Keychange Charity

Keychange Charity The Mount Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 13, 14 and 15 October 2015 and was unannounced. At the last inspection on 15 July 2014 we asked the provider to take action to make improvements in respect of the safe administration of people's medicines. We found the administration of medicines on this inspection continued to be unsafe.

Keychange Charity The Mount Care Home is known locally as 'The Mount' and can accommodate a maximum of 28 older people who may be living with dementia. The Mount provides residential care without nursing. Nursing care is provided by the community nursing team. When we visited, 25 people were living at the service.

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

Summary of findings

However, the registered manager was absent long term at the point of the inspection. A temporary manager had been overseeing the service. They were supported during the inspection by a temporary deputy manager. Both the temporary and deputy manager were from another service owned by the same provider.

We inspected the service due to concerns raised with us. In July 2015 we were made aware of concerns about how the service was being run and whether people's needs were being met. There were concerns about the lack of care plans, poor risk assessments, unsafe medicine practices, no personal evacuation plans and not recording how staff were meeting people's individual needs. The provider sent us an action plan. This told us what action the provider was taking and how they were seeking to put things right. This inspection reviewed the action plan and what the provider had put right. However, we found a number of on-going significant issues. These have been passed to the adult safeguarding team at the local authority.

The administration of medicines was very unsafe. All records recording people's medicines were inaccurate and incomplete. This made it impossible to determine whether or not medicines had been given as prescribed. People did not always receive their medicines as required and the service often ran out of medicines or required emergency prescriptions. People were at risk of over and under dose. The stock of medicines was not being managed to ensure people only had their current medicines available and that others were returned when no longer required. There were times at night when there were no staff on duty who were trained to administer medicines. This meant people on 'as required' medicine had to wait. No staff were having their competency to administer medicines checked. We requested the temporary manager take immediate action to address the administration of medicines as people were at immediate risk of harm. Systems were immediately put in place to ensure the administration of medicines were safer in the short term. Before the inspection was completed systems were also put in place to administer medicine safely in the longer term.

There were not always sufficient staff on duty to deliver care safely. People were not protected by staff and systems which would ensure abuse was reported and acted on. Staff were also not always recruited safely or supported properly to ensure they could deliver care effectively. Training had been implemented since July 2015 and plans were in place to ensure all staff were suitably trained.

People had risk assessments in place but these were not clearly linked to their care records or reviewed. People's risks associated with specific needs to that person were not always in place and guidance was not then available to staff. For example, there were no records for people with diabetes of how staff could identify when their blood sugar was too high or low and what action to take. People had several falls in 2014 and 2015 and these were not being reviewed to identify why so many people were having falls in their bedrooms.

Fire and environmental risk assessments were in place. Not everyone had personal emergency evacuation plans in place. There was no plan for staff to safely deal with any emergencies such as a fire. We have passed on our concerns to the fire service.

Staff were not always following safe infection control practices to ensure people were protected from the likelihood of cross infection. Staff reported they did not always have the equipment available. The service was clean. People were happy their rooms were clean.

People's health, nutritional, hydration and care needs were not always met. The records of people's care had gaps in relation to people's needs and were inconsistent in demonstrating the role the person, staff and professionals had in meeting need. This meant it was not possible to confirm people were having their needs responded to and met. Details of people's health, diagnosis and the support required to meet these needs were not always recorded. Advice from professionals to staff were not passed on or recorded within the person's records to ensure consistency of care between staff. Staff told us they stopped passing on concerns that people's needs had changed as they had been told it was not their role. This meant changes in people's needs were not always communicated to the GP or district nurse to ensure their needs were met.

People were not always partners in planning their own care. People's preferences were not recorded. The recording of people's life stories ended when they came to live at the service or stopped some years before. People did not always have their needs or their choice

Summary of findings

about how their needs were met discussed with them. Assessments were not requested from their GP or other professionals to look for alternative ways to meet needs, when required. People told us they could only have a bath when staff told them. People said having a shower, getting up or going to bed was in line with their choice. People were also happy that they could have the choice of food they liked.

People's end of life needs were not planned with them. People's religious and cultural needs were not being planned for at this time. Health professionals confirmed they had no concerns about how people's end of life had been met by staff.

People's capacity was not assessed in line with the Mental Capacity Act 2005. There were no full assessments of people's capacity which advised what they could consent to and how people could be supported by staff to consent. Decisions had been made in respect of people's care without detailing if this had been in people's best interest. People's capacity was not always respected by staff when people had a different view of how they wished to receive their care.

People were not being supported to remain cognitively and physically active. Activities were not provided in groups or on a one to one basis. People's links with the community were not maintained. People's religious needs were not being met.

We found robust leadership and governance had not been in place for some time. Auditing of the service was inconsistent and did not ensure the service was able to meet the requirements of the regulations. Where concerns had been identified, such as those identified by the supplying pharmacist in relation to the safe administration of medicines, they had not been acted on. There was a division between staff and management with staff feeling undervalued and not listened to. Staff described how they hoped things would now change with the new managers and in the future. The provider told us they were discussing the issues with the board of trustees to ensure they addressed the concerns raised in this inspection.

People were rarely seen outside of their room except when some went to lunch or tea in the dining room. The brief observations we managed of staff with people living at the service showed no concerns. Staff treated people with kindness and respect. Consent was sought before continuing with supporting people to go to and from the dining room. People spoke about staff with fondness and told us they were treated kindly. People said they were treated with respect and their dignity was protected. Staff also spoke about people in a caring and compassionate manner.

There was a complaints process in place and people's complaints were reviewed. People felt they would talk to staff or the manager if they had a concern. People and family members did not feel they had any concerns or complaints to make.

We found a number of breaches of the regulations. You can see what action we have told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12

Summary of findings

months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. People's medicines were not administered safely. Immediate action was taken to address this.

