Care Quality Commission

Mr D Thomas & Ms N Gilera

Downs Cottage Care Home (with Nursing)

Inspection report

183 Great Tattenhams, Epsom Downs, Surrey
KT18 5RA
Tel: 01737 352632
Website: www.downscottage.co.uk

Date of inspection visit: 24 June 2015
Date of publication: 10/08/2015

Ratings

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

Overall summary

Downs Cottage is a care home with nursing for older people, many of whom live with the experience of dementia and other mental health conditions. The home is an old property with some modifications made to suit the needs of people, for example ramps so people can access the garden, and a stair left to help people get up the stairs. However it has narrow corridors, that make it hard for people that require support to move around, and the inside of the house has not been well maintained. Facilities such as bathrooms are also limited, for example people who live upstairs have to travel downstairs to have a bath or shower, even though they have a bathroom next to their rooms. At the time of our visit 21 people lived here.

This inspection took place on 24 June 2015 and was unannounced

Summary of findings

Everyone we spoke with praised the care and support the received from the staff and the registered manager. One person said, "Staff are really good here, they know me and what I like." A relative said, "The care staff go out of their way to look after the residents."

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

The home had a registered manager. 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 did not have the opportunity to be involved in how the home was managed. The registered manager carried out a number of audits to check that a good quality service was being provided, however the provider had not responded or taken action in a reasonable time.

People were not completely safe at Downs Cottage. The home was not clean and maintenance around the home had not been kept up to date to keep people safe. Not all windows had restrictors on them, so there was a risk people could fall out.

Training was not effective at keeping staff up to date with best practice on important areas such as first aid. The examples they gave us on dealing with medical emergencies did not match current best practice guidance, so people may not be supported effectively in a medical emergency.

The service was not based around the individual needs of people. People did not have activities that met their needs and the equipment and environment was not personalised to the people that used it, for example people did not have personal equipment when they needed help to move from one chair to another, and rooms were all decorated the same.

Care and support documents did not look at the person as a whole, for example care plans did not contain information about people's personal history or personal preferences. They were based on people's healthcare needs. Records of daily care did not give enough detail to show that people received appropriate care and support.

People were supported to maintain good health as they have access to healthcare professionals when they needed them. However improvements need to be made around people's access to specialists in mobility to ensure they are receiving the best support to meet their needs.

There were enough staff to meet the needs of the people that live here, however we identified that the deployment of staff around this building should be reviewed, as should the staffing levels at night. There was a stable permanent staff team that knew the people they cared for.

The staff were kind and caring and treated people with dignity and respect.

Before people received care and support their consent was obtained. Where people did not have the capacity to understand or consent to a decision the provider and staff had followed the requirements of the Mental Capacity Act (2005). However we noted that some capacity assessments needed to be reviewed.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards to ensure the person's rights were protected.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home.

People were offered a choice of food and had enough to eat and drink.

Processes were in place in relation to the correct storage of medicine. All of the medicines were administered and disposed of in a safe way. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

People knew how to make a complaint. Feedback from people was that the registered manager would do their best to put things right if they ever needed to complain.

Summary of findings

We have identified eight breaches in the regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Risks to people from a poorly maintained environment had been identified but action had not been taken in a timely way.

Staffs practical knowledge in how to respond to identified risks such as heart attacks or choking did not always match current best practice guidelines..

There were enough staff to meet the needs of the people; however these were not always deployed effectively around the home, and night time levels were to be reviewed.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm. Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Requires improvement

Is the service effective?
The service was not always effective

Peoples rights under the Mental Capacity Act and Deprivation of Liberty Safeguards were met, however not all of the documentation had been completed correctly.

Staff said they felt supported by the manager.

People received the support they needed to eat and drink and had specialist diets where a need had been identified.

Requires improvement

Is the service caring?
The service was not consistently caring.

The homes decoration and facilities in bedrooms were not completely appropriate to meet people's needs. There was no individuality to people's rooms to show they lived in a caring environment.

