KRG Care Homes Limited

Lound Hall

Inspection report

Jay Lane
Lound
Lowestoft
Suffolk
NR32 5LH

Date of inspection visit:
31 October 2017
01 November 2017

Date of publication:
11 December 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Lound Hall is registered to provide nursing and personal care to a maximum of 43older people, some of whom were living with dementia. At the time of our visit there were 36 people using the service.

The inspection was unannounced and took place on 31 October 2017 and 1 November 2017. The inspection was brought forward due to concerns raised with us by the Clinical Commissioning Group (CCG) and because of a safeguarding concern shared with us by Suffolk County Council.

At our previous inspection on 25 and 30 January 2017, we identified shortfalls in the service which meant people did not always receive the care and support they required. We found that the service was in breach of regulations and needed to make improvements to staffing levels, the management of medicines, activities, the support people received to eat and drink and practices around the Mental Capacity Act (MCA). We rated the service Requires Improvement overall and asked them to provide us with an action plan stating how they would make improvements to the service. At this inspection we identified significant failings which put people at risk of harm. The service continued to breach regulations and had not made the improvements they were required to make following the previous inspection.

The service had a registered manager in place. 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.

People were put at the risk of significant harm in the absence of clear records and assessments which reflected all current areas of risk and how these should be managed to protect the person from harm. In particular, adequate action was not taken to protect people from the risk of developing a pressure ulcer or to identify and adequately care for pressure ulcers.

There were limited care plans available to guide staff on how to meet people's needs. For some people, there were no care plans at all and there was confusion from staff about what people's needs were and how they should be met. Relatives and people using the service raised concerns about staff's knowledge of their needs and told us they had not been involved in the planning of their care.

People were not supported to maintain good nutrition, and action had not been taken by the service to reduce the risk of people becoming malnourished.
Medicines were not managed and administered safely. Ordering and return procedures for medicines were inadequate and resulted in some people not receiving their prescribed medicines. There were other discrepancies in Medicine Administration Records (MARS) where it was unclear if medicines had been administered.

There were not enough staff to meet people's needs and provide them with support at the time they needed

it. People using the service, relatives, staff and healthcare professionals raised concerns about the staffing level.

The service did not practice safe recruitment procedures. Staff started working for the service before appropriate checks had been carried out to ensure they were safe to work with vulnerable people and had the appropriate character for the role.

People were not supported by staff to have maximum choice and control of their lives. Assessments of people's capacity had not been completed, and determinations about people's capacity had been made inappropriately. Improvements were required to the knowledge of the staff and management team around the Mental Capacity Act (MCA).

People were not supported to live full, active lives and to engage in meaningful activity within the service. We observed that some people were socially isolated and disengaged from their surroundings. People who were nursed in bed had little access to engagement or activity.

Improvements were required to the knowledge of the staff team. Staff we spoke with and observations of staff practice did not demonstrate a good knowledge of subjects they had received training in, such as nutrition, MCA and Medicines. Improvements were required to fully implement consistent supervision and appraisal for care staff and nursing staff.

There was a failure of the management team to ensure that systems in place to monitor the quality of the service were effective in identifying shortfalls and areas for improvement. The management team had not taken appropriate action to make necessary improvements following our previous inspection. This meant people had been placed at continual risk of receiving poor care.

There was not an open, honest and transparent culture in the service. People using the service, relatives, staff, healthcare professionals told us they felt a disconnect between the management team and themselves. Relatives and people using the service told us they did not feel listened to and did not have confidence in the management team to take on board their comments and act on these.

Notifications had not been made to CQC where this was necessary.

Following our inspection we were so concerned that we took urgent action to protect people. We have issued a Notice of Decision to prevent further admissions to the service and a Notice of Decision to require the provider to send us information about how they are meeting people's individual needs.

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

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

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.

There remained significant shortfalls in risk management and systems in place to protect people from harm.

Recruitment procedures were unsafe.

Medicines were not managed and administered safely.

Is the service effective?

Inadequate

The service was not effective.

People did not have their capacity to make decisions assessed and best interest's decisions were not made appropriately.

The service was not taking appropriate action to monitor people's risk of malnutrition and act on risk.

Improvements were required to the knowledge and training of staff.

Systems in place to support and drive improvement in the staff team had not been consistently implemented.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring towards people.

Widespread significant shortfalls in the service meant that people's health, safety and welfare was not upheld.

People and their representatives were not consistently involved in the planning of their care.

Is the service responsive?

Inadequate

The service was not responsive.

We observed that people were disengaged, bored and did not have access to appropriate stimulation and activity.

People's care records were not consistently person centred, and did not reflect in sufficient detail people's preferences or interests.

People had opportunities to feed back their views but told us they did not feel their views would be acted on.

The service did not learn from complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and management team failed to make sufficient improvements which meant the service continues to provide people with unsafe care.
The management team was not visible and there was not an honest, open and transparent culture in the service.

The management team failed to make notifications to CQC where these would have been appropriate.

Lound Hall

Detailed findings

Background to this inspection

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

This inspection took place on 31 October and 1 November 2017 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor in Tissue Viability. Before the inspection we examined previous inspection reports and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with six people who used the service, three relatives, four members of care staff, two nursing staff, the registered manager, deputy manager, Clinical Lead and Nursing Supervisor. We looked at the care records for 14 people, including their care plans and risk assessments. We looked at staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

Inadequate

Is the service safe?

Our findings

At our last inspection on 25 and 30 January 2017 we rated the service 'requires improvement' in this key question. We found the service was in breach of regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service needed to make improvements to medicines administration practices, staffing levels, recruitment procedures and the management of risk. At this inspection of 31 October and 1 November 2017 we found that the service had failed to improve in these areas and there were further significant shortfalls in this area which put people at risk of harm. The rating in this key question is now 'inadequate'.