People's risk assessments were not updated to mitigate risks people faced living at the service. There was no link to people's care plans. People's falls were not being reviewed to reduce the likelihood of them happening.

People were not protected by a system which supported staff to pass on concerns about people's care.

Staff were not always recruited safely. There were enough staff to look after people during the inspection. We were told this had not always been the case. People told us they would struggle or be uncomfortable rather than ask for staff support.

Staff were not always following safe infection control procedures. The service was clean. People were happy their rooms were clean.

Fire and environment risk assessments were in place. Not everyone had personal emergency evacuation plans in place. There was no policy available to support staff safely to deal with any emergencies such as a fire.

People told us they felt safe living at the service. Relatives had no concerns about the safety of their family member.

Is the service effective?

Inadequate

The service was not effective.

People's right to consent to their care was not being assessed in line with the Mental Capacity Act 2005 when they lacked capacity.

People's nutritional and hydration needs were not always met.

Inconsistent recording and communication in respect of people's health meant people were at risk of not having their health needs met.

Staff were trained to meet people's needs but staff were not receiving support to carry out their duties fully and effectively.

Is the service caring?

Requires improvement

The service was not always caring. People's end of life choices and care needs were not planned for.

Summary of findings

People were not always in control of their care. Staff were focused on physical tasks rather than on people's wellbeing.

People felt staff were kind, compassionate and treated them with respect. People said their dignity was always protected. Family spoke positively of the staff.

Is the service responsive?

Requires improvement

The service was not always responsive. People's records and care plans lacked sufficient detail to ensure people's needs were met, care was appropriate and reflective of people's preferences.

People were not being supported to remain cognitively and physically active. There were no activities taking place. People's religious needs were not being met.

There was a complaints policy in place. Some people said they would speak to managers if they had a concern. People's complaints were reviewed.

Is the service well-led?

Inadequate

The service was not well-led. Robust systems were not in place to ensure the quality of the service. People were not assured of good care or actively involved in feeding back about the service on a regular basis.

Staff did not feel valued or listened to. The culture was not open, inclusive or empowering.

Good leadership and management was not demonstrated.

Systems of auditing aspects of the service had lapsed or were not currently in use. Recordings to ensure the day to day maintenance of the building were being developed. There were appropriate contracts in place to ensure the building and equipment was safe.

Keychange Charity The Mount 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.

The inspection took place on the 13, 14 and 15 October 2015 and was unannounced.

The inspection was completed by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the previous inspection report, notifications and the Provider Information Return (PIR). Notifications are information on events registered persons are required to send us. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. The PIR was completed by the registered manager in September 2014 and did not reflect the level of concerns in the service.

During the inspection we spoke with 16 people, one visitor and two relatives. We reviewed five people's care records in detail to check they were being cared for as planned. We also reviewed parts of six other people's care records to check if aspects of their care had been followed through by staff. We observed staff when they brought people to the dining room to check how staff communicated with people.

We spoke with six staff by themselves on the first day and a group of seven staff on the second day of the inspection. We reviewed five staff personnel and training records. We reviewed the training plan for all staff. We spoke with the temporary manager and deputy manager. We had email contact from the nominated individual (NI). The NI is a person appointed by the provider who is responsible for supervising the management of the service. An operations manager representing the provider also attended the inspection from the second day.

We spoke with a district nurse and community pharmacist during the inspection. Following the inspection we sought feedback from the GP with the most knowledge of the service. We also had discussions with a social worker and fire safety officer.

Inadequate

Is the service safe?

Our findings

At our previous inspection on the 15 July 2014 we found appropriate arrangements were not in place in relation to the recording of people's medicines. We requested the registered provider address this. We reviewed the administration of medicines during this inspection and found the concerns from the previous inspection had not been addressed.

People's medicines were not administered safely. People's medicines were managed inadequately and were very unsafe. All records recording people's medicines were inaccurate and incomplete. This made it impossible to determine whether or not medicines had been given as prescribed. People's medicines administration records (MARs) had several gaps, were unclear on dosage, times of medicines given and altered, without clear evidence who had authorised the change. Staff were not accounting for the stock of medicines to ensure they had enough available to meet people's needs and the service had run out of prescribed medicines for several people. The GP advised they had received several calls for emergency prescriptions. Trained staff were not always on duty to administer medicines and some staff had not received up to date medicines training. We found two to three nights each week there were no staff on duty trained to administer medicines. Meeting people's request for pain relief, for example, relied on an 'on call' member of staff travelling to the service which meant people had to wait for pain relief.

People did not always receive their medicines as required. For one person, staff were found to have omitted medicines for a two week period and medicines prescribed for once a week were found to be given daily. Another person was due to have an injection at 8am on 14 October 2015. It had been omitted due to lack of communication. When the district nurse indicated that this injection needed to be completed the service had none in stock. An emergency prescription was obtained and the person received their injection eight hours late. The person was also an insulin dependent diabetic. The insulin used was not labelled when it was opened when guidelines clearly state that it should be discarded after 28 days. The person had been incorrectly advised by staff when to test their blood sugar levels. The district nurse assisted this person during the inspection and advised them on the correct process.

There was no evidence staff were returning to administer people's medicines if it was not possible at that time. People noted as "asleep" or "too early" were not being offered their medicines at a later time. For one person, they had their medicine omitted which helped them to maintain a stable mental health as they were described as "asleep". This could result in this person's medicines being less effective in managing anxiety or low mood.

Staff were not ensuring medicines given 'as required' were clearly recorded. They were also not recording the time, amount and reason these medicines were being given. For example, one person had been prescribed a pain relief medicine "one or two tablets, four times a day for a two week period, when required". However, the MAR recorded this person had only received this medicine for nine days and not 14 days as prescribed. The MAR had also been altered by hand with no staff signature or date why this had changed from four times a day to five times a day. There was no record if this person had taken one or two tablets at each time. There was no record in the person's care records as to why their prescription had changed.