People felt the staff were caring, friendly and respected them.

Staff were seen to treat people with respect, and knew them as individuals.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not have access to activities that interested them. They spent long periods of time with no activities or interaction with others. The service was not always person centred to meet the needs of the individuals that live here.

Requires improvement

Summary of findings

The service was not always responsive to people's needs. For example: by involving Occupational Therapists to ensure people had the best possible support with their mobility.

Care plans were not person centred. They focussed on medical needs, and not the person as an individual.

There was a clear complaints procedure in place. The manager was able to show what actions they had taken to satisfy the person who made them.

Is the service well-led?

Requires improvement

The service was not well led.

Records were not person centred. They did not contain information on people's history and personal preferences, nor did they give enough detail on how people received care and support.

The registered manager carried out checks to make sure people received a good quality service, but the provider had not responded in an appropriate time to act on issues raised.

People were complimentary about the friendliness of the staff and the registered manager; however they had no opportunity to be involved in how the service was run.

Care Quality Commission

Downs Cottage Care Home (with Nursing)

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 24 June 2015 and was unannounced.

The inspection team consisted of one inspector, and a nurse specialist.

We had brought forward this inspection due to concerns we had received. Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed information we had received about the service, such as notifications of accidents and incidents which the provider is required by law to tell us about, or information sent to us by the public.

During our inspection we spoke with six people, three relatives, a visiting health care professional, and six staff which included the registered manager. We observed how staff cared for people, and worked together. We used the Short Observational Framework (SOFI) to try to understand the experiences of people we were unable to verbally communicate with. We also reviewed care and other records within the home. These included six care plans and associated records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in September 2013 we did not identify any concerns at the home.

Requires improvement

Is the service safe?

Our findings

People were not always safe at Downs Cottage Care Home. Everyone we spoke with said they felt safe living here. A relative said, "I feel my family member is safe here, carers are always there to support them." We identified concerns around the maintenance and safety of the premises, and staff deployment within the home to ensure people were kept safe.

People were not always kept safe because maintenance issues highlighted by the registered manager and outside agencies had not been addressed by the provider. For example, a fire safety officer had highlighted that not all the fire doors sealed correctly and recommended these be fixed. Window restrictors were not in place on several windows on the first floor which was a risk to people. This risk been identified but no action had been taken to protect people from this risk. Some people were unable to access their call bells as they were either inaccessible to them or out of reach. People with increased mobility needs would not be able get up and operate them. The registered manager explained that they were getting quotes to get extension leads for people to access the call bells when needed.

The home was not consistently clean nor was it well maintained. People and relatives told us the home had not been maintained by the provider. Carpets around the home were worn and stained in places, as were the chairs in the lounge and bedrooms. There were malodours smelt around the home that indicated cleaning was not effective. Dust and cobwebs were also seen around the home, for example at the top of doorframes and in skylights in people's bedrooms. The sink in the sluice room was heavily lime scaled and the rack that bedpans were stored in was rusted and damaged which would make it difficult to effectively clean. Decoration and doors were marked and damaged around the home, as were items such as radiator covers and seats that people used when they bathed or went to the toilet. Window frames were seen to be rotting in places, and some windows had been sealed shut so that they could not be opened if people wished. When we raised these issues with the registered manager they were not able to show us any plan for how they would improve the environment for the people that lived there.