Prior to this inspection we received concerning information from other organisations such as the Clinical Commissioning Group (CCG) and Suffolk County Council. This included concerns about the safety of people using the service, particularly around pressure care, end of life care and a shortage of staff. We brought forward our inspection as a result of these concerns.

People were not protected from the risks of developing pressure ulcers. We reviewed the care records of nine people assessed as at risk of developing a pressure ulcer. There were no preventative care plans in place for these people to guide staff on how to reduce the risk of them developing a pressure ulcer. Three of these people were nursed in bed and were unable to reposition themselves which made them vulnerable and completely dependent on staff to support them to maintain their skin integrity. Despite this, actions to reduce the risk were not consistently implemented. For example, people at risk were not consistently repositioned where this would have been appropriate. Where people did have repositioning charts in place, staff were not consistently repositioning them in line with the frequency specified on the chart.

In the care records for one person we noted that redness to their sacrum had been recorded in July 2017. In August 2017 it was recorded that the person had developed a pressure ulcer in this area which records indicate had healed in September 2017. At the time of our inspection we were informed that this person had developed an ulcer to this area again. We reviewed their care records and found that whilst they had been identified as at risk of developing a pressure ulcer, no preventative care plan had been put in place. We spoke with the management team, nursing staff and care staff who were unable to demonstrate what preventative action had been taken to reduce the risk of this person coming to harm.

Five people had developed a pressure ulcer, but there were no care plans in place to instruct staff on how to care for their wound and reduce the risk of further deterioration. For example, one person had a grade three pressure ulcer to their heel but there was no information for staff on how to care for the wound and prevent the skin from breaking down further. A grade three pressure ulcer is categorised by full thickness skin loss. This person had a pressure relieving mattress in place which we found was on the wrong setting according to the person's weight. This meant that its effectiveness in relieving pressure was compromised. This had not been independently identified by the service and there was no system in place to ensure that pressure relieving mattresses were on the correct setting.

There was confusion among the management team, nursing staff and care staff about who required

repositioning and who had a current pressure ulcer. On 27 November 2017 we requested information from the management team, which included the names of anyone with a current pressure ulcer. We were told on this date that two people had a pressure ulcer. However, during our visit on 31 October the registered manager identified four people with a pressure ulcer. A member of nursing staff later identified a further person with a pressure ulcer. During our inspection a visiting health professional raised concerns about the way the service managed people's pressure care and treated people's wounds. A report following a visit from Suffolk County Council in August 2017 identified areas for improvement. For example, they identified that one person required a care plan around pressure care and they told the service to implement this. During our inspection we found that this person still did not have this care plan in place, despite being assessed as at high risk of developing an ulcer since June 2017. There was no clear oversight from the registered manager of how pressure care was managed in the service and the management team were not checking that appropriate action was being taken to protect these people from further skin breakdown.

Two of the fourteen people whose records we reviewed had been assessed as at high risk of choking. There were no care plans in place to guide staff on how this risk could be managed to protect the person from harm. The relatives of one of these people told us the person had to be seated at a certain angle when eating in order to reduce their risk of choking. They told us that their relative had been admitted to hospital previously due to choking; however this was not recorded in the persons care records. The person's relatives raised concerns about staff understanding of choking and said that on occasions they arrived to find staff supporting the person to eat when they were lying flat, which increased their risk of choking. We were concerned that in the absence of care planning staff may fail to take the action necessary to reduce the risk of these two people choking.

People's care records did not accurately reflect their needs. For example, one person was now nursed in bed but their care records stated they could mobilise with the support of carers. Similarly, they were now incontinent but their records stated they were continent and required support to visit the toilet. For some people, there were no care plans in place. Whilst there was a summary of their needs, this did not include enough detail for staff to be able to provide them with safe and effective care. New staff had recently started at the service at the time of our visit and the service planned to recruit more staff. It was unclear how new staff would have the information they needed to provide care to people in the absence of accurate care records. This meant there was a risk of people receiving inappropriate care which did not meet their needs and put them at risk of harm.

During our inspection on 25 and 30 January 2017 we told the service that improvements were required to the management of risks. At this inspection we found that the service had not addressed this shortfall.

Risk assessments in place for people were generalised and did not adequately plan for the unique risks to each individual. We identified that the two staircases in the service did not have gates at the bottom to ensure people with poor mobility did not attempt to climb them without the support of staff. There were no risk assessments in place to assure us that measures were in place to reduce this risk. This meant we were not reassured that people were protected from the risk of falling down the stairs and incurring an injury.

Staff were not actively aware of risk and reducing risks to people around the service. For example, we observed that large items of furniture had been placed in communal hallways due to bedroom refurbishment. A hoist had been placed in a way which meant the protruding wheels constituted a trip hazard for anyone with limited or poor mobility. In addition, we observed that on one occasion staff had left an electrical cord across the floor in a communal hallway serving people's bedrooms.

External healthcare professionals raised concerns with us about how the service manages falls. They told us

that advice was not followed to reduce the risk of people falling and that falls diaries were not completed as advised. We reviewed the contents of accidents and incidents records and found there was no formal monitoring of these to identify trends. Where people had been identified as at risk of falls it was unclear what action had been taken to protect them. For example, there were no care plans in place for one person who had been falling regularly and was being visited by the Falls Prevention Team. This meant we were not reassured that staff had the information required to guide them on how to support the person to mobilise safely and reduce the risk of falls.