People who self-administered their medicines, such as insulin, did not have their capacity and ability to do this clearly recorded or reviewed regularly. This meant people were not being monitored to ensure they could do this safely. Safety was not assured other than by the district nurse and GP having an oversight of the people concerned. Advice they had given had not been recorded or passed between staff to ensure it was followed. There was also no link between people's medicines and their care plan. The list of current medicines was not up to date and there was no information to staff about specific medicines and linked health issues or side effects. For example, we only identified one person was taking warfarin by information held in the kitchen, which said which food they could not eat. Warfarin is an anticoagulant that stops blood from clotting and staff needed to know how to act in the case of an emergency. There was no risk assessment, care plan or linked recording of when this person should have had their blood tested or what amount of warfarin they should be taking.

Medicines were not always stored and returned safely. Each person had a lockable cabinet in their room which, in some cases, the person had access to with their own key. One medicine was also stored in a cupboard that was very warm when it was recommended it was stored below 25

Is the service safe?

degrees. None of the cabinets had thermometers available to check the temperature was correct for the medicines stored there. This person and other people had excess medicines stored in their medicine cupboard. This included discontinued medicines in a high number and pain relief medicines held in a very high number. The medicine room, holding stock was found to have an excess amount of medicines either no longer in use or for people no longer resident at the service. We also found the service had not completed any medicines audit nor followed advice given by the pharmacist.

The improper and unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested the temporary manager took immediate action to address the administration of medicines as people were at immediate risk of harm from the current system. A plan was put in place to ensure the administration of people's medicines were safe that day. This included making an accurate record of people's current medicines and ensuring they were available. Staff were observed to complete this task. The following day, the temporary manager brought in other resources and support to ensure the administration of people's medicine was improved. This included the community pharmacist and a external trainer.

People's records had risk assessments in place for manual handling, supporting good skin care, identifying the risk of malnutrition and falls. However, these risk assessments had not been updated and were not clearly linked to people's care planning. For example, one person had been weighed once in July 2014 and once in July 2015. Their malnutrition universal assessment tool (MUST) showed they had lost weight and had a body mass index (BMI) which noted them as being 'underweight'. The guidance in the MUST stated referrals should have been made for assessment and their weight monitored closely. There was no nutritional care plan, no actions noted and no further weights recorded. The person was weighed during the inspection and was noted to have lost 5.5kg further in weight. The same person's falls risk assessment noted they had two falls in July 2015 and two in August 2015. Their risk of falling was noted to have increased however, there was no action taken to assess this person further. Their falls risk assessment had not then been reviewed since 29 August 2015.

The accident book records detailed people had a lot of falls in both 2014 and 2015. All these falls were in people's rooms. Staff were not routinely assessing or acting to mitigate the risks to people. People's individual risk of falling, or a review of why so many people were falling, was not routinely taking place. An overview of the falls records had been completed in June 2015 but records did not then show if people had been referred to other services for assessment and support. For example, one person's records and accident records showed they had potentially had six falls in 2015 and one in November 2014. The records in their files and accident record did not reflect each other. Their falls risk assessment noted they were at medium risk of falls and stated "consider referral to the falls prevention programme". This action had not been followed despite the number of falls. The district nurse confirmed they had not been asked to review anyone in respect of falling or to support the service to manage people to prevent falls. The GP also confirmed they had reviewed this person recently and been advised there were no concerns.

Where there were concerns about some people's individual risks, these were sometimes mentioned in a standalone risk assessment. However, these were not linked to people's care plans. For example, one person was noted as being at high risk psychologically. This was not then converted into a care plan or regularly reviewed to ensure this person's needs were being met. There were no risk assessments, or linked care plan, for people with specific health needs or people taking certain medicines; for example, people with diabetes or taking warfarin. One person was cared for in bed and there was no assessment of their ability to eat or drink safely without choking.

Not assessing the risks to health and safety of people and doing all that is reasonable to mitigate these risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The temporary manager stated they would seek to review all the risk assessments to ensure they reflected people's current needs. Referrals would then be made to relevant services through the GP, as required.

People were not protected by safe staff recruitment practices. Not all staff had the necessary checks in place to ensure they were suitable to work with vulnerable people. The temporary manager advised that five staff were identified as not having Disclosure and Barring Service (DBS) or Adult First checks in place to check their character.

Inadequate

Is the service safe?

Satisfactory evidence of conduct in previous employment or explanations of gaps in staff employment history had not been routinely sought. Only one staff file included a health questionnaire.

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

The temporary manager immediately put systems in place to protect people and seek DBS checks for the five staff without them. They also started to address recording staff recruitment in manner that would ensure all necessary checks were in place.

On the day of inspection there were sufficient staff to meet people's needs safely. The provider had advised us in July 2015 that the service was under staffed and they would take action to address this. The current and future staff rotas were showing enough staff, however, old rotas were not available to check the staffing in the past days. We were told by both people and staff there had regularly not been enough staff and they felt this was still the case. Comments included: "No, we have to wait. Since I came here the newer people need more care but no more staff have been taken on"; "Always short staffed and often agency staff brought in. More people eat in their rooms and staff are slow in bringing others to the dining room so meals are late"; "The number of staff vary" and, "Not at night when only two staff are on. What happens if they are busy with someone fallen out of bed and then another bell goes?"

People also told us staff often did not answer their request for support in a timely way. People were then taking themselves to the toilet as they could not wait for staff to come. One person we spoke with recognised this could place them at risk of falling. Another person looked uncomfortable in bed. We asked if they had called or would call staff to support them find a more comfortable position. They stated: "What's the point of ringing the bell; they wouldn't come anyway" adding, they would prefer to be uncomfortable than call staff who they viewed as "busy". Another person said that at weekends: "Not so much is done; they don't do baths at the weekend." They confirmed they believed there were not enough staff.