The provider had not taken all reasonable steps to mitigate risks of health and safety issues. **This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Risk assessments had been completed that identified the risk of potential harm. Clear plans were in place to reduce the risk to people, for example falls. Staff followed the guidance that had been recorded in these assessments. For example the risk to people from the spread of infection was minimised as staff wore disposable gloves and aprons when carrying out tasks such as supporting people to eat, cleaning and providing personal care. Risks to people from pressure sores and diabetes had been identified by staff and assessments had been completed. However the records were not as detailed as they could be to ensure that staff had the appropriate guidance on how to manage them. Staff knowledge of how to respond to some identified risks to peoples health and safety needed to be improved. For example although staff knew how to give chest compressions if someone had a heart attack, their description of the process did not match current best practice guidelines. We asked three staff members, "What would you do if a resident began to choke?" Although they did describe what they would do this did not match the protocol for basic life support as per Resuscitation Council guidelines. **This was a breach in Regulation 12of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People's medicines were managed and dispensed safely, however we did see one instance where the organisations medicines procedure was not followed. When medicines were given, best practice was not followed by the staff member giving medicine. The medicines trolley was left open and unlocked and medicines were left on top of the trolley. This meant they could be accessed by other people. The risk of this happening was low in this instance as the staff member was present in the same room.

We recommend that the registered manager review best practice guidelines as issued by the National Medical Council with regards to dispensing of medicines.

People told us that they got their medicines when they needed them. Medicines were stored and recorded in a safe way, for example medicines that required secure storage were in a suitable locked cupboard. These

Requires improvement

Is the service safe?

medicines were also disposed of so in a safe way so that they could not be misused by others. Accurate records of medicines were kept, and stock was regularly checked against these records so that people could be assured they always had their medicines available. People were asked if they would like to take their medicines and could refuse if they wished. Systems were in place to record if medicines were refused.

There was a sufficient number of staff deployed to meet the needs of people. People and relatives told us there were enough staff to meet people's needs; however we did identify some areas for improvement. Due to people's mobility and support needs, and the layout of the building the manager was unable to demonstrate how the night time staffing level was suitable to support people at night, for example in the event of an emergency. The manager was in the process of reviewing the night staffing levels to ensure there were enough staff to meet people's individual needs. We also identified periods of time when 15 people were left in the lounge with no member of staff present. For example there was a 10 minute period when no staff were in the room. The staff had left the room to support a person to the toilet. The registered manager had said that a member of staff should always be present in the room, as people were at risk of falls. Existing staffing levels matched the current identified need, and staffing rotas recorded that this level of staff had been on shift each day and night.

It is recommended that the provider review the assessment of people's individual needs to ensure that staffing levels and staff deployment around the building are sufficient at all times.

Appropriate checks were carried out to help ensure only suitable people were employed to work at the home. The management checked that they were of a good character, which included Disclosure and Barring service checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People told us they felt safe living at the home. Staff understood their responsibilities in relation to safeguarding people. Staff were able to identify the signs of abuse and knew what action they needed to take should they suspect or see it taking place. They also knew what to do if the manager or other senior person did not act on their concerns. Information for staff and others on whistle blowing was on display in the home. Where people had made an allegation of possible improper treatment the staff had referred this to the correct authorities. People and visitors were given information on how to report abuse. There was a poster on a notice board which gave details of the agencies that could be contacted if people suspected abuse was taking place.

Equipment used to support people was regularly checked to make sure it was safe to use. Items such as hoists, fire safety equipment and specialist baths were regularly checked. Other safety checks carried out included checking the temperature of the water before people were given baths to reduce the risk of scalding. Records seen were complete and up to date.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. These gave clear instructions on what staff were required to do to ensure people were kept safe. Staff were aware of their role in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

People had support from staff who had received training in order to carry out their role. People said the staff were well trained to meet their needs. However the training was not completely effective as staff's knowledge of key areas did not match current best practice at keeping staff up to date with current best practice.

The design and decoration of the home was not good at promoting peoples independence, or meeting their mental health needs. While some systems such as clear signage had been put up around the home, there was very little else provided to meet the needs of the people that lived here, most of whom lived with the experience of dementia. Walls around the home were the same colour so could cause confusion to people as they may not know where they were in the house. There were no appropriate pictures to stimulate people's memories. People's bedroom doors were not individualised so it would not be easy for people to recognise their room. One toilet seat that followed best practice with regards to people living with dementia had been fitted, but this was in an upstairs toilet that was not accessed by the people that it would benefit the most. People who lived here on a residential and not nursing basis had limited access to bathing facilities that would help them maintain independence. For example people who lived upstairs on both sides of the building had to travel down stairs if they wanted a bath or a shower, even though there were bathrooms next door to their bedrooms. These bathrooms had not been made accessible to meet the needs of the people who may want to use them.