We observed that a fire alarm sounded during our visit. Staff were unsure of what to do and did not implement evacuation procedures. The management team spent time looking at the fire alarm panel and could not ascertain where the suspected fire was located. The management team later drew the conclusion that refurbishment work in the building may have set off the alarms. However, they did not call the fire brigade to ensure the building was thoroughly checked for fire. We reviewed the fire policy in place at the service which stated that when the alarm sounded, all staff should report to the nurse's station whilst closing all the doors on the way. The policy also states that in the event of an incident, the nurse in charge will inform the fire brigade by dialling 999. Our observations demonstrated that this policy was not followed and we were concerned that staff may not take appropriate action early enough in the event of a real fire.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Information shared with us prior to our inspection raised concerns about the management of people's medicines in the service. Whilst people told us they received their medicines when they needed them, we found that medicines were not managed or administered safely. We identified that three people had not received a prescribed medicine for three days in the week prior to our inspection. We spoke with a member of the management team about this, who confirmed that the nurse on duty informed them the medicines were missing. They said that they faxed the doctor's surgery to obtain an emergency prescription, however, a prescription was not received and this was not followed up by the service. This meant that these people did not have their medicines for a further two days. The management team confirmed that they had not contacted the GP for these people to ascertain whether there was likely to be any detrimental effect on their health. They also confirmed that they had not asked the GP for advice on whether it was safe to recommence these medicines immediately.

We reviewed Medicines Administration Records (MARS) and compared these with the available stocks of medicines. We found numerous discrepancies which meant that we could not be assured that people had received their medicines in line with the instructions of the prescriber.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Adequate procedures were not in place to ensure the consistent cleanliness of the environment. There were no clear roles between cleaning staff and care staff, and one member of staff said that on occasions they were there to clean but needed to go and deliver care instead because there was no one else available. They said this meant that the cleaning was not completed as needed.

Whilst we observed that the service was generally clean, carpets in some areas were heavily stained and were in need of cleaning or replacement. There were unpleasant odours in the service which indicated that cleaning practices were not as robust as they should be.

Audits and checks on cleanliness were in place, but these had not identified the staining to carpets and odours around the service so we were not reassured that these were thorough enough. There were records in people's rooms which stated when their bedroom had last been cleaned, and we saw that some of these records had not been completed for an extended period of time so it was unclear if the person's room had been thoroughly cleaned or not.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

We identified that many people using the service had bruising, cuts or wounds for which there was no explanation in their care records. Staff could not explain how people came to have these injuries. Care records demonstrated that staff recorded when they found a bruise or mark on a person. However, staff did not report these injuries to senior staff so the reasons for these injuries could be fully explored and investigated. Whilst staff we spoke with demonstrated an understanding of safeguarding and who they would report to, they did not understand that unexplained bruising could indicate abuse and should be highlighted to senior staff for further exploration. The training matrix showed that 18 of the 35 staff did not have up to date training in safeguarding.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

During our inspection on 25 and 30 January 2017 we identified the service did not have enough staff to meet people's needs and keep people safe. We told the service to take action to address this shortfall. At this inspection we found that there were still not enough staff to meet people's needs and that the service had failed to address this shortfall in the nine months between our inspections.

People and their relatives told us there were not enough staff to meet their needs. One person said, "I can wait an hour for help sometimes. I'll ring my bell and wait. Staff come in and say they're sorry but they will be back in 15 minutes. Then half an hour passes and I have to call again because no one comes." Another person told us, "It compromises my dignity if I have to wait an hour or more to [receive support around going to the toilet]." One other person commented, "If I ring the bell, I sometimes have to wait a long time for a response or they come and reset the bell and say they will be back soon, sometimes they do come back and sometimes they don't." Another person said, "There aren't enough of them [staff]. [After an event] that ended with me falling I had to wait for a long time for someone to pass by so I could call out for help." A relative said, "Staff try but they don't have the time. You ring the bell; they come and say they can't help yet because they're waiting for another carer to be free to assist them. They turn off the bell and then never come back so you call again." Another relative told us, "The staffing level is disgusting. On weekends it's even worse. And the number of staff that come in for their shift isn't necessarily the number of staff that you end up with later on because they all seem to go off early."

What people told us was confirmed by our observations. During inspection visits we found that call bells were ringing consistently throughout the day because there were no staff available to answer them. This meant that people were left waiting for support for long periods of time which compromised their safety, welfare and potentially their dignity if they required support to use the toilet. External health professionals told us they had concerns about staff shortages and that people using the service had made comments about waiting a long time for staff to help them. Staff confirmed that there were not enough staff to support people. One said, "I have recently been told [by a relative] that one person [who cannot see well] liked to have the bible read to them. I promised I would do that if I had time. I wish I hadn't made that promise now because I will never have the time to do that."

We reviewed call bell histories for October 2017. These record when people rang their bell for help and the length of time they waited for the bell to be answered. We found that on 42 occasions call bells were not answered by staff for over 60 minutes. There were 526 occasions where call bells were not answered for over 20 minutes and an additional 422 occasions where call bells were answered within 10 and 20 minutes. This further demonstrated that there were not enough staff to provide people with the support at the time they needed it and to ensure that they were safe.

The service used an industry recognised dependency tool to calculate the staffing hours needed to keep people safe and properly cared for. The calculations showed repeatedly that the service did not have enough staff to meet peoples. The records showed that appropriate staffing levels calculated in the dependency tools had not been met since it was first implemented in May 2017. Despite this, the service had not taken action to address this shortfall and had not considered other ways of managing the staffing level in the interim. For example, they had not considered the use of agency staff as a short term solution to ensure people received support from staff at the time they needed it.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

During our inspection on 25 and 30 January 2017 we found that recruitment procedures were not robust and that staff members had started working for the service before the appropriate checks had been completed. The registered manager told us at the time that they were unaware that these checks had not been completed. We told the service to take action to ensure that this shortfall was addressed.

