had been raised. People told us that when they had raised concerns they had not been addressed.

There were not enough meaningful activities for people to meet their social needs and some people living at the home felt isolated.

The home had not ensured that they knew people's life stories, hobbies and interests before coming to the home. Therefore, the activities in the home had not been designed to meet the needs of the individual.

Is the service well-led?

Inadequate

The service was not well led.

People were put at risk because systems for monitoring quality were not effective.

Quality assurance systems were insufficient to identify areas of concern. Where areas of concern had been identified systems were not robust enough to improve the quality of the service provided.

Records relating to people living at the home were not always well maintained and were not always accessible for staff to use and refer to.

Riverside Court Care Home

Detailed findings

Background to this inspection

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

On 23 & 24 February 2015, CQC carried out an unannounced inspection of Riverside Court Care Home. This included a site visit by two Adult Social Care (ASC) inspectors. Other team members included a specialist nursing advisor and expert by experience working on behalf of CQC. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. A CQC pharmacy inspector visited on 9 March 2015 as part of this inspection.

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 used this across three mealtimes.

Before the inspection, the provider was sent a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was not returned.

We contacted the commissioners of the service, and healthcare and social care professionals to obtain their views about the care provided in the home. We checked the information we hold on the service and followed up on concerns logged, and whistleblowing sent into CQC website.

During the visit, we spoke with 23 people and eight relatives and friends of people who lived in the home. We spoke with six nurses, ten care staff, the registered manager, the regional operations manager and the senior regional manager. We observed care and support in communal areas and looked at the kitchen, the majority of people's bedrooms and some bathrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for 17 people, the training and induction records for staff employed at the home, eight people's medication records and the quality assurance audits.

Inadequate

Is the service safe?

Our findings

We spoke with ten people living in the home, who were able respond, and eight relatives. We received mixed views on the care. All the people we spoke with felt there should be more staff.

Some people we spoke with were happy with the home. One person said, “I have only been here two weeks, I came in to see if I would like it, I had been falling at home, it is much better here, I am going to stay. I couldn't ask for better”. Another said, “They are very good to me.”

For those people who had limited verbal communication, many of their relatives told us that they were unhappy with the care received by their relative. One person told us that their relative had to wait for an hour to be helped to go to the toilet. Some people told us they mostly had bed bathes and one person reported, to a friend who was visiting, that they had not had a bath in four weeks. The friend said this person “didn’t look particularly well-cared for.” We found on the inspection that this was the case, and that people were not routinely given or offered baths or showers; this was based around staff availability.

We received reports from adult social services and health professionals about unsafe care in the home, to the extent that a suspension to new admissions had been placed on the home.

On the inspection beginning 23 February 2015 there were 53 people receiving care and support. We looked at the records of care for 17 people living at the home. We did not see that people’s individual dependency needs had been assessed in relation to ensuring sufficient staff being available at the time people required assistance.

We looked at the staffing rota for the last four weeks. We saw that the shifts covered were the same each week. We found that on both floors the staffing levels were the same, set at five care staff and one nurse. The staffing levels had been set for sometime and did into take into account the changing needs, and the increased dependency needs of people living in the home. For example, during a recent outbreak of norovirus, when additional care tasks and careful monitoring of people where required.

Inspectors found evidence that people were not given the level of supervision and care required in order to be safe. We saw that some people were not checked by staff at the required frequency, as set down in their risk assessments. This meant, for example, that people who were at high risk of falls or developing pressure sores did not receive the level of monitoring and intervention in order to reduce these risks. We found that call bells were either not in place, or were not readily to hand for people to call for assistance and help.

Staff reported to inspectors that they did not always have enough time to carry out these tasks and checks. Inspectors saw that some people who could not move without help from staff were not checked on by staff at all in three hours. We saw one person who had slipped down their wheelchair and was at risk of falling out; they told us that they were uncomfortable. We went to find staff to reposition this person.

We saw that people had to wait to be given personal care; this included assistance to use the toilet or that people had to stay in the same position for longer. Staff said this was why so many people were in wheelchairs and in their bedrooms as they didn’t have the time to “keep hoisting people.” One staff member said, “We try our best but with the numbers of staff we just can’t do it any quicker”.

We found that the registered person had not protected people against the risk of unsafe care by the means of ensuring adequate staffing levels. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that risks both at an individual and at a service level were not always identified and managed in order to protect those people using the service. Assessments did not cover all the assessed needs and risks to people. For example, we found that for people with behaviours that may challenge, and for those with mental health needs, some had no risk assessments to instruct staff on keeping them and others safe. We found that there was very little in the way of analysing the triggers and patterns of these behaviours so that they may be avoided or the risk reduced in the future. This meant that other people in the home and staff were vulnerable when dealing with, or encountering behaviours that challenged the service.

