Central and Cecil Housing Trust

Queens Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Queens Court is a care home with nursing that is based in a residential area of Windsor, Berkshire. The location is registered to provide care and support for up to 62 people. Queens Court is located in a modern built, fit for purpose premises with three floors. The building is not owned by the provider and another company gives support to the provider regarding the premises.

At the time of the inspection, there was no registered manager. The last registered manager left their position in October 2014. 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. There had been no registered manager at Queens Court since the last inspection. A series of managers had been in charge of the service since then. The provider told us they were recruiting a new manager who would become the registered manager.

The last inspection was conducted on 13 October and 16 October 2014 under the 2010 Regulations. At the last inspection, we asked the provider to take action to make improvements to people's care plans and risk assessments, staff personnel files and staff training and support. The provider sent us an action plan on 1 April 2015 setting out how they would take action to address the breaches in regulations. The current inspection occurred over two days on 2 November and 5 November 2015. We found that compliance had not been achieved by the provider with regards to the previously breached regulations. Further breaches are evident under the 2014 Regulations.

People's feedback regarding Queens Court was mixed, but overwhelmingly critical. They told us that they felt there were too many agency staff working at the care home and this impacted on the quality of the care they received. They also told us that their social and emotional needs were not taken into consideration and there were too few activities, including outings. Several people told us they had provided feedback to staff and management, but often they felt this had not been listened to and no changes were evident as a result. Despite this, people told us about their favourite staff members and that staff were mainly kind and gentle. When we spoke with relatives and visitors they confirmed what people who live at the home told us.

A number of professionals who visited the care home or were involved because of people's care arrangements expressed their concerns regarding the standard and quality of care at Queens Court. They also told us they were concerned about the lack of leadership, the high use of agency staff and the absence of social activities that people could take part in. Other agencies had increased their monitoring of the service and required the service to keep in regular contact so that people's safety was not further compromised.

People were safeguarded from abuse and neglect at Queens Court. Staff demonstrated good knowledge of what to do if they suspected someone had been inappropriately treated. The provider was reporting instances where this had occurred to the local authority.

Staff handling medicines had not received satisfactory training or competency assessment to support them with this role. Appropriate protocols were not in place for the administration of 'as required' medicines. The location had ordered and overstocked too many medications, leading to wastage.

There was an insufficient investment in staff training. Some staff had not received important training in topics like fire safety, mental capacity and moving and handling. This meant people were at risk of receiving care from staff that did not know how to provide safe and effective assistance. Staff had also not participated in regular reviews of their performance with supervisors. Areas for staff improvement had not been discussed with individual team members.

People's privacy was maintained and they were treated with respect. There were some examples of staff 'going the extra mile' when it came to people's care. On the whole however, people did not feel part of the service. They told us they had little or no input into the management of the care home. They felt that when they did get to have a say, their opinion was not taken into account by the provider.

People's care plans and risk assessments required improvement to provide the best care for them. We found examples where the construction of the care documentation was not followed through to ensure gaps had not developed in the planning. Some people and relatives told us they had been involved in the creation of their care plans, and other people said they did not know about them.

We found people's care was task-focussed and not person centred. We observed people taken to communal lounge rooms in wheelchairs where they sat in front of loud television sets, or fell asleep without staff present. At meal times, people were taken to the dining room and had sufficient to eat and drink, but it was not a sociable environment.

People and relatives were concerned about the leadership and management of Queens Court. They told us they could not determine who was running the care home because there had been many changes in the management. There was not a strong system in place for monitoring, auditing and driving improvements in the quality of care. The provider failed to tell us about important statutory events associated with the care and management of the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

registration.

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

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.

Oversight of maintenance of premises and equipment was not robust, meaning people had been placed at unnecessary risk. Where risks were identified, they were not always actioned in a timely manner.