At this inspection we found that recruitment procedures were still unsafe. Appropriate checks had not been completed to ensure that prospective staff had the right background for the role and were safe to work with vulnerable people. For example, we found two members of care staff had started working at the service before criminal records checks were completed and before employment references were received. These two members of staff were also employed without being interviewed for the role. We were told they did not carry out unsupervised personal care during this time, but one of these staff members told us they did. Another staff member who formed part of the senior management team had also started working for the service prior to their criminal records checks being completed and before adequate references had been received. We discussed this with senior staff who confirmed that these checks had not been completed. We discussed this with the registered manager who told us they were unaware these staff members had started without appropriate checks. Despite unsafe procedures being highlighted to them in January, they had failed to take appropriate action to ensure that robust recruitment procedures were followed to protect people from the risk of potential abuse.

This was a breach of Regulation 19: Fit and Proper Persons Employed of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Maintenance checks had been carried out at the service to ensure the safety of the building and the equipment within it. These included checks on window restrictors, mobility equipment, fire safety, water quality and the safety of electronic items. Where issues had been identified we saw that work was carried out promptly by the service's maintenance staff.

Inadequate

Is the service effective?

Our findings

At the last inspection we rated the service requires improvement in 'effective'. We identified that improvements were required around the monitoring of people's nutritional needs, Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) practices and staff training. At this inspection we found that improvements in these area's had not been made and further improvements were required. The rating in this key question is now 'inadequate'.

During our inspection on 25 and 30 January 2017 we identified that improvements were required to how people's nutrition was assessed and monitored. For example, keeping accurate records of how much or how little a person ate or drank. Further improvements were required to ensure that the service recognised the importance of offering high calorie foods and snacks to boost people's nutritional intake. At this inspection we found that no improvements had been made in this area.

National Institute For Health and Care Excellence (NICE) produces guidance about best practice in caring for people. These guidelines enable services to meet Care Quality Commission standards and demonstrate good or outstanding care. In terms of nutrition, NICE guidelines state that service providers should ensure that systems are in place for all people who are malnourished or at risk of malnutrition to have a management care plan that aims meet their complete nutritional requirements. We found that you had not followed these guidelines and did not have a system in place to ensure that people's nutrition was robustly assessed, monitored and appropriate action taken where necessary.

Four of the 14 people whose records we reviewed were assessed as at risk of malnutrition. There was no care planning for these people to guide staff on how to reduce the risk of them losing further weight and becoming malnourished. There was no consistent system in place for weighing people and reviewing Malnutrition Universal Screening Tool's (MUST) which assess people's risk of malnutrition. Some people were not being weighed for an extended period of time, even where weight loss had been evident previously. Staff told us this was because these people were too frail for weighing. However, the service had not considered other industry recognised methods of assessing someone's body condition, such as taking arm measurements. This meant the service could not identify whether these people's risk of malnutrition was increasing and whether they needed assistance with reducing this risk.

We reviewed the care records of one person who was significantly underweight and had a BMI of 12. A BMI of 18.5 and over is considered healthy. There was no care plan in place to guide staff on how to support the person to reach and maintain a healthy weight. The person's food intake was not being routinely monitored which meant that the service would be unable to identify if there was a decline in the person's eating. A one off five day food chart completed previously showed they ate well. Despite this, the service had not considered offering the person extra snacks and meals to increase their calorific intake. A member of the management team confirmed to us that the person wasn't offered extra snacks and meals routinely, but said they did have a hot drink before bed as a snack. Whilst staff told us the person had seen a healthcare professional about their weight, there was no record of this or what advice was given on supporting the person with their nutrition. We spoke with the person's family, who showed us supplement drinks the

person was now having. However, this wasn't documented in the person's care records so it was unclear how newer staff would know to provide these.

We identified that another person had lost 15.4kg between 16 February 2017 and 30 October 2017, which accounted for 27% of their body weight. Despite this, there was no adequate care plan in place to guide staff on how to support the person to reduce the risk of malnutrition. The person's food intake was not being monitored which meant that staff would not be able to identify if the person's food intake was declining. Staff told us they did not offer this person extra snacks and drinks to boost their calorific intake. We were concerned that appropriate action was not being taken to support people to reach and maintain a healthy weight which put them at significant risk of malnutrition.

Staff and the senior management team did not have an awareness of how people's dementia or mental capacity could affect their ability to request extra foods and the importance of ensuring they were offered snacks regularly. This meant we were not assured that these people could access sufficient amounts of nutritious foods.

A report produced by Suffolk County Council following a visit on 20 September 2017 stated that the meal time experience observed was poor. The service was told to make improvements; however, during our inspection we observed that the mealtime experience remained poor.

Meals were not served at the point at which people were ready to eat them. Instead, they were plated up in advance and left on the trolley until people arrived in the dining area or they were taken to where the person was choosing to eat. This meant that staff could not ensure that the meals were served at an appropriate temperature.

The environment during meal times was noisy. Staff were pushing noisy trolleys in and out of the room which was unpleasant and could cause distress or distraction to people living with dementia.