We saw that the home was not effectively managing the risk of falls occurring to people in the home. For example we saw one person who had become unwell and was

Is the service safe?

unable to get out of bed without the support of staff. This had not been risk assessed and we saw staff trying to help this person without the appropriate instructions. The paperwork to identify a change to risk had not been completed. We saw that this was unsafe and put the person at risk.

We found that risk assessments at a service level were also ineffective. For example, we saw that environmental risks were not always undertaken. We found the use of portable heaters in people's rooms that had not been assessed for the risk they may pose to people. These had been placed in the bedrooms of people who may be at risk due to reduced capacity or who were prone to falls. There were no measures to reduce the risk of burning, for example by regularly checking temperatures or by putting a guard around them.

We also found that plans to reduce risk for emergencies and untoward events had not been actioned. For example, staff reported to us that the home's hoists, for moving and handling people safely, were frequently breaking down. We were told by staff that often there was only one available for the whole home. We found that a hoist was out of action on the inspection visit; we also found that the home's weighing scales were out of order. This placed people at high risk of receiving unsafe care, through inappropriate moving and handling and failing to monitor peoples weights.

We found that the registered person had not protect people from risk by means of effective systems and processes that enabled them to identify and assess risk to the health, safety and welfare of people who used the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected from abuse and avoidable harm. We found that the staff team needed updates to their safeguarding training. When we spoke with staff we found that they were not able to identify all forms of abuse and had therefore had not been reporting these. We found that the registered manager had not been making referrals to the local authority about safeguarding matters.

We noted in the records that the staff team were having some problems with managing people with behaviour that could be challenging. Staff told us that they were having difficulty keeping these people and others in the home safe. When we looked at some of the issues resulting from this we judged that safeguarding referrals should have been made about incidents with people who challenged the service. These were not identified as potential safeguarding concerns.

The home's monitoring system recorded unexplained bruising to people living in the home. These were not all reported to the relevant authorities. We also saw that not all bruising was recorded onto this system. For example, when inspectors looked at one person's file their family had reported concerns about what they thought were "fingertip bruising". The manager had recorded in the notes that she thought they were "just scratches" and had not made any referrals to the local authority safeguarding team. This had also not been recorded onto the home's reporting system. This meant people had not been protected by ensuring the relevant authorities had been notified of the incidents. People were denied access to health and social care professionals that could provide input and interventions to assist in reducing and managing these behaviours and the risk of harm.

We spoke to the local authority safeguarding team and they confirmed that, while some had been reported, those that we raised had not. The local authority team also reported that the home had not followed the local protocols in an allegation of abuse investigation. They reported that the home's manager and operation's manager had carried out interviews with staff before being instructed to do so by the safeguarding team. The investigation had been compromised and as a result could not be properly investigated.

We found that people had not been protected against the risk from abuse and improper treatment because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines. We observed medicines being handled and talked to staff

Inadequate

Is the service safe?

about how they carried out medicine rounds. We looked at medicines, records and care plans in detail for ten people. We found that the service was not safe because people were not protected against the risks associated with use and management of medicines.

For example, we saw a medicine being given inappropriately with food that would result in it being ineffective. We saw that sedating medicines and medicines used to control behaviour that maybe challenging were administered on a 'when required' basis. But records failed to justify their use. A person who was prescribed a blood–thinning medicine was given the wrong dose twice within three weeks. Another person who was prescribed a strong pain-killing patch had an identification photograph of another resident alongside their medicines administration record. This increased the risk of the second people receiving an incorrect medicine that could be harmful.

We found that self-medication by a person was not managed safely. For example, one person who self-medicated had a risk assessment in place that identified a concern. However, we found no evidence that this concern was managed to protect them from harm. A medicine that was brought into the home by a resident's family was not managed well. We found that the person had inappropriately self-medicated with this medicine and there was no risk assessment or management plan in place to ensure safe self-medication.

We found that care plans relating to the management of medicines and medical conditions were poor. For example, there were no care plans for a person who received treatment for seizures or for another who received treatment for diabetes. This meant that staff lacked guidance to ensure safe management of people's medical conditions. Another person was prescribed powder to thicken drinks to assist with swallowing difficulties. There was no care plan in place and we could find no information about the consistency of drinks prescribed for his person. This could result in the person receiving drinks that were not of the required consistency and this could cause choking.

We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the staff recruitment systems in the home were not robust enough to ensure that vulnerable people were protected from potential harm and abuse. We found that on checking staff recruitment files that some staff had only one returned reference, when two had been requested. We found that staff who had been subject to disciplinary procedures in other work places did not have proper checks. Further follow up checks were not carried out, as would be expected by good recruitment practices.

We found that not all staff had a vetting and barring check to see if they had any criminal convictions that would prevent them from working with vulnerable adults, and we found others were out of date.