One visitor said, "Yes there were enough staff during the day but I don't know about the night".

Staff told us: "Lots of people need a lot of care; we have to double up a lot. Only four staff were working yesterday (12 October 2015) and it was difficult to keep up with the bells". They said in the afternoon only two staff were working and five bells went at once which made it very hard to respond in a timely way. Another staff member said: "There are sufficient staff today but, it can be very stressful due to lack of staff" and, "we sometimes can't get ahead to do the care; we have to say we will be with you as soon as we can". A third staff member said: "The lounge is not used; we don't have time to do more than care; we just bring people down for their meals and then take them back to their rooms".

People's dependency needs were being recorded however, how this was used to calculate staffing levels was unclear. One staff member told us: "Only seven people self-care; the rest require two staff." They confirmed the other 18 people required two staff for all or some part of their care or supporting them to mobilise. The provider told us at the time of the inspection three residents self-cared, six required two staff and the remaining 15 required one staff member.

We observed that the call bells rang for varying levels of times during the inspection. Most were answered within a reasonable amount of time.

Not having enough staff to deliver care safely at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider states there were sufficient staff at all times. We discussed staffing with the temporary manager and operations manager who confirmed there had been issues with staffing. They felt there were issues in respect of staff being safely distributed. We were told a new shift pattern had been introduced on the first day of the inspection and there should now be enough staff to meet people's needs. They advised they would review people's care needs and how staff were organised.

Safeguarding concerns were not always acted on. The GP advised they had raised two safeguarding concerns one in relation to giving a person their medicines as prescribed and another of a practice issue which they could not recall the full detail off. We had not been notified of these. Staff were able to identify signs of abuse and confirmed they had updated training in safeguarding vulnerable adults. Staff told us they would not report concerns about people or their care. Staff understood what whistleblowing meant however told us they would not whistle blow as they told us they had been treated negatively by managers in the past for raising issues. Also, previous concerns which they

had raised had not been acted on. Staff agreed they would share the concerns among themselves but not with management. Staff said they felt too vulnerable to share their concerns with higher management. They were not aware of the role of CQC and the local authority in respect of safeguarding. We reviewed the provider's whistleblowing policy which stated staff could only approach CQC if they were unhappy with how the whistleblowing alert had been handled at 'Stage 1'.

Not having systems and processes in place to protect people from abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the operations manager about the whistleblowing policy and staff not feeling safe to raise concerns. They stated they would address both these issues. During and following the inspection, staff raised concerns with the temporary manager which were then reported to the local authority and CQC. Action has then been taken to keep people safe. The provider told us two staff had told them of concerns in the 18 months prior to the inspection and action had been taken.

Without exception people said that they felt safe living at The Mount and their possessions were also safe. People said they would speak with staff or managers if they had any concerns.

People were not protected by safe infection control practices. Risks of infection were not properly communicated. Staff said they would only know there was an infection risk when they saw gloves and aprons outside a room. Staff told us they had been limited to using five pairs of disposable gloves on each shift which meant they were using the same pair of gloves for several people. This increased the risk of spreading infection among people. Protective aprons were not provided for staff in the laundry. Staff were observed not wearing aprons when handling the dirty laundry. One staff member was also observed handling clean laundry wearing the gloves that had been used to deliver care. We observed staff were not prioritising contaminated laundry. There were 12 bags of contaminated laundry stacked in a plastic basket leaning against the driers. Staff told us the contaminated laundry had to be washed after all the other laundry had been put through the machines. The temporary manager agreed to address these concerns with staff at staff handover.

Staff told us they had not always had the personal protective equipment they required. For example, the home would run out of gloves or toilet rolls. Staff who were responsible for cleaning also told us they would run out of cleaning products. We were told by the temporary manager that this was being addressed. A new ordering system had been put in place.

Not following safe infection control practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean with no adverse odours throughout our time at the service. All bedrooms visited and the lounges, dining room and corridors were clean and tidy and people said they were satisfied with the cleaning of their rooms. Everyone confirmed staff used gloves and aprons when assisting with personal care. A relative said: "I am quite impressed with the cleanliness". Hand sanitisation liquid was available at various locations throughout the building for staff and visitors to use. We observed staff using this after leaving a person and before going into a room with another.

The service's fire risk assessment and health and safety risk assessments were completed regularly by a specialist contractor. When we arrived at the service there was not a current list of people living within the service available. It was also not known what staff were on duty so there was no knowledge of who was in the building. People who were resident in the home on a permanent basis had personal emergency evacuation plans (PEEPs) in place. However, four people who were at the service on a temporary basis did not have PEEPs in place. The service did not have an identified system in place to ensure staff could react in the event of an emergency. The operations manager stated they thought a contingency plan should be in place but they could not find it. Under current fire safety legislation, it is the responsibility of the person having responsibility for the building to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be in the premises and how that plan will be implemented. We have passed our concerns on to the fire service to review.

Not having the means to ensure there were systems in place to meet people's needs in an emergency was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

The temporary manager ensured a current list of people in the building was available by the end of the first day. A system for staff to sign in and out was introduced. PEEPs for all people were being addressed to ensure everyone's plans were up to date and each person would have their needs known should the building require evacuation.

Inadequate

Is the service effective?

Our findings

People were not having their mental capacity assessed in line with legislation. Staff were trained in relation to their role and the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, staff were not following guidelines in relation the MCA and DoLS in practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People's records mentioned them having or not having the ability to consent to their own care. However, there were no full assessments of people's capacity which advised what they could consent to and how people could be supported by staff to consent. Decisions had been made in respect of people's care without detailing how this had been in people's best interest. People or their relatives had signed some care records.

DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. We reviewed people for whom DoLS authorisations had been requested but not yet agreed. To have a DoLS agreed, the person has to be under constant supervision and control and is not free to leave. However, one person's record for which a DoLS had been requested showed they were of low dependency and required little staff support only for personal care. Information about their mobility stated they were able to walk freely with a walking stick by themselves. If they went outside they required a wheelchair for longer distances. In relation to their diagnosis of dementia it stated: "I can suffer from short term memory loss." The person had expressed a desire to walk with staff outside to support them to remain active. In the care plan it stated they were not safe to go out on their own as they were not aware of personal safety issues. There was no MCA assessment available to show how this person lacked capacity and required their liberties to be restricted to keep them safe.

Not acting in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff always asked for their consent before commencing personal care. We had very few opportunities to observe staff interaction with people as people spent their time in their rooms. When staff supported people to the dining room for lunch and back to their rooms staff sought their consent to do this.

People's need for adequate hydration was not always met. This was placing people at risk of dehydration. In all bedrooms visited, cold drinks were to hand and drinks were provided with meals and mid-morning and afternoon. However, when monitoring people's fluid intake was required, these records showed people were not taking on adequate fluids. For example, two people with a catheter in place were identified as being at risk of urine infections and needing good fluid intake to maintain a healthy bladder and urine flow. Neither of these people were having sufficient fluid intake. One person told us they had a drink in a small tea cup with breakfast at 11am and then another with their lunch. When seen later, they told us they had only been brought a jug of water at 1pm which they were supposed to have available from the morning, to enable them to drink steadily through the day. We observed the person had less than 50mls urine output which was reported by us to the temporary management. Their catheter blocked that evening and had to be replaced. Previous records showed that of their expected intake of 1650 mls per day of fluid this was between 500-700mls a day. There was no expected outflow of urine recorded to ensure the person was passing enough urine to alert staff there may be concern with the catheter.

People's need for adequate nutrition was not always being met. One person we observed at lunch had expressed their dislike of one of the choices on offer and was offered the other which they then did not eat. The staff member present commented they hoped they would like their dessert. No alternatives were offered. Their records detailed they had refused much of the food on offer over weeks, but it did not detail what foods had been offered as an alternative. When we checked with the chef they confirmed they had not been told there was a problem or requested to prepare other foods. The chef advised they would have tried to work with the person to identify food they may like. Staff told us when family visited they ate all they were given. Their records showed they had started to have issues with food soon after they came to live at the service in June 2015. Records stated they were on a food monitoring chart because: "Doesn't like anything we make." Their MUST also showed they were losing weight. In June they had weighed 52.90 kg but their latest recording

stated they weighed 51.50kg which was a weight loss of 1.4kg. There was no record of action being taken in respect of their weight loss to ensure their nutritional and emotional needs were being monitored.

Not meeting people's nutritional needs in line with their risk assessments was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person was identified as being overweight, and the GP and dietician advice was to limit the person's food intake in an attempt to encourage weight loss. The advice from the dietician and GP had not been built into a nutritional care plan and there was no evidence the restrictions had been discussed with the person. Their likes and dislikes were not recorded and they were not supported to make decisions about how they managed their weight. We were told by the temporary manager that staff were telling the person they could not have certain foods, such as a second pudding, as they were overweight. This was publicly in the dining room. The person saw the dietician on 16 September 2015. Monthly weighing was recommended. Their recorded weight had been calculated as 'obese' however, they were too tall for the BMI (Body Mass Index) chart in use and staff had not located the BMI for taller people to ensure they were accurately recording the person's weight and BMI.

Not ensuring care was appropriate, met people's needs and reflected their preferences that also met their nutritional and hydration needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were prescribed food supplements these were not recorded in the person's care records. We became aware one person was on a food supplement because stock of this was located in a cupboard. Their MAR showed they were prescribed it but no other record. There was no nutritional care plan in place to detail they were to receive the supplement, when and how they preferred it. We spoke with the person who confirmed they had one supplement a day. They liked this to be given in the morning and for it to be cold. They told us they had not had the supplement that day "because they told me they had run out." Generally, they received it every day but there was no recording of this.

Not keeping accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chef told us new systems had been brought in to ensure the kitchen staff knew of people's needs and how to meet them. People's preferences, foods that contradicted the effectiveness of people's medicines and special requirements had been recorded. This had been reviewed in the past month. People with special diets had their needs met. Staff could use the kitchen and provide snacks and drinks for people at any time.

People told us they were given the menu each week and were asked the day before what they wanted to eat the following day. The confirmed they could contribute to the menu planning. People were positive about the food and the portion sizes. Comments included: "The food pretty good, midday excellent"; "The food is very good, enough and sometimes too much"; "The food is very good and plenty of it"; "The food is generally alright, enough and hot" and, "The food is very nice".

The recording of how staff met people's health needs was inconsistent. There were gaps in records which made it very difficult to evidence people were having their health needs met. For example, staff were advised to book an x-ray for one person. It was difficult to locate information on whether this action took place. We located a letter which was loose within the person's records. This advised the person what they needed to do before the x-ray. There was then no record which showed if there was any follow up advice or outcome of the x-ray. Another person was due to have surgery with the only evidence this had taken place being in a document of how to support the person with post-operative care.

People told us they could see their GP when needed. Advice given from health professionals was not routinely converted into people's care plans. We also observed staff had been writing advice from health professionals in the daily records which had then been archived or were unavailable. We spoke to the GP and district nurse to gauge the advice they had given about the people we reviewed. Both of these health professionals detailed the advice given and none of this was evident in the records for the people concerned. The GP and district nurse confirmed staff were not consistent in updating them consistently on people's needs. The GP advised there was a lack of communication between staff and staff would often contradict each other.

Inadequate

Is the service effective?

Some records showed people saw the chiropodist and optician as required. There was no record of anyone having seen a dentist. Staff believed this was an omission but people did see a dentist. There was also no record of people having had regular health or medicine reviews. The GP confirmed health reviews for people with diabetes, dementia and other conditions had taken place but not recorded. For example, after one person's review they advised they had given very specific advice to support this person maintain a healthy heart but this had not been recorded for all staff to follow.