Staff were not proactive in identifying whether people required support to eat. For example, we observed one person struggling to eat their meal and using their knife to try and eat. Staff did not recognise this until a relative of another person intervened and asked if they needed help. The meal they had been provided with was difficult for the person to manage and staff did not offer them any support with making it more manageable. A plate guard was later provided for the person which seemed to help them eat more independently. However, when we reviewed their care records we found there was no care planning around supporting them to eat. Food preferences specified in their records indicated that the person did not like the particular meal they had been served. Kitchen and care staff told us they were unaware of this persons dislike.

People who required full support from staff waited an extended period of time for support with their meals. We observed that some people were not supported to eat their meal until 1.30pm. Staff told us one person had been supported with their breakfast at 7am that morning. This person was significantly underweight and records did not demonstrate they had been offered snacks between their meals. The person was unable to request food themselves and we were concerned that staff did not offer them any food for six hours which could have led to them being hungry and frustrated at being unable to express this need.

There were inadequate procedures in place to ensure that people were supported to maintain good hydration. The fluid intake for people was being recorded; however, the six fluid intake charts we reviewed showed a consistently low intake. For one person who was nursed in bed, there were records of them only having had 450mls of fluid the day prior to our inspection. Reviewing older records confirmed that a

consistently low intake was recorded. This person was unable to drink independently and reliant on staff to offer them drinks. We spoke with staff about whether they recorded all the drinks they gave to people. They told us they did, but that now they had more hospitality staff it was partly their job to give people drinks too. We spoke with hospitality staff, who said it was their job to provide people with a drink, not support them to drink it. There was no system in place to identify where people were not drinking enough so these shortfalls had not been identified by the management team. This meant we were not reassured that people unable to drink independently were supported to maintain safe hydration levels.

This was a breach of Regulation 14: Meeting Nutritional and Hydration Needs of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had not carried out assessments of people's capacity to make decisions. Some people's care records referred to them as 'not having capacity' or having 'fluctuating capacity' but in the absence of formal assessments it was unclear how the service had come to this judgement. The deputy manager confirmed to us that these assessments had not been completed.

Formal best interest's procedures were not followed where these would be appropriate. For example, some people had bed rails in place but were unable to verbally communicate whether or not they consented to their implementation. Staff had recorded the person couldn't consent to the bed rails and stated they were put into place because it was in their best interests. However, there were no records to indicate that these decisions had been discussed with the person's family or that other appropriate professionals were included in the decision making process. Following a formal best interests process means that a decision made on someone's behalf is agreed jointly by people involved in their care, including external healthcare professionals. This ensures that any interventions are truly in the person's best interests.

We observed that staff did not always support people to make day to day decisions about where they wanted to sit or what they wanted to do with their time. Our observations demonstrated that staff did not consider other ways of supporting people who were unable to verbally communicate their choices. For example, we observed one member of staff giving people a choice of drinks. However, when they came to one person who was unable to verbally communicate they made a choice on their behalf rather than showing the person the two options and encouraging them to make a visual choice. This meant that staff were not consistently supporting people to express their wishes.

We saw that staff did not always ask people for consent before supporting them. For example, we observed staff placing aprons on people without asking if they wished to wear them. One person told us that staff did not always listen to their wishes. They said, "There's one thing that really annoys me. [The staff] come and say are you ready for bed? If I say no, they don't just leave me to it. They get my pyjamas ready, turn the bed

down and ask me again if I'm ready for bed. Then they rush me. I have bad knees that don't always want to move. They say, 'come one move your legs.' I can't move as fast as they want."

This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People and their relatives told us they were not reassured that staff had the training required for the role. One person said, "I'm not sure really, some of them are good but then others really don't know what they're doing at all." A relative told us, "Well the training is inadequate. Most of the staff have no clue. They are told how to do things and physically shown by the management team but they still get it wrong. They might do it right for a little while but it soon tails off and we have to raise it with the manager again." A healthcare professional raised concerns with us about the training and knowledge of staff. They said that staff did not demonstrate a good knowledge of subjects such as pressure care, nutrition, dementia, end of life care and falls prevention. Some staff we observed and spoke with did not demonstrate a good knowledge of subjects they had received training in. For example, we observed staff supporting one person to eat in an inappropriate way that did not protect their dignity. We observed other staff not giving people choices and not encouraging them to make day to day decisions in line with MCA. A review of the training matrix showed that only six of the 35 staff members had up to date training in MCA and DoLS.

Staff told us they did not feel the training they had been provided with was adequate. One said they had recently started working for the service. They said they had not worked in the care sector before and felt that the workbooks they had been given for training purposes did not provide them with the knowledge they required for the role. They told us that they were upset because two carers were off sick when they had started their shift and they did not feel confident enough to carry out their role alone without other more experienced carers. Three other staff members told us they did not think the training they received was appropriate and that it provided them with the knowledge they needed for the role.

We reviewed the training matrix and found that staff required updates to much of the service's mandatory training. For example, the matrix showed that only seven of the 35 staff had received training in dementia, only three staff had training in health and safety, seven in first aid and 11 in infection control. Staff did not receive formal training in nutrition or pressure care. This meant we were not assured that staff had the appropriate training to provide people with safe and effective care.

Staff told us they did not feel supported by the management of the service and did not have access to regular one to one sessions with their manager. Records demonstrated that some supervisions had been completed by one member of the management team. However, other supervisions assigned to different staff had not been completed regularly. Staff had not had annual appraisals to discuss how they could develop in their role and improve upon their skills. The registered manager told us they were planning to implement these.

Guidance from the Royal College of Nursing and Nursing and Midwifery Council states that registered nurses should have regular clinical supervision. The purpose of this is to provide space for the nurse to reflect on their clinical practice, identify areas for improvement and discuss these with their manager. The registered manager confirmed that nursing staff had not had received clinical supervision for an extended period of time. This was confirmed by speaking with the nurses on duty during our inspections. This meant we were not reassured that staff received appropriate support and development from the registered manager.