We found that the organisation's disciplinary procedure had not been followed. For example, we saw that the suspension of a staff member while an investigation was carried out had not been instigated quickly enough to ensure that people were not placed at risk. Where poor staff practice had been identified in the home these staff had not been subject to regular review and supervision.

We found that the registered person did not make sure that safe recruitment practices were followed, and did not ensure that a regular review of fitness of employees was undertaken. The registered person did not initiate systems to respond to concerns about a person's fitness to carry out their duties. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We looked at the arrangements in place to support staff to develop the skills they needed to effectively meet people's needs. Training records showed that the majority of staff had received training in basic areas of care. This included safeguarding adults, moving and handing people and fire safety.

However, we found that staff had not received more specialist training to support people with specific or more complex needs who lived in the home. For example staff had not had training or assessments of their competency to give out medication. During the inspection we saw that medicines were not consistently given out safely or in a manner that met the person's needs, this was because staff were not always competent or sufficiently trained.

We reviewed staff training records and saw that staff had gaps in their training. For example, we found that some new members of staff had not received any training or supervision since being employed. This was confirmed when we spoke with the staff in question. We found some staff who had worked in the home for a number of years were not on the staff training matrix, including four qualified nurses.

From our observations we found that the training that staff had received was often not put into practice. This was evidenced by unsafe moving and handling practices and unsafe handling of medicines in the home. We could see no effective measures to check staff competencies being used in the home. For example, nurse's personal development files were not checked to demonstrate their fitness to practice as a nurse.

The manager was asked by the inspectors about formal supervision where staff sit down to discuss, in confidence, their job role, their practice, safeguarding matters, training needs and any personal issues they might have. The manager told inspectors that formal staff supervision was not up to date. Records demonstrated, and staff told the inspectors, that supervisions were not regular. This had included supervision of staff on the night shift. This was particularly concerning as a serious allegation of abuse had been made against staff on the night shift.

We found that the registered person had not taken appropriate steps to ensure that staff had the skills, expertise and training to meet people's assessed needs.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provided support to a number of people living with dementia. We found that there was a lack of appropriate arrangements for supporting people with fluctuating capacity as the service did not have arrangements in place to make sure that people living with dementia had their mental capacity assessed and support needs met.

When we looked at people's care files we saw that in some files people's capacity had not recently been assessed and documented, and on other files there was no assessment or mention of capacity. This is the first step of the Mental Capacity Act (MCA) Code of Practice and sets out how to ensure that the rights of people who cannot not make their own decisions are protected.

We saw one person with fluctuating communication needs that had not had any input from a speech and language therapist. Staff were struggling to understand this person. This was not documented in the section of their care plan that gave instructions to staff on this person's capacity to understand and make decisions. In one section of this person's plan it was recorded that they could make decisions for themselves, and in another it stated that 'next of kin' should make decisions. There were no details of best interests meeting being held, as is set out in the code of practice of the MCA. Offering appropriate support to people with communication difficulties is a requirement of the MCA code of practice.

We saw that restrictive practices were in place in order to keep people safe. However, measures to ensure that these restrictions were lawfully applied had not always taken place. These included coded locked doors, the use of bed rails, restrictive seating and the use of alarms to monitor people's movements.

We saw that the legal status of people was not clearly documented and it was difficult to tell who had control over people's affairs and who could make important decisions on their behalf. We did not see any evidence to

confirm that relatives had the legal right to give consent or make decisions on behalf of people who used the service. When we asked staff about this matter, they were unsure about this too.

We looked at people's end of life decisions and the paperwork in place to support these. We checked the Do Not Attempt to Resuscitate Orders (DNAR) in place. We found many DNAR forms that had not been reviewed and there were no details about the people and professionals involvement in the decision-making process.

We also found that people with a DNAR in place did not have an End of Life Care Plan. This meant that information was not available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met. We also found that some people had not had their needs reviewed and that a DNAR was no longer appropriate. This could lead to some people not being resuscitated when they would want to be, as their condition had improved. We alerted the senior managers in the home of this.

We found that the registered person had not ensured sufficient measures were in place to protect people's rights and to gain, wherever possible, their informed consent. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting people's mobility while also reducing people's risk of falls through the use of appropriate equipment was not well managed by staff in the home. Equipment was not always available to safely move and handle people with reduced mobility. We found that staff were not given clear instructions on the use of equipment. This meant that people were not protected from the unsafe use of, or unsuitable equipment. We also saw that equipment that had been identified in care plans had not been used, for example pressure cushions and foot plates for wheelchairs.

We contacted the occupational health team who reported to us their concerns about the equipment and its unsafe use by staff in the home. They had carried out a review of people in the home who needed support with mobility and seating issues. They told us of the following issues of concern: the majority of the people were using slings which were the wrong size; multiple items of manual handling equipment (hoists and stand aid) were broken and awaiting repair; no safe methods of working detailed within the mobility care plans. They found that, for people who were immobile, care staff were leaving them sat on slings for long periods due to difficulties inserting and removing the sling. They said that staff did not have any awareness of the implications of this on skin integrity or that alternatives available, such as glide boards or seat slings.