Not maintaining accurate and complete records to ensure continuity of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The temporary manager advised that prior to their starting in July 2015, staff training was not as up to date as the provider expected. Since that time staff had been booked onto courses and there were plans in place to ensure all staff were updated as required. Staff had received training to meet people's needs by attending a number of courses including safeguarding adults, MCA and DoLS, food safety, fire safety, manual handling and infection control.

Staff records did not contain any information relating to induction training. The operations manager was aware of the Care Certificate however this had not been implemented at the service. The Care Certificate is a national initiative to improve standards in care and is aimed at all staff new to care.

Records of staff supervision and appraisal were sparse and the content of those available had little detail in them. There was no record of personal development. Supervision and appraisal is the opportunity for staff to consider their personal and professional development and their practice. Only one supervision record showed supervision had taken place in 2015. Staff were also not routinely having their competency observed and reviewed to support them to maintain good practice. Staff told us they had the training they felt they needed to do the job but did not have regular appraisals or supervision.

The temporary manager advised that staff were not receiving the level of training appropriate to their roles. For example, staff in senior roles had not been supported or trained to carry out their role effectively. They were seeking to address this.

Not providing appropriate support to staff, personal development, supervision and appraisal necessary to enable them to carry out their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt staff were trained to meet their needs. Comments included: "Yes, [staff are] pretty good", "Yes, but I am concerned due to people who need more nursing than in the past" and, "Staff are pretty well trained with lots of courses".

Requires improvement

Is the service caring?

Our findings

People did not have end of life care plans in place as required or details of what the person wanted their end of life to look like. One person was identified as being in the final stages of their illness. They had medicines available when required to ensure they had pain relief which would be administered by their GP or district nurse. They were also having regular visits from the district nurse and a specialist nurse. The district nurse and specialist nurse were working closely together to ensure continuity of care. The person's records showed they had the capacity to make decisions about their own care. For example, there was a treatment escalation plan (TEP) in place which had been drawn up by their GP after a clear discussion with the person. This stated the person had capacity to decide on their own future. However, there was no care plan in place for staff to provide the necessary care and support for this person at their end of life.

People's end of life needs in relation to religion and culture were not identified in their care records. This meant their spiritual needs may not be fully met as required. For example, people who identified themselves as practising a specific religion were not having their specific needs identified. Also, there were no details of their family, friends and others role at this specific time.

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

Health professionals told us they had no concerns about how people's needs were met by staff at people's end of life.

There was no feeling of the service being a home. For example, every person spent their time in their room. No one used the lounge, in which the radiators were not on and the walls needed redecorating following repairs. The dining room was laid out with tablecloths and napkins however, there was little or no conversation. One person described the dining room as: "Like a morgue". Lunch was advertised to start at 12.30pm but was not served until later with people in the dining room waiting a long time for their main meals and desserts to be served. People confirmed this was usual and complained this was unacceptable. One staff member stayed in the room but completed paperwork. There was little interaction or encouragement for people. People told us this was new and usually there were no staff in the dining room. One person added it was probably because more people needed support. People were only offered water until we asked if that was by choice. One person said: "Oh no, on a Sunday we are given juice or we can have a glass of wine with lunch." From the second day people were offered juice as well as water.

People were not having their social and emotional needs thought of as part of their basic care needs. People were not supported to interact socially or spend time together. Interaction with staff depended on whether they required staff support with their care. People told us they only saw staff when they called for their assistance or it was a set time to see them for personal care or to be served drinks or meals. Staff confirmed they were unable to offer one to one support and therefore emotional support when required.

People did not always feel in control of their care. Some people told us they were listened to by staff and encouraged to remain independent. Others told us they were not. One person replied when asked about whether staff listened to them: "Staff are very nice; some though are better than others." Everyone was satisfied that they rose and retired (with or without assistance) at a time of their own choosing. In respect of personal care, most people seemed to have body washes. When we asked a person about having a bath and if they had choice they replied: "No, we get one a week" and no more. Two other people at the dining table agreed this was the case. All confirmed they had a specific time allocated to them to have a bath once a week and there was no flexibility in this. For people who preferred a shower this seemed to take place more readily. For example, one person confirmed they had a choice in this and had more than one a week, if desired.

People told us they stayed in their room by choice but other people's records noted they would do more with their time if this was available to them. For example, one person would walk outside with staff and others would take up activities. This had not happened. Staff said this was due to issues with staffing. The temporary manager advised the service had become "very institutionalised" and staff agreed they would like to do more to ensure the quality of people's lives at the service. Staff confirmed their role was task focused. One staff member said: "Our job is personal care, toilet, wash and change people".

When we observed staff, they showed positive interactions with people. For example, staff observed at lunchtime

Requires improvement

Is the service caring?

treated people with kindness. People were encouraged to make choices in their own time. People were also supported to walk to the dining room at their own pace. Staff always asked people where they wanted to sit or ensured they sat at their usual place. On another occasion, we observed one member of staff knock on a closed bedroom door, enter and enquire if the person was all right. They commented to the person it was unusual to see their door closed so were just checking all was well. On being reassured that all was good, the staff member departed. When we asked people if they felt special to staff comments said they felt special due to "Birthday teas", or "when staff make a nice fuss over me" and "staff have a laugh with me".

People's view of the staff was that they treated them with kindness, compassion, respect and ensured their dignity was always looked after. Comments included: "All the staff are very good to me, fine with me"; "They are very kindly people. A pretty nice bunch" and, "Staff are courteous and respectful, they couldn't do any better". Relatives also told us they had no concerns about how staff spoke to their loved ones and in themselves felt welcomed. One visitor said: "The atmosphere is warm and welcoming, seems like a happy place. People do stay in their rooms. My friend is happy here". And two relatives told us: "We can't complain about the place; staff are lovely. We are always made welcome." They added: "Staff will do anything. When on holiday they kept us updated; we have no worries at all and reassured mum is safe."