The issues identified with the environment not meeting the needs of the people that lived there meant there was a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A training plan was in place to ensure all staff had up to date skills to support the people that lived in the home. Day to day information to give staff knowledge on specific care needs was discussed at staff handover meetings. Staff induction included a period of new staff shadowing a more experienced staff member.

Staff received regular one to one supervision meetings with their manager in line with the provider's policy. All staff had received supervision at least once in the previous three months. They were able to discuss how they were doing in their role supporting people, and any issues they may have. The management ensured that nursing staff were up to date with their professional membership by monitoring when their membership would lapse and making sure it was renewed in a timely manner.

Peoples consent was sought before staff gave care or support. On person told us, "I can make decisions for myself and they (staff) do what I say." The registered manager had an understanding of their duties under the Mental Capacity Act (2005) (MCA). Where best interests decisions had been made for people these had been recorded so that it was clear why the decision had been made. We identified that some assessments of people's capacity were not based around a specific decision, but a general assessment that they lacked capacity to make any decision.

It is recommended that the provider review care files to ensure they clearly document mental capacity assessments for specific decisions.

Areas of a person's life that they may be unable to manage themselves were assessed and plans made. Capacity assessments around managing finances were in place. These included who the legal person was that could manage them if the person was unable to themselves.

Guidance on people's rights was available to staff because information on the MCA, and Deprivation of Liberty Safeguards (DoLS) was available.

Most people's freedom was not restricted. Where people lacked capacity to understand why they needed to be kept safe the manager had made the necessary applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. It was noted that one DoLS application was in the process of being completed and the registered manager assured us it would be completed by the end of the week. The care and restrictions provided by the staff matched with what had been authorised by the local authority.

People received enough to eat and drink. People were positive about the food they had. All of them said they had enough to eat and drink. People were adequately supported to have the food that met their needs or requirements. People who stayed in their rooms were

Requires improvement

Is the service effective?

supported to eat by staff during the lunch time period. Where people had a pureed food diet each food item was separate on the plate so that the individual flavours of the meal could be experienced by the person.

People's nutritional support needs were met by staff. These needs were identified by the use of an assessment. Where people had been identified at risk of poor nutrition or hydration staff took appropriate action. The chef had a clear list of people's dietary requirements and food given matched the needs of the people. Examples included fortifying meals so they contain more calories where people were losing weight, or specialist diets to manage diabetes. People received the food that was appropriate to their identified need.

People received support to keep them healthy. The home had a close relationship with the local GP practice. People were also able to keep their own GP if they chose. Where a need had been identified, such as a person becoming ill, the appropriate agencies were consulted to ensure that person was supported to get well. People also received care and treatment from dentists, chiropodists and other healthcare professionals.

Requires improvement

Is the service caring?

Our findings

People were supported by kind and caring staff. A person told us, "They are all very good to me. I don't think I can find fault with any of them." Another said, "I feel at home here." A relative said, "The carers go out of their way to look after the residents." People's rooms were personalised with family photographs and ornaments, however for those people that did not have relatives, or they did not visit very often, the rooms were sparse with very little in the way of personal touches that showed that the room belonged to the individual.

Information was available to keep people orientated on the day/time of year, as well as keeping them informed of what was going on around the home. Noticeboards in the lounge gave information on the date, the weather, any events or entertainment that were happening.

People's needs with respect to their religion or beliefs were met. Staff understood those needs and people had access to people and services so they could practice their faith. Staff were able to identify peoples beliefs and describe how the service supported them to practice them, such as visits from local clergy.