The registered person had not ensured that the equipment and adaptations intended to promote the independence and comfort of service users were provided to all people in the home and applied safely and consistently around the home. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service supported people to eat and drink and what arrangements they had in place to meet people's nutritional needs. We observed people during the lunchtimes and saw that support to eat meals and take drinks was inconsistent. We saw some polite and caring interactions from staff but we also noted a number of negative interactions resulting in a poor outcome for some people.

People, who needed little assistance from staff, told us that they enjoyed the meals and the food offered in the home. They told us, "The food is lovely" and another said, "The food is good, you get plenty of it". We spoke with the cook, who was knowledgeable about fortifying diets to make them more calorific and also had a good understating of the dietary needs of older people. A number of people in the home commented on the good variety of homemade cakes and puddings.

However, inspectors saw that people who required staff assistance to eat and drink, and those who had more complex dietary needs, were not being supported with appropriate diet and hydration. We saw that some people did not have, or had incomplete nutritional assessments and nutritional plans of care. The organisation and the home had a range of tools to assess and monitor people's nutritional needs, but we found that these were not being used effectively by the home.

We found that not everyone was weighed regularly, or as set out by the frequency recorded in their individual plan of

Is the service effective?

care. We saw weight loss that was not properly recorded and monitored. The inspectors found significant weight loss in eight people across the three months prior to the inspection. When we checked care notes for these people, for some we could not find referrals to seek medical support or intervention, such as from a dietician. And in others we found delays in taking appropriate action when people were not eating and drinking.

People who required support to eat and drink, as identified in their care plans, did not all receive that practical support. We saw some people waiting for considerable periods before staff came to help with their meals which meant some people were being offered meals that were cold. Staff told inspectors they didn't always have the time to sit with people to ensure they ate all their meals.

We observed lunchtime for six people, all living with dementia, who found managing a meal quite problematic. The inspector observed that for the majority of the mealtime there was one care staff to six people, with an occasional 'floater' staff member coming in and out of the dining room.

We saw that people did not get enough help and support to eat their meal in a timely fashion. Some people were still trying to manage to eat half an hour after they had been given their food. We saw some people who received support eating well, however as soon as the staff member moved away they stopped eating. One person was presenting with behaviours that challenged, being quite vocal. Another person left the dining room, without eating their meal, stating it was impossible to eat with all the noise. We saw in this person's notes that they had lost a considerable amount of weight since arriving at the home.

The food and fluid charts for many people were either not filled or were inaccurate. For example: one person's chart had no target to aim for and there was no adding up of the amount given across the day. The inspector asked the care staff how much this person should have each day. The care staff said they didn't know. This made it difficult to tell if the person had received adequate hydration and food intake. These records showed that this person had very little to eat or drink across the two day period of the inspection.

We found that care staff had a lack of knowledge, instruction and guidance on meeting people's nutritional needs. When we checked people's care plans, important information with regard to people's diets had been omitted, such as a person being diabetic. When we asked care staff about what food this person could have if they were a diabetic they did not know. We asked if their diabetes was controlled by medication, and they said they weren't sure, but "thought so".

Another example of this lack of knowledge was observed when staff had used a tin of 'thick & easy' from the general drinks cupboard. This is used to thickened drinks so that people with swallowing difficulties did not take fluids onto their lungs. This tin was not labelled and when asked, staff said they had used it for everyone who needed a drink thickened. Thick & easy should only be used for the individual it is prescribed for and should be labelled with their name and the amounts to be used. The practice of sharing is not safe and is open to error, and to the person not receiving their prescription and treatment.

We observed one person being offered water by care staff when they appeared to be having a coughing fit. This person's care notes stated that they should have thickened fluids on the advice of a speech and language therapist. This put them at risk of harm as this can lead to aspiration of fluids onto the person's lungs causing pneumonia and other complications. This can be life threatening. We reported this to the manager and the two senior managers who were present on the inspection.

We found that the registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration. This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

One relative said, “They look after mum well, the girls are smashing”, another relative said, “I can come and go as I want. There is a bird feeder outside her window, the staff put it there for her, she likes to see the birds”. However another relative said, “The care you get depends on which staff are on duty, some take the line of least resistance. Some are good and can go the extra mile but others do not, if you get my meaning”. Another relative told us similar views and felt that some staff didn’t care and were “lazy”. They reported a lack of care and attention, such as finding their relative with dried food on their clothes and around their mouth, and frequently not having slippers or tights on. They said their relative was often cold and had been dressed in flimsy clothes with no cardigan.