Requires improvement

Is the service responsive?

Our findings

We were advised by the provider in July 2015 that no-one had a written care plan in place. We could see care plans had been written for everyone in July-August 2015. We were told by the temporary manager that the writing of the care plans had been difficult as people's records lacked the historical information to build into people's current care plans. All care plans had needed rewriting. We found the records of people's care needs lacked the detail that showed people's needs were known, planned for and therefore met. Each record we reviewed required speaking to the person, staff, health professionals to be able to understand people's needs and if they were being met. Gaps in assessments, not converting oral and written advice from professionals into care plans, putting information in different sections of people's files or not recording important information meant records were incomplete. Care plans also did not always cover people's full needs. For example, there were no care plans in place to meet people's needs who were diabetic, were on warfarin or had specific health or behavioural needs which required staff to understand how their needs should be met. There were no warning signs of when things were not right, for staff to be aware of and what action to take.

People's pre admission paperwork was often incomplete and lacked the detail for staff to use to build an initial care plan. We were told people were visited and an initial assessment of their need completed. However, there was often only "yes" or "no" responses recorded rather than the detail necessary for staff to understand how they wanted that need addressed.

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

Staff told us there was a "lack of communication" to them from managers as they were often not informed of new admissions. This meant they were unaware someone was coming to stay at the service or prepared for them.

People were familiar with the term "care plan" and most recalled signing it on a monthly basis following an informal discussion with a member of staff. Some said the care plan did not change, as their situation was stable. There was no evidence in people's records that the care plans had been reviewed. Family we spoke with had no recollection of being involved with the care planning process.

People were not always having their needs planned for and met in a collaborative manner. For example, one person had been cared for in bed for some considerable time. We asked them if this was from choice. They told us: "No, I would be up and out of bed." The new manager established from family they had been cared for in bed since May 2015. They had been admitted to the service in June 2009, but there was no clear record, and staff could not remember, when being cared for in bed started. This person said they had expressed very strongly to staff they did not want to be kept in bed. Records did not detail their choices, preferences and how they wanted their care to be delivered. They told us that they were finding having to use a bedpan very embarrassing and would prefer to use the toilet. They told us there had been an issue with hoisting them comfortably. They told us that they had found the current sling aggravated their condition but one had been identified by the occupational therapist which they found more comfortable. They told us a staff member had told them: "I can't get out of bed until the sling comes". They told us staff had told them the new sling had been ordered six to eight weeks ago. The temporary manager confirmed no sling had been ordered. This was ordered during the inspection and was due to arrive on the 17 October.

Another person had been at the service since June 2015. Their care plan was dated August 2015 with no evidence this person had any care plans in place before this date, even though they had been in the service for 11 weeks. This was despite them having side effects from their treatment and illness which required careful care planning and support. For example, they were noted to have blisters in their mouth and leg ulcers which needed staff to have specific knowledge about how to support them. Good pain support was important and they were also diabetic. There was no evidence how their needs had been met from admission until the care plan was created in August 2015.

Records showed this person had capacity to make decisions about their care. In relation to their leg ulcers it was noted they had been advised to take bed rest by the GP and district nurse for lengths of time. However, they were finding the bed aggravated their pain. The records said they found it more comfortable to stay in their chair.

Requires improvement

Is the service responsive?

Their care plan stated: "I am supposed to stay on bed rest [but] I do not always listen to advice and stay in my chair". The instruction to staff was to complete a behavioural chart on the person if they failed to take the bed rest advised. The GP and district nurse confirmed they had not been asked for further guidance. There was no evidence of raising with the person the possibility of referring them for a suitable seating/sleeping assessment in order to meet their needs in their preferred way.

Not ensuring care was person centred and not making reasonable adjustments to enable the management of people's care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being supported to remain cognitively and physically active. There were no activities or one to one sessions taking place with people. One person said: "If someone had asked me personally if I would like to go to the lounge for an event I suppose I would have gone. I needed a push". People were not supported to maintain their hobbies or outside links. The recordings of people's history ended at the point they entered the service. These records were not used to plan people's time with them. People's religious needs were not being met. For example, one person stated in their preadmission information that they were a practicing Roman Catholic and would like to see a priest often. There was no record of their religious preference in their care records or evidence this need had been met. Staff confirmed they had never known a priest be asked to visit this person..

Not providing for people spiritually, cognitively and physically was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider stated a member of the local clergy visited the service on a monthly basis to provide a communion service.

No one told us they had raised a complaint. Most people however, said they would speak to one of the managers or staff. Another person said they would ask family to raise any concerns.

The service had a complaints policy in place. People could access this information in their service user guide. Staff told us they would try to resolve a concern raised by someone there and then. This would prevent it having to become a big issue. One staff member said: "There is a formal procedure in place" and they would go to the manager if they could not resolve the issue. We reviewed a list of undated complaints received in 2015. These demonstrated people's complaints were reviewed. The content of some of the complaints related to concerns we found on inspection such as people not having their care delivered as they desired and issues with staff members medicine's practice. There was no evidence complaints were then used to change practice or improve the service.

Inadequate

Is the service well-led?

Our findings

The Mount is owned and run by the Keychange Charity. Keychange Charity is a Christian-based not for profit registered charity governed by a board of trustees. There was a nominated individual (NI) who is a person appointed by the provider to be responsible for supervising the management of the service. The NI was also the Chief Executive Officer (CEO) who was part of a senior management team. The CEO was contacted as part of this inspection. They nominated an operations manager to support the inspection but were also involved in answering questions at a distance. The current registered manager was not working at the service during the inspection. Locally, a temporary management team was in place to manage the service.