Insufficient staff were deployed. The location employed no permanent registered nurses that worked on the floor and therefore a complete reliance for agency nursing staff to work with people. Numerous shifts each week were also filled by agency care assistants.

The location did not follow national guidance and standard practice for infection prevention and control in care homes, which placed people at risk.

Is the service effective?

Inadequate

The service was not effective.

There was insufficient appropriate training and supervision for registered nurses and care assistants to ensure they had the knowledge and skill necessary to effectively care for people.

The location failed to follow the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Most staff had not received training in mental capacity principles and restraint. There was no evidence of best interest decision making for people.

People received adequate nutrition and hydration, although improvements were required with the service and delivery of meals and drinks to prevent malnutrition and dehydration.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found limited opportunities for people to provide feedback about the service and to be involved in how the location was managed. People felt that their comments were not listened to.

People's comments about the care they received from staff were positive. They said that staff were kind and permanent staff knew how to care for them.

People were treated in a dignified manner and privacy was maintained when tasks like personal care were carried out.

Is the service responsive?

Inadequate

The service was not responsive.

Risk assessments and care plans were rewritten. However, risks for people were not always followed up by care plans or evaluated to ensure they were still valid. Inconsistent risk assessment meant sometimes people's care was delayed by failure to involve the multidisciplinary team.

People's social and emotional needs were not always taken into consideration. There was a lack of activities that kept people motivated and promoted a positive well-being.

Complaints were ineffectively investigated, managed and responded to. There was a lack of documentation associated with responsive complaints handling.

Is the service well-led?

Inadequate

The service was not well-led.

There was still no registered manager more than a year after the previous one left their position.

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service.

A robust system for detecting areas for improvement was not in place. Trends and themes in items like incidents and accidents were not used a learning tools to improve the care people received.

Queens Court

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 2 November and 5 November 2015 and was unannounced.

The inspection team comprised an inspection manager, two inspectors, a pharmacist specialist, a specialist advisor in adult social care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Prior to the time of the inspection a Provider Information Return (PIR) had been requested, and one was submitted by the provider on 28 July 2015. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke with 17 people who used the service and 11 relatives or visitors. We also spoke with the provider's nominated individual, the clinical services manager, the estates manager, the area manager, the deputy manager and thirteen other staff. Outside of the home we contacted the local authority, Clinical Commissioning Group (CCG), a GP and district nurse.

We looked throughout the home and observed care practices and people's interactions with staff during the inspection. We reviewed ten people's care records and the care they received. We looked at people's medication administration records, (MAR). We reviewed records relating to the running of the service such as six personnel files, staffing information, documents associated with the equipment and premises and quality monitoring audits.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service that could not communicate with us.

Inadequate

Is the service safe?

Our findings

At the previous inspection on 13 October and 16 October 2014, the provider was found in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Care and welfare of people who use the service. An action plan was received from the provider on 1 April 2015. On this date, a new set of regulations also commenced operation. Although this inspection was under the new regulations, we also looked at whether the provider had made improvements since the last inspection.

We asked people if they felt safe living in Queens Court and received mixed feedback from their feelings. For example, one person told us: "It was much better when I came here a few years ago. Manager came and went, then another. I really don't know what is going on here anymore so it doesn't feel as safe as it was". Another person said: "Not safe; they don't care about you here". However, some people demonstrated they felt secure with their feedback. One person stated: "They look after me well enough. Things feel safe and sound". Another person commented: "…I feel safe enough; lock on outside door so nobody can get in". We saw the provider had some external closed circuit television (CCTV) monitoring people's safety, had locked doors on the entrances to the homes, but not the floors, and staff that checked who was coming in when they were present in reception.