People spoken with reported that their visitors were welcomed into the service. One relative told us that they always felt welcomed and were offered a cup of tea. A relative told us that they had always been made to feel welcome and that there were no restrictions placed on them visiting their relatives at any time. Throughout the day we observed that visitors came and went freely to the home.

We saw that interactions between people living in the service and staff were not always consistent. We found that staff empathy, care and attention to detail differed between care staff. We observed one person ask for help with their meal on several occasions. They received no response from staff who were busy doing other things. When staff were asked why they did not respond they explained that the person was often “agitated”. There was no information in the person’s care records that said this was their normal behaviour and how staff should respond.

We saw two care staff and one nurse chatting with each other in the dining room that had no residents in it. Whilst along the corridor we observed one person sat with their head in their hands crying, and another two people engaging in an altercation. We pointed this out to the staff who again commented that this was normal behaviour.

We observed that some people did not looked well cared for. For example, we found numerous people with no footwear on, neither slippers, tights nor socks. We saw people who had slumped into chairs and looked very uncomfortable. We saw one person who was resting their head on a chest of drawers. One person had jog pants on that were too tight and short, they cut into their legs and it was evident that the person was wearing continence pads. This person’s dignity was not respected. Other people were wearing clothes that did not match and generally looked unkempt.

We found examples of people’s needs not being responded to quickly to ensure that they were comfortable. When we revisited two weeks after the first inspection day we found the home was still cold. People told us they were cold and their hands were cold to the touch. When we asked a member of staff about how the home felt cold, they replied that she was very hot with “all the running about” and she wouldn’t want it any hotter.

We saw that one person had to wait several days to get painkillers from their GP. Another was told by staff that they weren’t a priority for the GP. We had pointed out to care staff that one person did not have a call bell, and asked if they could sort this out, when we visited the next day they still didn’t have one.

Some care staff engaged in a very warm, caring and empathic way with people. They adjusted clothing, sorted people’s hair out while having pleasant conversations. These care staff made the most of every care task to chat to people and ask them if they were ok, and ask if there was anything they needed. We noted that they used touch to enhance interactions with people in a reassuring and calming way. When staff did make use of the opportunity to chat to people whilst carry out tasks we saw that people became animated and visibly lit up with these positive interactions.

We reported to the manager and the operations manager both the positive and the negative interactions we had observed. We reported on the lack of consistency in the approach of staff, and that evidence of kind and compassionate care appeared to be due to the skills and efforts of individual members of staff. We judged that there was an institutional acceptance to the level of neglect that was occurring in the home. Some staff told us that they had tried to complain and raise concerns with the manager, and had been in tears on numerous occasions, but said it was like “banging your head against a brick wall”.

We noted that those people who were more able to hold conversations and engage with staff received the most staff attention. The expert by experience reported that she also

Inadequate

Is the service caring?

found that people received very different care and attention. The expert reported, "I observed a number of good on-going conversations between staff and residents with a lot of family knowledge displayed. I also observed four residents in the downstairs floor who were very frail and sitting/ lying in supportive chairs who had almost nothing spoken to them in the six hours I was there. Visits to these rooms were brief and task orientated. Upstairs one lady sat in an armchair in the corridor facing a wall and was only moved later in the afternoon to the upper sitting room to see a film by one of the visiting managers. Downstairs two lady residents were sitting with the television on loudly but neither were seated in a position to be able to see the television."

We saw that one person had three care staff sat in their room and they were enjoying a lively chat. At the same time other people, we noted were in their rooms for long periods, with staff only going in to do tasks. A member of staff told the inspectors that they felt that staff had 'favourites' and felt it was unfair that some people 'missed out'.

We found that there was little evidence of a person centred culture in the home. When we asked people if they had been involved in setting up care plans, most said they weren't sure, while others said they left it to their relatives to sort this out. Some relatives told us that they had only just been asked for a life history after their relative had been in the home for several months. The majority of care plans and records we looked at did not have any record of the person's, nor the relative's involvement.

We asked if the home listened to people and relatives. Relatives reported having to insist on certain standards of care and felt that, as one person said, "They were made to feel they were being a nuisance".

People's experience at the end of their life was variable. Some relatives told us that this time was being handled well with open visiting times, and empathy expressed by staff. However we found that paperwork on peoples' end of life choices was not always completed or reviewed. This could lead to peoples' end of life wishes not being followed. We were also made aware of poor handling of a person's end of life that meant that a relative could not be at their bedside when they passed away.

We found that the registered person had not ensured that people were treated with dignity and respect. We found that not all staff treated people in a caring and compassionate way. The most suitable means of communication had not been facilitated for all people in the home, this made it difficult to know and respect people's wishes and preferences. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We asked people about the care and treatment they received in the home. And we also asked them about how responsive the home was to either their changing needs or to concerns or complaints.