We spoke with the operations manager and temporary manager about the action plan which had been provided in July 2015 after concerns were first received. We also asked about the updated action place we received in September 2015 which informed us progress had been made to improve the service. We were advised changes had been made from July however this had not been sustained. Some areas we had been told were in place had not been progressed as reported. Evidence of supervision of staff responsible for management of the service was in place, however, it had not ensured the quality of the service locally. Oversight had not been robust enough to ensure the service was safe for people, particularly in relation to the management of medicines, infection control practices, environmental checks and emergency plans. There was no effective quality monitoring in place to ensure that people's needs were met, that people's records were accurate, complete and contemporaneous, and to improve the quality of the service for people.

Not having effective quality assurance systems in place was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CEO advised us that the concerns from the inspection had been raised with the trustees and improvements will be monitored through a subcommittee responsible for monitoring safety. The CEO advised they aim to improve services by a more robust quality assurance process through all their services. The appointment of senior posts will be reviewed and they are establishing a peer review process amongst all registered managers to monitor each other's services. This will share good practice as well as pick up concerns. Operation managers will also receive support more often from the senior management team. This will enable direction and support to be given to react to concerns quickly.

We found there was a division between the staff and management of the service locally. Staff also felt disconnected from the provider. One staff member said: "There is no morale. No one smiles; I have never known a place where morale is so low." Another staff member said: "It is sad that staff work hard, running around because they are short on staff. Morale is really low; it is very noticeable. People see this, it affects everyone". Staff said they did not feel listened to and had been told it was not their responsibility to raise concerns and ideas about how the service was run. One staff member said: "Support hasn't been there; you are left to do your own thing. Care is not an easy thing, you get fond of the ladies and gentlemen; you hope it will be turned around but when will this happen?" Staff also commented that with the new temporary management team in place, they felt things could change. Staff also raised with us they were confused about everyone's roles and responsibilities. One staff member commented: "We want it to change; it has to change." Another added: "I want to look forward to coming to work again." We discussed what staff had raised with us with the temporary manager and operations manager. They had already arranged to speak with staff on the 14 October to discuss their concerns.

There was some evidence of residents' meetings having taken place with the last one in May 2015. However, issues raised about the lateness of meals and entertainment (activities) was not addressed. There was no record that the issues had been resolved and people had received any feedback. The previous meeting had been in August 2014. Five people had completed questionnaires on the service on the 17 July 2015 and the responses were largely positive however, there were comments about the food, choices of meals available, using the garden and the lateness of meals. There was no evidence of how these issues were resolved. Lateness of meals was also raised as an issue during this inspection.

Staff meetings had taken place at regular intervals which raised issues about staffing. In June 2015 it was written: "Staff are very stressed with being short on the floor because the needs of residents have increased." Also, at an

Inadequate

Is the service well-led?

undated meeting, there was discussion about 'best practice' and how this could be encouraged with staff. However, it was noted: "Felt everyone was 'flat'; enthusiasm for good care had gone. All staff agreed."

The Care Quality Commission had not received all required notifications as required. We had not been notified of all safeguarding concerns and information affecting the running of the service. For example, we had not been told of two stair lifts not working for three weeks which limited people's ability to move freely around that part of the building. One person told us: "I would like to go out with my family, but I can't because the [chair] lift is not working."

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

There were systems in place to ensure the building was maintained however, the recording of when these took place, and therefore were due, was incomplete or missing.

However, the provider demonstrated over the week following the inspection that contracts were in place to monitor equipment, the building and ensure waste was removed safely.

The process to ensure the day to day maintenance of the building was in the process of being established. A new reporting process of breakdowns or issues that needed addressing had been started in the days before the inspection. Some aspects were not currently in place, such as ensuring water temperatures were checked to prevent scalding. There was no audit system in place to ensure water temperatures were safe. Other audits such as auditing infection control, medicines and care records had lapsed or needed to be established.

We were told there was an internet location where staff could access up to date organisational policies. We were told that all homes should have a guide available for people which would highlight what standard of care to expect; this was under development.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9(1) and (3)(a)(b)(c)(f)(h) The care and treatment of people was not always appropriate, met their needs or reflected their preferences. Assessments were not always carried out in a collaborative way with people; people were not always supported to understand the care and treatment choices available so they could balance the risks and benefits; there was not always regard to people's well-being when meeting a person's nutritional and hydration needs. Reasonable adjustments were not made to enable the management of people's care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11(1) (2) and (3) People who lacked capacity were not having their needs assessed in line with the Mental Capacity Act 2015.

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1) and (2)(3) People were not protected from abuse and improper treatment. Systems were not being operated to prevent abuse. Where concerns were raised by staff these were not investigated.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)and (2)(a)** **Sufficient staff were not employed at all times to ensure people had their needs met. Staff did not receive appropriate support, professional development, supervision and appraisal to enable them to carry out their duties.**

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18(1) and (2)(e)(g)** **The Commission had not been notified without delay of allegations of abuse and an event which prevented the provider to continue to safely meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19(1)(a)(c)(2)(a)(3)(a)** **Safe recruitment practices were not always followed. Steps had not always been taken to ensure staff were of good character, had their history checked and were able to perform the tasks appropriate to their role by reason of their health.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(a)(b)(g)(h) Care and treatment was not always provided in a safe way for service users. The registered person was not complying with: assessing the risks to the health and safety of service users and doing all that was reasonably practicable to mitigate the risks; the proper and safe management of medicines; preventing, detecting and controlling the spread of infection.

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 15 January 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1) and (2)(a)(b)(c) Systems and processes had not been established to effectively: Assess, monitor the quality and safety of the service; assess, monitor and mitigate the risks relating to the safety and welfare of people and others in the event of an emergency; records were not kept which were always accurate, complete and contemporaneous.

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 15 January 2016.