This was a continued breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014

People told us they could have support from external healthcare professionals such as GP's when they required it. One person said, "The doctor comes regular." Another person told us, "I'm just back from the hospital, they [staff] noticed I had a bad leg yesterday and they called in the doctor. They said I needed to get it checked out." Records confirmed that staff had acted quickly to ensure that this person was seen by a doctor. Improvements were required to ensure that records of visits people had from healthcare professionals included information about the purpose of the visit and the outcome.

People told us they enjoyed the food served to them at the service. One person said, "The food is nice." Another person commented, "I enjoy my food and I don't go hungry." We observed that the food served to people looked appetising and people told us they were given a good choice of meals. One relative told us that the kitchen staff had formulated a special menu for their relative as they had several dislikes and preferences.

Requires Improvement

Is the service caring?

Our findings

At our last inspection the service was rated requires improvement in 'Caring'. At this inspection the service remains requires improvement in this key question.

We identified widespread failings in the service provided to people which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare.

The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused around good practice.

Whilst we observed that staff were kind to people, they were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

Staff were not implementing the Mental Capacity Act (MCA) effectively, and this meant that they were not promoting independent decision making. Improvements were required to ensure that care records reflected the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

People and their relatives told us they were not involved in the planning of their care. One person said, "No I don't know about any care plans. They asked me to sign something but I don't know what that was." Another person commented, "I didn't get asked what I wanted." A relative said, "I have raised lots of concerns about [relatives] care records but they still haven't offered me a meeting or anything to discuss them. They are out of date and don't say what [relative] needs anyway." Care records we reviewed did not reflect that people had been involved in the planning of their care and their views were not documented.

The senior management team had failed to address shortfalls that compromised people's dignity and respect. As a result, they were not leading by example and embedding a culture of caring throughout the service.

A lack of attention to the cleanliness and environment in the home meant people's dignity was not consistently upheld. Some areas of the service still required refurbishment and updating. Carpets in the service were heavily stained and soiled in places and there were unpleasant odours in some area's which did not contribute to a homely environment. We entered the bedroom of one person with a member of the senior management team and found there was a strong unpleasant odour. This member of staff was unable to identify the source of the odour and said they were unaware of the condition of the bedroom as staff had not informed them. This did not reassure us that staff were able to identify where people's dignity and respect was compromised.

We observed that staff did not always take practical action to uphold people's dignity and respect. We observed one person who was dressed in a way which compromised their dignity. We observed that two members of staff checked on this person but made no attempt to support them to be appropriately clothed to uphold their dignity and respect. We observed two other staff members opening the door to the toilet in a communal hallway when someone was using it and speaking to them. Conversations staff had with people about personal care needs were not discreet. For example, we observed one carer repeatedly saying "Do you want to go to the toilet?" very loudly in a communal area. The staff member did not make any attempts to move closer to the person so they could speak to them more quietly and be more discreet.

A shortage of staff meant that people were not able to receive personal care, be assisted to the toilet or get up from bed at the time they wished. One person told us that they felt the shortage of staff compromised their dignity, and told us of occasions where they required staff support to maintain their dignity but had to wait a long time for this.

Discussions with staff demonstrated that some staff knew people's needs well and knew of their individual interests. However, other staff were unaware of people's interests and preferences and therefore did not support them with these. Adequate records reflecting people's individual preferences, dislikes and personal histories were not in place which meant that newer staff were not able to learn about the individuals they were caring for.

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection we rated the service Requires Improvement in 'Responsive'. At this inspection we found they had failed to make improvements and were now 'inadequate' in this key question.

At our last inspection in January 2017 we identified that improvements were required to ensure people received personalised care, had access to appropriate sources of meaningful activity and were protected from the risks of social isolation. Improvements were also required to ensure that people's comments and concerns were acted on. At this inspection we found that the service had made no improvements in this area.

People's care records contained insufficient information about people to guide staff on how to provide them with individualised, person centred care. For example, the majority of care records did not contain sufficient information about people's likes, dislikes, hobbies and interests. Information people told us about themselves and that staff told us about people was not documented in their care records. Not all staff had knowledge of people on an individual basis and the service had recently recruited new staff. We were concerned that new or less experienced staff would not know enough about people to provide them with care that met their preferences.

Where people were living with dementia, there was limited information about their life history. This information would help staff to better understand the person and respond to their needs more effectively.

There was limited information about how people who did not verbally communicate might engage with staff and express thoughts and feelings. For example, several people using the service were nursed in bed and were unable to verbally communicate their views. However, care records did not state if they could communicate in other ways, such as by facial expression, and what these expressions might mean. We observed that one of these people did make facial expressions and movements to indicate how they felt, but as this was not documented it was unclear how staff could understand what they may be trying to communicate. This could result in people not receiving support they required to relieve their distress.

People were not protected from the risk of social isolation or loneliness. People told us staff did not have time to sit and speak with them. One person said, "They do try but they are so busy they don't have time for that." A relative commented, "I think the will is there but they don't have time to spend with people. I'm here every day because if [relative] is alone [relative] becomes distressed and I know they'll be scared and alone if I am not here." Records demonstrated that people who preferred to stay in their bedrooms received very little interaction from staff and went long periods of time without staff checking on their wellbeing. We observed that people in communal areas were disengaged with their surroundings and were not engaged in meaningful activity throughout our inspection. This meant we were not reassured that people were protected from the risks of social isolation.