We looked at the provider's policy for safeguarding last revised December 2014. This was satisfactory and explained what staff and managers must do in the event that abuse or neglect of people is alleged or evident. We noted a large increase in the number of notifications to the CQC since the start of 2015, and so we looked at the provider's evidence they were protecting people from abuse. However when we looked at the provider's folder containing documents associated with safeguarding, we noted that information was missing, thorough investigations had not been recorded or retained and that analysis of themes and contributing factors in cases was not considered. This meant people were at continued risk of harm because of the provider's lack of a robust process for the identification, recording and analysis of abuse or potential abuse. Staff that we spoke with throughout the inspection were able to adequately describe what they would do in the event of neglect or abuse and mostly stated they would report to managers. However, staff were not aware they may have to notify other authorities like the safeguarding team, police or CQC.

We saw the service used paper-based risk assessments, care plans and other documents related to plan and record people's care. At the inspection, the area manager explained that Queens Court had moved away from a common computer-based care recording system because they had identified a failure to keep an accurate and contemporaneous record of people's risks and care plans. We found not everyone's care plan documents had been transferred to paper yet. We asked the provider to specifically point out people's care plans that were completely rewritten, and at the time of the inspection 20 were finished.

During the inspection, we noted some staff had continued work on assessing and recording people's risks in order to ensure all care plans being rewritten and updated. We looked at ten people's recently updated risk assessments and care plans. We could see that better risk assessment and care plan records had been written. We saw that information specific to risks like moving and handling, eating and drinking, falls and bathing had been completed. However, when we asked staff about the content, they told us they did not

always read it, know it or use it to inform their assistance with people's personal tasks. One person we spoke with confirmed they felt this, but also stated they were previously asked for input into their care plan. Another person we spoke with stated that agency staff in particular did not know her care preferences.

We looked at risks to people from buildings and equipment. No maintenance person was employed at the location, and an external contractor provided four hours of 'handyperson' duties each week. We toured the building and looked at required records for maintenance risk assessment and management. At the time of the inspection, we asked about portable appliance testing and managers told us this had not recently been conducted and was now overdue. During the inspection, a qualified electrician came to test items and three were unsafe for use due to electrical risk.

We looked at the records for the prevention of Legionella in the water supply and stores. We saw a risk assessment dated 5 December 2014 had rated the overall risk rating as very high. The risk assessment concluded that risks were due to stagnation of water in some parts of the building, debris in cold water tanks, temperature control issues with supply and calcification of fittings and fixtures. A total of 25 management controls were reported in the risk assessment, but none had been signed off or dated as complete. Another contractor had examined water storage and temperatures on 21 January 2015. This corroborated what the risk assessment had concluded. We were shown records of limited water temperature testing and flushing of seldom used taps by the administrator who performed this role. However, they had not been trained or assessed as competent in completing this task and covered only random small parts of the building. The administrator also did not complete descaling of taps and water outlets like shower handles, which is a necessary preventative mechanism.

We looked at fire safety around the building. We saw that one fire escape route outside had been blocked by a trolley with compost on it, a wound up garden house on the path and a tap that was constantly spraying water on the paving and had created a slip hazard. We pointed this out to the administrator who stated they would report this for repair. There was a fire risk assessment dated 9 September 2015 which contained four 'significant findings'. However, the actions had not been completed at the time of the inspection and were not signed off or dated. The service had a fully functional fire alarm system and panel, emergency lighting, fire extinguishers and necessary fire doors. The provider's estates manager provided evidence that routine testing and servicing of these items was conducted. We found that routine checks required by the fire safety regulations were not always conducted and were being carried out by a staff member who was not trained to do so. Additionally, doors across the building were consistently held back for ease of access, but not by appropriate door restraints. We have referred our findings to the local fire authority for their consideration.

Other routine maintenance included safety checks of electrical fixed wiring, gas appliances, the passenger lift, bath hoists and moving and handling hoists. We noted the local authority environmental health officer had visited the kitchen in September 2015 and made remarks in their report about the seal of the meat fridge and the waste disposal system in the sink. When we asked staff in the kitchen, they confirmed these items needed repair but that no maintenance staff had commenced work on correcting the issues.