We received mixed views on the care and treatment. One person told us, "I'm not comfy in here, there's nothing to do". Another two people reported being "fed up". We were told by some relatives that a vicar came to the home and that in summer the garden area was a nice place to sit. We saw a weekly activity list on the notice board for the home, two days were listed as "sit and chat" with staff. The hairdresser and vicar were also listed as activities.

A number of relatives told us that they had concerns about the care received by their relative. One told us their relative had been in slippers that weren't theirs, being "too small and split down the seams. Their feet were all scrunched up and they had visible blisters on their feet." The home had been defensive and dismissive they said when they had reported concerns. The family moved their relative to another home. Another said that they did not feel confident with the care their relative received and so visited frequently to check they were getting the care they needed.

We had also been contacted by a relative to say that they were unhappy with the time it took the home to call a GP out to see their relative. Another told us they had been very unhappy when they had turned up at meetings only to find they had been cancelled. Other relatives said that the reviews of their relatives care had taken place without them being informed.

When we asked people about their experience of making complaints or raising concerns with the home, all the relatives we spoke to, and those who contacted us were unhappy about how these were dealt with.

We found that the management of complaints was not handled well by the home. Inspectors found numerous complaints that had not been recorded. We spoke to a relative who said that they often went to the manager about concerns and to make complaints. When we checked the complaints file for the home there was no record of any of these concerns or complaints. Another person contacted our website after getting no response to complaints made to the home. They reported that nothing had been done in response to their complaints and that "It's getting worse."

We looked at one complaint in detail and found that the organisation's complaint procedure had not been followed. This had led to the complainant being very unhappy with the response and outcome. We saw that they had tried to speak to the manager on numerous occasions but she didn't return any of their calls. We found another complaint on a person's care file that used inappropriate language and demonstrated a defensive attitude towards complaints. For example, "they were going on about it" (meaning the complainant). The registered manager said that "there was a breakdown in the relationship at that point". The registered manager stated that she had not taken this as a complaint or concern that required investigation or recording.

The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaint and concerns. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the care they received in the home and how involved they were in setting up care plans. Most people were aware that they had a care plan but some said they had little involvement in making choices about their care and treatment. Some said they left this for their relatives to sort out.

We looked at 17 care plans in detail belonging to people that used this service. We saw that people did not receive care and support in the ways that had been identified within their care plans. We found that there were significant gaps between what was recorded in risk assessments and care plans and what happened in practice. This put people at risk of inconsistent care or not receiving the care and support they need.

People's care plan were not responsive to their individual needs. We found that information provided in care plans were tick box based which provided no clarity or

explanation. Staff told us that they thought that there was too much paperwork and the care planning system was too difficult to follow. We also found that care plans were cumbersome, repetitive and were not up to date.

We found that when care plans had been reviewed the changes to the person's condition were not reflected or updated in the care plan. For example, one person had unexplained bruising that was documented on a body map. There was no update to the care plan that would assist staff to monitor the person's bruise and no investigation was in place that would assess the likelihood of any risks to the person.

Staff demonstrated a lack of knowledge about the people they were caring for. The care plans and documentation did not give staff sufficient information to have a working knowledge of people's assessed and current needs. Two care staff spoke to the inspector about a person's health needs and life story. When the inspector spoke to a nurse later she was shocked by what the care staff had reported as this person needs.

We found this to be the case in many of the files and across areas of healthcare, finding that care needs had not been identified, and also updates to people's care had not been recorded or risk assessed.

This was a particular concern where people were identified as being at high risk of breakdown of skin. We found that care plans for the use of creams were poor and did not always identify the creams to use or instructions for use. This meant that care workers did not have clear guidance to follow to ensure that they were used correctly. For example, one person was identified as being at very high risk of skin breakdown and also had an existing pressure ulcer. This person was unable to change their position independently and the care plan stated that a barrier cream was prescribed and staff must apply it as required to protect the skin and reduce the risk of damage. Records showed only five administrations of the barrier cream since August 2014. The last recorded administration was on 1 September 2014. The person was also recently reviewed by the Tissue Viability Nurse who made a recommendation for treatment. We did not find any records to show that this recommendation had been followed.

For another a person who had fallen a number of times we could see no advice or instructions incorporated into the care plan in response to these falls. There was no referral on file to seek support from an occupational therapist for use of appropriate equipment to support this person. We had also been sent information from adult social care (social services) about a delay in the home seeking medical assistance for another person who had fallen in the home. This person had a delay of five days before medical advice was sought, and on hospital admission it was found they had a broken hip.

We found that the registered person had not protected people against the risk of receiving care or treatment that was unsafe or inappropriate by means of thorough care plans based on people's assessed needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We judged that providing a person centred approach to people's care and support needs had not been properly implemented in the home. The majority of care plans we viewed did not have life histories and there was limited information about people's preferences. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. However this relied on staff remembering information and passing it on to other staff correctly rather than making sure all staff were aware of the same information about people. There were also a number of people from outside of the local area who were new to the home, and they too had very little personal information and life histories for staff to refer to. For example, one person's record had only two preferences recorded: the name they wished staff to use and a wish to have a single bed.