People were not supported to live full and active lives because they did not have access to meaningful activity. One person told us, "I'd like to get out more, I have my newspaper but that doesn't keep me busy for

very long." Another person said, "A man comes and sings with us, that was not very long ago but it doesn't happen that often. We don't get out very often either." A relative commented, "Activities are pretty much non-existent." We observed that there was an activities notice board in the communal area. However, the activities displayed on the board did not happen during our visit. We spoke with the activities co-ordinator, who told us that they had not had any training in providing activities. They could not demonstrate to us that they had a good understanding of providing activities that were stimulating and meaningful for people. They told us they had no budget for activities and the service didn't have its own transport so people couldn't go on trips. This meant we were not reassured that people were protected from the risk of under-stimulation and boredom.

There were inadequate records in place for people coming to the end of their life, and the service was not identifying when end of life care plans should be implemented. NICE guidelines state that end of life care planning should be implemented when a person is believed to be in the last year of their life. When we asked nursing staff and the registered manager if anyone was receiving end of life care, they told us they were not. Further discussion demonstrated that these staff members did not have an adequate understanding about best practice in end of life care and at what point care planning for the latter stages of life should be implemented. There were several people using the service at the time of visit who this may have been appropriate for, but the service had not given consideration to this. The hospital discharge summary for one person dated June 2017 stated that they should be placed on an end of life care plan. This had not been implemented by the service and in a report prepared following a CCG visit on 5 October 2017 concerns were raised that this was not in place. As a result the person had been taken to hospital when this wasn't in their best interests and went against their wishes. A healthcare professional informed us of two other people using the service who they considered to be coming to the end of their life. There were no end of life care plans in place for these people either. This meant that the service was not ensuring that people's wishes in coming to the end of their life were planned for and that there were plans in place around how people should be supported to be dignified, comfortable and pain free.

This was a continued breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place and people told us they knew how to complain, but did not feel they would be listened to. One said, "I know how to complain but there is no point, I haven't the confidence changes will be made." A relative said, "I've made formal complaints but the issue is they are never sorted out properly." We reviewed the complaints folder and found that there were limited records of what action the service had taken in response to people's complaints. One complaint made by a relative stated their relatives care records were not sufficient and weren't accurate. We reviewed this persons care records and found there were still no adequate care plans in place which demonstrated that the service had not acted on this complaint.

This was a breach of Regulation 16: Receiving and acting on complaints of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 25 and 30 January 2017 we identified shortfalls in the service which meant people were not consistently provided with safe, effective care which met their needs. The service was rated requires improvement overall. We found the service was in breach of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. We asked the service to provide us with an action plan stating how they intended to improve. They told us they would complete all the required improvements by 19 June 2017.

In October 2017 the Clinical Commissioning Group (CCG) raised concerns with us about the quality of the care the service was providing to people. Shortly after this Suffolk County Council shared with us the details of a concerning safeguarding referral that had been made about a person using the service. As a result of this information we decided to request information from the service to reassure us that people's safety was ensured until we could carry out an urgent inspection. When we visited the service on 30 October 2017 we found that the information we had been given by the service was inaccurate. There had been a significant decline in the standard of care people were provided with which placed people at an increased risk of harm.

During this inspection we identified that the service was in breach of Regulations 9, 11, 12, 14, 16, 17 and 18 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. The systems in place to monitor the quality of the service were not robust enough to identify shortfalls in the service. The registered manager and provider had failed to implement a robust system following our previous inspection to ensure that people were not exposed to potential harm. For example, there was still no formal system in place to monitor daily records, pressure care or nutrition. This means that the service has been unable to identify shortfalls in these areas that have exposed people to the risk of deterioration in their health.

There was a lack of action taken by the registered manager and provider to act upon shortfalls they were made aware of in order to improve the service and safeguard people from harm. In November 2016 the Clinical Commissioning Group (CCG) raised concerns about the quality and safety of people using the service. It took the decision not to admit further people to the service whom they funded the care for. This was as a result of a visit where they identified a lack of adequate care planning and discrepancies in medicines administration.

In January 2017 we visited the service for the purposes of inspection and identified a number of quality and safety issues. We told the service to make improvements in care planning, Mental Capacity Act and Deprivation of Liberty Safeguards practices, staffing, recruitment and how the quality of the service was monitored.

In April 2017 a member of staff from the CCG visited the service and found that there remained a lack of care planning and that the care planning that was in place was poor. They raised concerns that they had requested risk assessments were updated for one person but found these had not been updated two weeks later. They informed the service of these shortfalls.

In July and October 2017 the CCG made further visits to the service and found that shortfalls had not been addressed. Following their October visit they wrote to the service stating that there were shortfalls in the staffing level, care planning in place was inadequate and did not reflect current needs and that there were no care plans in place for someone with complex needs.

On 30 August 2017 Suffolk County Council visited the service and raised a number of concerns about its quality. These included continuing concerns around inadequate care planning, conflicting information in care planning, no information around MCA and DoLS and gaps in daily charts. They informed the service of these shortfalls.

In October 2017 a GP wrote to the service with concerns about how people were cared for, in particular, how their personal hygiene needs were met and how wounds were cared for. They also raised concerns about discrepancies in medicines administration, including medicines not being administered or being administered incorrectly.

During our visit on 30 October 2017 and 1 November 2017 we identified that all the above shortfalls remained, despite them being highlighted to the service on numerous occasions. The registered manager and provider had failed to take any action to ensure that people received the care they required to protect their health, safety and welfare. They repeatedly failed to take action to ensure people were not exposed to the risk of harm.