This was a breach of Regulation 15 (1) (a) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the previous inspection on 13 October and 16 October 2014, the provider was found in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Requirements related to workers. An action plan was received from the provider on 1 April 2015. On this date, a new set of regulations also commenced operation. Although this inspection was under the new regulations, we also looked at whether the provider had made improvements since the last inspection.

The provider had a recruitment and selection policy dated February 2014 accompanied by guidelines dated December 2013. When we looked at the policy and guidelines, we saw that little information was captured to assist managers understand the types of documents they should have checked, copied and recorded. The role of each staff member involved in a new staff appointment was not clearly detailed. The policy detailed procedures for recruitment dated before the latest set of regulations commenced on 1 April 2015. They did not capture the enhanced legislative requirement to ensure fit and proper persons were employed.

We looked at six personnel files to assess how new staff applicants were recruited and what documents were checked and recorded. The administrator advised that recruitment files were not saved at the care home, and had to be sent electronically from head office and printed out. We saw that inadequate assessment processes had been followed at the interview stage which ensured fit and proper persons were employed. Although a previous manager had used templates with suitable questions, they had not rated candidate responses and instead had offered roles regardless of knowledge, skills, experience or competence to work in that role. In addition, some personnel files had gaps in required documents. We saw some new starters did not have previous relevant qualifications recorded had gaps in their provided previous employment history and did not have their reasons for leaving other similar roles noted. For one staff member, a single check of previous conduct in prior employment was on file whilst another had not received a full Disclosure and Barring Service (DBS) criminal record check and should have been working under constant direct supervision.

The care home suffered from an ongoing registered nurse recruitment and employment problem which had left no permanent nurses, except the deputy manager, working on the floor. This meant that the location ran completely on external agency nurses at the home for all shifts. We were told by managers that this equated to six full time nursing positions being unfilled. When agency nurses came to the home, the location failed to check nursing registration details, identification and criminal history checks undertaken by their employer. These had to be printed out from a computer system. When we looked at four examples of the agency profiles for nurses we were provided, we found three had outdated nursing registration details on file. Despite recognition of potential factors that impacted on the permanent recruitment of nurses, like hourly wage rates or the cost of living near the location, the provider had taken little positive action to alleviate the situation. The area manager explained that a sign had been placed at the front of the building and vacancy advertisements had been authorised to go in newspapers, journals and online. On occasions, the deputy manager was required to work clinically on the floor in lieu of any other nurse.

This was a breach of Regulation 19 (3) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's feedback indicated they were not satisfied with the number of agency staff that worked at the home. One person said: "Don't have enough regular staff. Some agency staff fine others couldn't care less". Another person we spoke with also stated: "Sometimes I am on the call bell for a long time before anyone [agency] comes to help". The area manager explained that on the two floors where nurses were not positioned, 'senior' care assistants were the team leader. This had increased the management and deployment of other care assistants on that floor. Permanent care assistants were employed at Queens Court, although there was a significant regular usage of agency workers to fill full time equivalent roles. When we spoke with care assistants, they explained that turnover was high in their opinion and that newly recruited staff often came and left soon after. We looked at two months of staff attending shifts, including agency, for September and October 2015. We saw that agency care assistant usage fluctuated throughout the period of staffing we examined. In some weeks, agency workers on one floor comprised more than 30 per cent of all staff for the whole week, meaning people did not always receive care from staff that knew them well. On a small number of occasions, agency workers made up 50 per cent of staff on a floor's shift.