We observed that there was little in the way of meaningful activities arranged to meet people's needs, or for them to engage in. The activities recorded for many people was receiving personal care such as a bath, shower, shave or sitting in the lounge with other residents. We did not see any activities take place that met the needs of people living with dementia. The manager told us that the home was due to have training in all aspects of dementia care, including appropriate activities for people living with dementia to engage people in.

We observed a high number of people spending long periods alone in their bedrooms. On the inspection we

Inadequate

Is the service responsive?

were told by the manager that both activity coordinators were off sick. The expert by experience had reported that she saw people spending all day in their bedrooms with little interaction from staff and with no stimulation. On the second day of the inspection we noted that the same people were still in their bedrooms.

We saw that the one activity coordinator for the home was, for part of the morning, carrying out care tasks. One person who was in bed all day had no television in their room, when asked care staff were not sure why. We found that the lounges on all the units were not well used by people in the home. On the days we visited the lounges were often empty with the majority of the people in their rooms or wandering along the corridors.

We judged that for many people their quality of life was poor due to a lack support to engage in meaningful activities and to have contact with other people. This meant that people were at risk of being socially isolated and lacked stimulation. The home did not respond well to this aspect of people's well-being.

We found that the registered person had not made suitable arrangements to ensure that people's psychological, emotional, social, cultural and spiritual were met by the home. People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) (a)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Overall we gained mixed views about people's experience of the quality of the service people received. In some areas, such as meals and the design of menus people reported positively about being involved in these decisions. With other areas we could see that people's choices and preferences on their life style and care choices had not been gathered, and where they had, these had not always been implemented. We were told that the residents meetings were poorly attended.

One person, a friend of a relative said, "People don't like to make a fuss, I know many relatives who have complained in the past have given up and now just make sure they visited a lot so they can check for themselves that their relative is getting the right care."

We found that the home did not promote an open, honest and transparent culture. Staff told us that when they did report concerns and issues of poor practice that senior managers within the home did not listen. Some staff told us that they had found this very upsetting and had been in tears trying to get senior staff in the home to listen. We, CQC, had a number of staff whistle-blowers who reported directly to our website stating that when they had raised concerns in the home nothing happened.

We saw that the good interactions and care given to people was through individual members of staff rather than it being led by the values and ethos of the home's leadership. Staff reported cliques within the staff team, and some staff "not pulling their weight."

We saw that the culture of the service was not based on the needs of the people who lived in the home but was task orientated. This could be seen by the routines in place in the service. These were not flexible to meet people's needs. The lack of choices available to people, and the care they received did not meet people's needs as care was not appropriately planned.

We found that roles and responsibility within the service were not clear. We found that the deployment, direction and supervision of staff were not well managed in the home. This was made even more difficult by the communication systems of the organisation not having been properly implemented.

We were told by the manager that the home had a detailed quality assurance (QA) system for monitoring all aspects of quality in the home. This was a formal system in place for all Four Seasons Healthcare (FSHC) establishments.

However, we found that the systems had not been effectively adopted in the home. During the inspection we identified failings in a number of areas. These included the safe management of medications, meeting people's choices, stimulating activities for people, adequate nutrition, managing risks to people, dealing with complaints, identifying and managing safeguarding.

Risks posed by the environment were also not subject to adequate monitoring, such as ensuring that the home was adequately heated. We found areas of the home, including bedrooms that were cold. The FSHC central quality auditing system had not identified these shortfalls and areas of risk.

One of these FSHC systems was for monitoring the quality of care planning. We saw that the care planning system provided by the organisation was not followed by staff in the home. We saw that staff were not following the step by step instructions as set out by the Four Seasons organisation's care plan booklet. We found numerous examples where staff had left out sections of the care plan and risk assessments were blank and not complete. This had led to staff making decisions and setting up care plans that were incorrect and did not meet people's needs.

We found that in 11 files people's capacity care plans had had not been completed. This placed people at risk of receiving care and treatment they had not consented to, and exposed people to the risk of abuse.

We asked the manager about how care plans were checked to ensure they were up to date and that they were followed by staff in the home. The manager told us that she knew there was an issue with the quality of care plans and she had asked her deputy to look into it. The deputy said she had carried out some random spot checks of fluid and balance charts and if she saw any errors she would put a line underneath them. We saw no evidence of auditing or checking by a senior person on the care plan booklets or within people's files.