People were involved when staff provided support. When a person was supported in transferring from a wheel chair to an armchair by the use of equipment the two care staff spoke gently to them the whole time and explained what they were doing. The person was clearly reassured. People said that staff gave them the care when they wanted it, not when staff wanted them to have it.

Staff took time to talk with people. We saw a staff member support a person to go into the garden and then sat talking with them for some time. While people were supported to eat, staff sat with them and talked with them. Staff talked with people when decisions about care or support where needed, for example when giving medicines or when people needed to be moved. People told us that staff did involve them in their care.

Staff knew the people they cared for. People and relatives confirmed that staff knew who people were as individuals and what their needs were. Staff were able to tell us about the people and their relatives, for example there histories.

Where people did not have anyone to help them understand decisions, an independent mental health advocate had been used. This meant they were supported by an impartial person to ensure any decision made were in their best interests.

People and relatives said that staff always treated them with dignity and respect. Relatives confirmed that they could visit the home whenever they wanted, one said, "The door is always open to us." Staff were seen to thank people when they had helped them with a task, such as layout out a table cloth at dinner. Staff knocked on bedroom doors before going into people's rooms. People were called by their preferred name by staff.

Staff understood the importance of protecting people's dignity. They showed this by responding quickly when people asked to be supported to the toilet. Where people needed to support in mobilizing out of chairs, staff did this quickly and ensured peoples clothing kept them covered. People were also appropriately dressed and looked clean.

Requires improvement

Is the service responsive?

Our findings

Care was not always person centred. Staff treated people as individuals but some of the providers systems were very institutional. For example until very recently people's toiletries and other items were bought in bulk and distributed to the people that lived in the home. Slings used to hoist people were not individual to the person, but shared. The majority of people needed support with their mobility; however the home only had two hoists to support people. This meant people had to wait to be hoisted. People had very little access to the outside community, and rarely if ever went out of the house. Outside areas such as the large secure and secluded back garden had been made accessible by the use of ramps. However during our inspection, which was a warm sunny day, only three people were seen to be supported by staff to go into the garden. Others who could not verbally communicate were seen to look out to the garden but staff did not ask them if they wanted to go out.

People did not always have their individual needs regularly assessed, recorded or reviewed. The majority of people who lived at Downs Cottage had mobility support needs, however very few people had received a recent review by an occupational therapist (OT). The registered manager had obtained quotes to have an OT visit but the provider had not yet authorised one to come. **This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People did not have access to activities that interested them. Although an activities person visited the home three afternoons a week, the activities were not based on individual choices, nor were they based on supporting people who live with dementia.

One person told us about how they used to like dressmaking and used to travel to a local shopping centre when they lived at home but because of their physical condition they couldn't do them anymore. No one had discussed this with them to see what support may be able to be given to enable them to try to continue with past interests. We observed all but one person spent the day of our inspection sat in the main lounge. There was a television turned on, but its position meant it could only be seen by a few people in the room. A radio was playing as well, which drowned out the sounds of the television. People sat in their chairs and stared around the room, or slept. There were no individual activities to keep them interested or entertained. **This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People received care and support as it had been detailed in their care plans. People told us that they were happy with the level of care provided by the staff. The care plans and other care documentation such as risk assessments were regularly reviewed by staff to ensure that the information was up to date. People had little input into these reviews, although relatives did comment that they were kept updated with the health of their family member by staff, and they could look at the care plan if they wished.

People's independence was promoted by staff, but only within the home. Throughout our inspection staff were seen to encourage people to mobilise on their own. Staff never rushed people. Equipment was provided to help keep people independent, such as specialist plates and cutlery so people could feed themselves. However people were not supported to go out into the community.

People and relatives knew how to raise a concern or make a complaint. A person said, "I would go to the manager, he would go through it with me. I haven't had to make a complaint yet." Information on how to make a complaint was clearly displayed in the reception area so that everyone could see it.