When we asked what system the care home used to calculate safe staffing numbers, the provider could not demonstrate any method of determining appropriate allocation of workers to people's needs. We asked whether any dependency tools were used in calculating staffing levels, but the provider did not utilise them for planning staffing. In people's care records, there was also no assessment tool of each person's needs and therefore no indicative calculation of how long each day they needed assistance for. The provider gave us a copy of their "Philosophy of Care" which demonstrated Queens Court would always aim to offer a ratio of "one staff member to five people" who used the service. We saw evidence that this ratio was consistently maintained in the rota records we reviewed. However, using a ratio meant the provider did not take account of alterations in people's care needs, admissions and discharges and times where extra staff may be required, like celebrations or outside excursions. In addition, as no activities coordinators were employed at Queens Court, care assistants were expected to ensure people's social and emotional needs were met. However, throughout the inspection, we observed people placed into lounge rooms in wheelchairs sitting in front of television for long periods of time, and other people confined to their bedrooms with no social stimulation.

This was a breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The medicines management processes in the care home did not ensure people would always receive their medicines safely. We observed three senior care assistants administering medicines to people. The carers had received some medicine training but they had not completed competency assessments to confirm that they could administer medicines safely. This put people at risk of receiving care from staff who were not fit to perform the task of medicines administration.

We saw medicines being administered up to two hours after the prescribed time and staff told us that this was a routine occurrence. This meant that people may have received doses too close together, for example painkillers and antibiotics. Medicines prescribed 'as required' (PRN) were offered to people but there were no protocols in place to support staff to administer the medicines to meet the needs of the residents. We noted that some people with limited communication ability had PRN medicines prescribed. There were no notes in their care plans or medication administration record (MAR) charts to inform staff when they should give these medicines. We could not determine if residents were always receiving their medicines as prescribed.

We saw that sometimes handwritten additions were made to people's MAR charts, but the care home's medicines policy was not always followed to ensure that the entries were signed by two people. The practice of one staff member handwriting medications on the MAR meant people were susceptible to medication errors, as the updated entry had not been cross checked by another staff member.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were stored securely and at the correct temperatures. In the treatment room there were large quantities of unwanted and expired medicines waiting for disposal in unmarked boxes. There was a risk that these medicines could be inadvertently used for people who use the service. Overstocking and wastage of medicines was confirmed to us when we spoke with other external professionals who had a relationship with the home.

Medicines that require additional controls because of their potential for abuse like controlled drugs (CD) were stored appropriately within the treatment rooms. When a controlled drug was issued from the stock

the records that we saw had the signature of the person administering the medicine and a witness signature. Staff told us stock checks were completed once or twice a day at shift handover. However, we found for one medicine the records were incorrect as the book showed that there was none present but there was some of this medicine in the CD cupboard upon checking.

The care home received pharmacist support from the community pharmacy and Clinical Commissioning Group (CCG). The CCG Pharmacist had recently reviewed all people's medicines and was liaising with the doctors to discuss the findings of the review.

Infection prevention and control was unsafe. On inspection of most areas of the care home, we found communal areas like lounge and dining areas clean. We saw cleaners involved in their work and that they used trollies with chemicals, some of them corrosive, on top. The trollies were not secured and often left outside bedrooms while the staff member attended to the cleaning. People were at risk of harm if they took one of the cleaning agents and spilt it or accidentally consumed it. We found dishwasher tablets unsecured in cupboards inside communal kitchenettes. Although safety data sheets for the chemical were in a folder, these were out of date and some were missing. We also observed both cleaners and staff members wearing long sleeved garments during their shift which could be dragged into bodily fluids or cause cross-contamination of other surfaces. Although cleaners were employed, several areas of the building were not kept satisfactorily clean. These included communal bathrooms which were observed to be used for storage of equipment and stores, and the cleaners' own storage cupboards which had not been cleaned between daily uses. In one cleaning store, we observed that chemicals had spilt onto the shelf, causing corrosion of the shelf and the risk the shelf could break or fall. We pointed this out to management. Staff we spoke with did not know who the infection control lead or 'champion' was. Managers we spoke with were unable to name and could not produce a copy of the guidance document updated in 2015 from the Department of Health regarding care home infection preventions and control. Documentation regarding cleaning that had occurred was not adequate to show the exact locations each day, the frequency for each task and not stored in a place convenient to the cleaning.