The monitoring system was also not identifying areas of risk and poor practice in the home with regard to the management of safeguarding issues. For example, we asked for safeguarding referral figures on the inspection,

Is the service well-led?

the home could not produce these. The home's operation manager sent these to us two days later, along with the falls and accident risk register, that we had also requested. These figures were not known by the home when we asked about the numbers for each. When we asked the manager she did not know if these figures were about average or whether the home had, for example, a high number of falls.

When we checked the numbers of safeguarding referrals recorded on the QA system there had been one in the last year. This figure is exceptionally low for this type of service but this had not been flagged up by the FSHC organisational QA system for action. We judged that both the home and the organisation failed to properly ensure safe standards of care and to monitor the quality of the service received by people living in the home.

We found that the registered person had failed to ensure that people in the home and others were protect against the risks of inappropriate or unsafe care and treatment, by means of an effective system to regularly assess and monitor the quality of the services provided. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further to this, we found that the organisation and the registered manager had not notified the Care Quality Commission, (CQC) of accidents and safeguarding incidents that had occurred in the home. We found a number of examples of falls where people had been taken to hospital. A safeguarding alert had been made by a professional body external to the home. These were both notifiable events that had not been sent into the Commission.

The registered person had failed to ensure that the Commission be notified without delay of specified incidents affecting people who use the service and incidents occurring in the service. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009; Notification of other incidents.

We found that record keeping in the home was poor across a number of areas. During the inspection the inspectors looked at forms which recorded when personal care was given to people. Many of these forms had not been updated, therefore, there were no accurate records of when people's personal care had been completed. For example a fluid chart, for a person with no verbal communication had not been completed so it was not possible to tell when a person had last had a drink. We saw that care plans were hand written by the nurses and many of these were not legible, while others had not been update to reflect the person current needs.

We found errors in the recording of the administration of medicines. We saw administration records that were not signed at the same time that medicines were given and other records contained gaps. This increased the risk of incorrect records and errors in administration of medicines. Records for the administration of medicated patches were poor. This could result in overdose of medicines.

Records for the administration of skin softening and barrier (skin protecting) creams were very poor. We could not tell if people received correct treatment. This was a particular concern where people were identified as being at high risk of breakdown of skin. The task of applying these creams was delegated to care workers and this was not monitored.

The records for 'hand over' at the end of shifts were incomplete and important information about changes to peoples' health were not passed on. This meant that the care people received was not effective in meeting their needs. Staff reported that care plan files were not easy to use and were located in the nurse's office. We found that this meant that not all staff had access to the most up to date information about a person's care needs.

We found that the registered person had failed to ensure that people in the home and others were protected against the risks of inappropriate or unsafe care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not protected people against the risk of receiving care or treatment that was unsafe or inappropriate by means of thorough care plans based on people's assessed needs.** Regulation 9(3)(a)-(h) **We found that the registered person had not made suitable arrangements to ensure that people's psychological, emotional, social, cultural and spiritual were met by the home. People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences.** Regulation 9(3)(a)-(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person had not ensured that people were treated with dignity and respect.** **We found that not all staff treated people in a caring and compassionate way. The most suitable means of communication had not been facilitated for all people in the home, this made it difficult to know and respect people's wishes and preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

We found that the registered person had not ensured sufficient measures were in place to protect people's rights and to gain, wherever possible, their informed consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that people had not been protected against the risk from abuse and improper treatment because the registered person had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that people had not been protected against the risk from abuse and improper treatment because the registered person had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that the equipment and adaptations intended to promote the independence and comfort of service users was provided to all people in the home and applied safely and consistently around the home.

Regulation (15) - 1(a)-(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaint and concern.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had failed to ensure that people in the home and others were protect against the risks of inappropriate or unsafe care and treatment, by means of an effective system to regularly assess and monitor the quality of the services provided. Regulation 17(2)(a) We found that the registered person had not protected people from risk by means of effective systems and processes that enabled them to identify and assess risk to the health, safety and welfare of people who used the service. Where risks were identified the measures to reduce or remove the risk within a timescale were not set out. Risks to health, safety and welfare had not been escalated within the organisation or to relevant external body as appropriate. Regulation 17(2)(b) We found that the registered person had failed to ensure that people in the home and others were protected

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	against the risks of inappropriate or unsafe care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records. Regulation 17(2)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled staff were deployed in order to meet people's needs. Regulation 18(1) The registered person had not taken appropriate steps to ensure that staff had the skills, expertise and training to meet people's assessed needs. Staff were not receiving appropriate support and supervision, as is necessary to enable them to carry out their duties. A system for checking staff competence was not in place. Regulation 18(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not make sure that safe recruitment practices were followed, and did not ensure that a regular review of fitness of employees was undertaken. The registered person did not initiate systems to respond to concerns about a person's fitness to carry out their duties. Regulation 19 (1)-(a)(b)(c), (2)-(a), (5)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered person had failed to ensure that the Commission be notified without delay of specified incidents affecting people who use the service and incidents occurring in the service.