Complaints and comments had been dealt with effectively by the registered manager to the satisfaction of the person who made them. For example relatives had commented on the appearance of the reception area. The registered manager had reorganised it in line with the comments. Records of complaints were kept and reviewed by the manager and the provider.

Requires improvement

Is the service well-led?

Our findings

There was a positive culture within the home between the people that lived there, the staff and the registered manager. We saw many friendly and supportive interactions. One person told us, "The staff are friendly and they get on well with us and with each other."

People and relatives were not included in how the service was managed. People said they were encouraged to give feedback about some aspects of the home, for example they were asked about the food by the chef. There were no formal resident or relative meetings. People and relatives we spoke with said they had asked for these but the provider had not arranged anything. People also told us that they had not been formally asked for their feedback about how the home was run. **This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff had group meetings where they we given feedback about the service, such as areas that needed to be improved. They were also able to give their opinions and ideas about improvements. These were recorded in meeting minutes. Where possible the registered manager used these suggestions, for example having specific staff to carry out some particular duties. Meetings also covered such things as staffing issues, feedback on the management action plan, infection control due to an increase in chest infections, importance of keeping records up to date, such as food and fluid charts and turning charts. Staff said they felt supported by the registered manager.

The service did not always have good leadership and management to ensure that people received good quality care. People said they thought the registered manager did their best but the provider was not doing enough to support them or improve the home. The registered manager was unable to confirm how the home would be managed in their absence, such as illness or annual leave. There was no identified senior member of staff that had the necessary skills or training to deputise for them. This could impact on the care people receive in their absence.

The registered manager undertook unannounced visits at night to ensure quality around the care being given. This enabled them to check on how well staff supported people, and if any improvements were required. The registered manager was very visible around the home, helping people and giving advice and guidance to staff to ensure people were happy and receiving a good standard of care. However we still identified a number of concerns around the home, as this report has highlighted.

The registered manager was aware of his responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken.

Quality assurance checks were carried out by the registered manager to ensure a good quality of care was being provided to people. Monthly reports on how the service was performing were also written by the registered manager. The results of audits and performance reports were discussed with the provider. The provider did not always respond to address the issues that were raised. The registered manager had identified areas for improvements during monthly audits which had not been dealt with within a reasonable time. For example not all windows had restrictors on them to reduce the risk of people falling out of them. Issues raised by a fire safety professional around gaps in fire doors had also not been addressed, so fire safety systems would not be as effective as they could be. **This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Records of care given to people were not detailed to show that people had received appropriate support. The notes of care provided by staff were very generic and only recorded very basic information. For example when recording care given to a person with a pressure sore staff only recorded that the dressing had been changed. They did not comment on the wound, for example to say if it had been improving or getting worse. Another example was where a record had been made on a number of days that a person was coughing with phlegm. No record was made of what was being done to support the person to manage this. A record was made further on that the person had been put on antibiotics by the GP, but this was not recorded if this was a result of the cough or something else. Care plans were not person centred. They gave guidance to staff on the health care people needed. However they only focused on the health needs of the person and not the person as a whole. For example records were not kept of people's

Requires improvement

Is the service well-led?

personal histories, their hobbies or interests, or how they would prefer their care to be given. **This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment** The provider had not ensured that staff providing care had the appropriate competence, skills and experience.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.** The service did not give care that meet people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Well Led.** The provider had not sought out feedback from relevant persons for the purpose of continually improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	**Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Well Led.** The provider had not mitigated the identified risks relating to the health, safety and welfare of people that lived here.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Well Led.** The provider had not ensured accurate and complete records had been kept in relation to care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.** The provider had not designed care with a view to meeting peoples preferences and ensuring those needs were met, for example not providing meaningful activities to meet individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and Equipment.**

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured that the premises and equipment were suitable for the needs of the people who lived there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and Equipment.** The provider had not ensured that premises and equipment was properly maintained, clean or suitable for the purpose for which they are being used.