This was a breach of Regulation 12 (1) (2) (h) and Regulation 15 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the previous inspection on 13 October and 16 October 2014, the provider was found in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Supporting workers. An action plan was received from the provider on 1 April 2015. On this date, a new set of regulations also commenced operation. Although this inspection was under the new regulations, we also looked at whether the provider had made improvements since the last inspection.

We found people were still at risk of being supported by staff without appropriate knowledge and skills to carry out their roles and responsibilities because not all staff were up to date with their training. When we spoke to various staff on the days of the inspection, all of them could tell us that they had completed various training in the preceding year. Topics that staff had attended included moving and handling and safeguarding. However they explained that they found it frustrating to travel mostly to London for the venue. One staff member we spoke with thought having more training on site could be beneficial. Another staff member told us their training was fragmented and they did not know when topics were offered or repeated. We looked at the provider's training master record dated 5 November 2015. There were obvious training topics where only a few staff had a recorded attendance such as fire awareness, food hygiene and pressure care and management. In other topics like safeguarding, infection control and fire safety we noted too few staff had attended or renewed their training. This put people at risk because staff did not have current knowledge of important safety topics. In other topics like handling dangerous chemicals, there were no recorded entries for staff training.

We saw the provider had created a short term training rota for November and December 2015. This showed the topics, dates of the subjects running and how many staff could attend. The provider was unable to tell us how many staff were already booked on these courses. We also spoke with a staff member who acted as a trainer for the company and mentor for new staff members. We saw there were clear agendas for induction training in week one including basic fire awareness and safeguarding and that staff shadowed more experienced team members for other days. We also looked at the induction training for four new care assistants who had commenced at Queens Court in either September or October 2015. The trainer explained that new care assistants had commenced Skills for Care's 'care certificate' and each staff member was part of the way through. The trainer told us that the home had not replaced the 'common induction standards' with the 'care certificate' until recently, based on advice received. This meant that the location was not well-prepared for industry changes that could affect the individual training of new employees.

The registered manager told us staff received ongoing supervision meetings with their supervisor and regular appraisals. Despite repeated requests at the inspection to look at staff supervision dates for 2015, the provider was able to supply only October's completed supervision list. We saw 15 staff had participated in a supervision meeting in October. There was no assurance that staff had been involved in supervisions over a longer term, and the manager told us this would involve looking in every single staff members records to determine dates. Evidence of annual objective setting and performance appraisal with staff was also lacking.

This was a breach of Regulation 12 (1) (2) (c) and Regulation 18 (2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 is legislation which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision-making within a legal framework. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found the provider was not operating in line with processes for seeking consent and restraint of people. Staff records we viewed did not contain information pertaining to staff training in MCA principles, however when we spoke with them they could tell us basic information about how to assist people make decisions. In addition, in the care files we viewed we could find little information about people's capacity risks or care plans that supported people with assessed mental incapacity. There was not a clear encompassing process for determining people's consent to important decision making. However, we noted that for basic tasks like entering a person's bedroom or where people's privacy needed to be compromised because of showering or dressing, staff asked for and sought permission first.

The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a lawful way to deprive someone of their liberty, provided it is in their best interests or is necessary to keep them from harm. At the time of the inspection, one DoLS had been authorised by a local authority and was being approved extended as needed. Another DoLS application was made leading up to the inspection, but had been refused by the local authority. When we spoke to managers, they were also unsure of a significant Supreme Court judgement in March 2014 which redefined how DoLS should be assessed and prioritised. This meant that not all people who lived in the home without capacity had a DoLS application underway or submitted. In view of the Supreme Court case findings, the provider had not acted in line with the revised definition of what constituted restraint. In some files we viewed we saw DoLS referral forms had been completed and stored for people where it was not required. For example, a person who is deemed to have capacity does not require DoLS authorisation, however a care assistant had completed one because they thought everyone needed it. This was unnecessary. Mental capacity assessments are also time and decision specific, and therefore require repeating, but we could not see evidence in care files for this. We asked to see any best interest decision meeting minutes or outcomes and the provider was unable to show any. Staff were uncertain about whether best interest decision meetings, use of advocates or other decision making tools like enduring power of attorneys of Court of Protection appointed deputies were in place.