The service failed to learn from the outcome of a complaint which was investigated by the Ombudsmen. Where complainants are unhappy with how their complaint is investigated, they can escalate this to the Ombudsmen who is an independent unbiased figure who can investigate the complaint. In this instance the complainant was unhappy with the care their relative received at Lound Hall. The investigation concluded that the care plans and other associated records were inadequate and did not evidence appropriate care interventions. For example, records did not demonstrate that the person had been repositioned at the required frequency to reduce the risk of skin breakdown. At our inspection visit we found that inadequacies still remained in care planning and daily records which meant that the registered manager and provider had not learnt from this complaint.

There were four registered nurses forming the management team at the service but there was no clarity around the responsibilities and accountabilities of each staff member. The registered manager did not recognise their overall accountability for ensuring that other members of the management team performed their role appropriately, which meant that shortfalls were not acted on. For example, the registered manager told us that one staff member had been allocated the role of completing care plans. The registered manager identified that the person was not performing adequately in their role and told us they were aware that the staff member was not implementing adequate care plans. However, the registered manager took no practical action themselves to rectify this shortfall and continued to allow this staff member to work on care planning. This meant that there remained insufficient records in place to guide staff on how to deliver people with care that met their needs and protected them from harm.

The management team did not promote a culture of openness and transparency and the registered manager was not adequately visible in the service. People using the service told us they didn't have much contact with the registered manager. One said, "I don't see much of the manager; they tend to stay in their office. Most things are dealt with by the admin and the other office staff." Another person told us, "I see the manager now and again, we don't speak but [they] pass by." A relative told us, "The manager is always in the office. I don't speak to them." Another relative commented, "I know who the manager is but I don't see much of them. I never see them getting stuck in and I'm here a lot." Whilst the registered manager told us they

participated in caring for people, staff told us that they spent the majority of their time in the office with the door closed. They commented that during our inspection the registered manager assisted during the meal time but that they had not seen the registered manager do this previously. This view was corroborated by three health professionals we spoke with, who told us they had not spoken with the manager and always dealt directly with other staff.

People and their relatives told us that they did not feel that their views and thoughts were acted on by the management of the service. One person said, "I have spoken out. Sometimes we have meetings but not often. I don't see the point in complaining because nothing ever changes." A relative said, "It happens time and time again, we raise the issue, at first everything is done right and then they stop doing it. I have no confidence in the [registered] manager." Another relative commented, "It's like banging your head against a brick wall. Nothing you say is taken on board and I don't believe any worries we voice will be acted on, they never have been before."
We reviewed the records of relatives and residents meetings from May and September 2017. These records demonstrate that people who attended raised concerns about care records, how people were cared for, staff shortages, poor communication between the service and relatives, daily records not being completed and people being lonely. The records of a survey of people's views in August 2017 shows that area's for improvement were identified. For example, nine people said that there were not enough activities to keep them engaged and stimulated. The findings of this inspection support that people's views, experiences and concerns were not acted upon and as a result people did not feel listened to.

Staff told us they did not have much contact with the manager. One told us they had been working for the service for over a month but had never met the registered manager. Another staff member said they did not see much of the manager but felt supported by other staff in the service. Staff meetings had not been held regularly to improve communication between staff and the leadership team. For example, a meeting with care staff had not been held since June 2017. Staff did not have other opportunities to express their views. For example, they were not invited to take part in surveys. This meant we were not assured that staff were involved in the ongoing development and improvement of the service.

This was a continued breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The registered manager and provider failed to make appropriate notifications to CQC where these were necessary. A notification is information about important events which the service is required to tell us about by law.

This was a breach of Regulation 18: Notification of other incidents of the Registration Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents 18— 1.Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. 2.The incidents referred to in paragraph (1) are— a. any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in— i.an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary, ii. changes to the structure of a service user's body, iii. the service user experiencing prolonged pain or prolonged psychological harm, or iv. the shortening of the life expectancy of the service user; b. any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent— i. the death of the service user

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9.— 1.The care and treatment of service users must—

a. be appropriate,
b. meet their needs, and
c. reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 10.— 1. Service users must be treated with dignity and respect. 2. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— a. ensuring the privacy of the service user; b. supporting the autonomy, independence and involvement in the community of the service user;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11.— 1. Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13.— 1.Service users must be protected from abuse and improper treatment in accordance with this regulation. 2.Systems and processes must be established and operated effectively to prevent abuse of service users. 3.Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints 16.— 1.Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. 2.The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 1.Persons employed for the purposes of carrying on a regulated activity must— a.be of good character, b. have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and c.be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. 2.Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— a. paragraph (1), or

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12.— 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment; b.doing all that is reasonably practicable to mitigate any such risks; c.ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; f.where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; g.the proper and safe management of medicines; h.assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

The enforcement action we took:

We placed conditions on the providers registration. These conditions mean the provider must send the Commission information monthly and must not admit people to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	1.The nutritional and hydration needs of service users must be met. 2.Paragraph (1) applies where— a. care or treatment involves— the provision of accommodation by the service provider, or an overnight stay for the service user on premises

used by the service for the purposes of carrying on a regulated activity, or
b. the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.

The enforcement action we took:

We placed conditions on the providers registration. These conditions mean the provider must send the Commission information monthly and must not admit people to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17.— 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a.assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b.assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c.maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; ii.the management of the regulated activity; e.seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; f.evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

The enforcement action we took:

We placed conditions on the providers registration. These conditions mean the provider must send the

Commission information monthly and must not admit people to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18.— 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2.Persons employed by the service provider in the provision of a regulated activity must— a.receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, b.be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

The enforcement action we took:

We placed conditions on the providers registration. These conditions mean the provider must send the Commission information monthly and must not admit people to the service.