This was a breach of Regulation 13 (5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with people about food and nutrition and their reaction was mixed. Some people were satisfied with the meals. For instance, one person told us: "I have only had four bad meals in 16 months". Another person said: "I can't describe it. I like and ask for a plain omelette - always comes with something in it. What you ask for, they don't take any notice". A person who had diabetes explained they were satisfied because they received appropriate marmalade and other foods. A relative we spoke with was not impressed by a meal served on one day of the inspection. They said: "The food varies in quality. The liver today was very poor quality".

During lunchtime we spoke to care assistants who were aware of people's dietary requirements. These were

checked against information sheets before meals were given out. We saw that staff were aware of people who had medical conditions such as diabetes or gluten allergy and ensured that they received the correct meals. In addition to regular food people were getting, soft, fork mashed and pureed meals were provided according to a small number of people's needs. All meals were well presented, especially the pureed ones. People who required fortified meals were reliant on prescription based products but we were told plans were in place for the kitchen to produce their own fortified food.

Although there were holders outside dining rooms and on dining tables, menus were not changed or not in place when we inspected. This meant people could not view in advance what meals they could choose. We observed that on multiple occasions, people did not always have access to drinks. This occurred when they were moved into the communal together in front of the television. On one occasion, seven people were seated in the lounge, none of whom could move and each without a drink. In other instances, we saw people in their bedrooms seated or lying in their bed without fluids. There was a risk that people would be dehydrated without regular access and encouragement to take liquids.

When we visited the main kitchen, we spoke with a chef and kitchen assistant. They showed they knew most people's preferences for meals and snacks. They also had knowledge of any intolerances and allergies that specific people had and could prepare meals that took this into account. Menus were rotated and changed for the season. We asked about how people's input was sought in preparation of new menus, but were told that little or no input from people using the service was taken into account in menu design.

Food temperatures were safely checked and recorded for catering food trollies and fridges. However, on floors where kitchenettes and under bench fridges were located, temperature checks were not always recorded. Where they were recorded, some readings were in excess of 10 degrees Celsius. The kitchen staff told us they were not responsible for the kitchenettes on the floors.

There was good support to the home from health professionals in the community. The local GP surgery provided clinics to people on site twice a week and ensured that minor illnesses were detected and managed, where possible, without transfer elsewhere. We spoke with one GP whose feedback was mixed. The GP explained that trying to obtain continuity of care for people was difficult, in part because of the high use of agency staff. They felt there was some caring staff who had people's interests "…at heart". However, the GP had moved back to paper prescribing from electronic prescribing due to mismanagement in the ordering and stock control at the care home. A district nurse we spoke with had similar comments when questioned. They said they felt changes in management caused confusion for staff, which then reflected on the quality of the care people received. They were also concerned about damage to people's skin from pressure and the failure to provide relief, and a lot of safeguarding cases in the past. The nurse said they had provided specialist training to staff at Queens Court in the past in using syringe drivers for end of life care.

Requires Improvement

Is the service caring?

Our findings

People provided mainly positive feedback regarding the relationships they had formed with staff. One person said: "They look after us in a fair way" whilst a different person told us: "They look after me well". A third person commented: "They can look after you here if you want them to". Another person stated: "Some carers are much better than others. I find it difficult to understand some of them". A different person we asked said: "I have some very kind carers". We asked a person if staff knew how they liked to be treated. They replied: "Carers who know me, know what I like and the way I like to be treated". Relatives' comments matched those of people who lived in the care home. For example, a relative said: "[X] is always very clean and tidy. She seems well cared for" and another relative stated: "There are two lovely carers who work here and I feel that I must pay tribute to them".

There was some ability for people to be involved in the running of the service, although this had been limited in 2015. There was evidence of only one 'residents' meeting held in March where people talked about staff uniforms, dining, outings and activities. It was clear that despite having one chance to tell the provider how they felt; there was no evidence people's views were taken account of. There had been no increase in activities or outdoor trips since the March meeting, and no further meetings. The managers could not show an action plan or a list of steps they took when people gave this feedback. Although we asked managers for evidence that surveys, questionnaires or other methods of seeking people's feedback about the service was in place, none was provided. When we spoke with relatives, they also could not remember the last time that they had been offered the opportunity to provide their opinion.

This was a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's privacy and dignity was maintained when they lived at Queens Court. We saw that doors were closed by staff when personal care took place and other staff that came to the room knocked and sought consent before entering. People were neatly presented and suitably dressed in communal areas. The outside of people's rooms was not personalised so they could easily recognise the door along a long corridor. However we saw that inside people's bedrooms they had decorated with their possessions including photos and pictures.

Inadequate

Is the service responsive?

Our findings

Visitors we spoke with told us that they were consulted about their relatives' care and were kept informed when anything changed. Some people, including staff, told us that they felt unsure about who they could raise concerns with. They were not sure that they would be listened to and that their issues would be addressed. They linked this to not really knowing who was in charge and to poor lines of communication. Some people we spoke with confirmed that they felt that they had been consulted about their ongoing care and that they had attended review meetings. Evidence of good practice we saw was that people's 'life story' was completed for some people, which gave a holistic picture of the individuals.

We looked at ten sets of care records during the inspection. We found that care documents did not always match up with the care that people received. In one example, we saw that in the nutrition section, the notes stated the person may need food cut up. However, there was no relevant plan of care available which detailed how food would be presented for the person. In the eating and drinking plan of another file we viewed, there were no records to indicate that the person's needs had changed over time. This was despite the fact that over the past few months, there was a change from eating normally to requiring thickened fluids with an increased risk of choking and aspiration pneumonia. There was no evidence in the person's file of a speech and language therapist (SALT) involvement or as to which stage the thickened fluid should be.

In another folder, we saw the person's care plan was last evaluated on 23 May 2015. There was a falls risk assessment that identified a number of risks like balance, dementia, confusion and an unsteady gait. We saw the falls history scored 13 which indicated a high risk. However, under the mobility plan associated with the falls risk we saw this individual walked independently with a frame. We noted evaluations in this file were not comprehensive for what the person should have had. There was evidence of a number of falls and so the care plan was re-written.

In one folder, we viewed a body map dated 7 August 2015 which identified a pressure sore. The body map did not identify the location or the grade. In addition, post-it notes were used with the body map which posed the risk of important information being lost about the person's care if the note fell out of the folder. In other people's files that had been re-written from computer based records, there was evidence of a wide variety of risk assessments. However, when we viewed them we saw all of the Waterlow scores had scored 22 despite some being higher than this. Waterlow scores are a type of risk rating completed to assess people's susceptibility of malnutrition. We found manual handling risk assessments had been completed, however, only one manual handling care plan had been completed out of those files we viewed. This put people at risk from care that was not personalised to their needs.

We looked at one person's file after our pharmacist specialist was concerned regarding pain control and manual handling provision. We noted the person had a previous spine fracture which required them to be turned every two hours. Although a manual handling assessment was in place there was documentation which demonstrated one of the person's analgesics had been discontinued. In the person's life story they said what made them distressed was pain. We observed the person was being turned every two hours but

there was a lack of more specific pain control guidelines. The care home had not considered a higher pressure relieving mattress could be used and symptom control may have been better managed. This was supported by the person's Waterlow score being assessed as one of the highest with an overall score of 30. We also saw the person had been diagnosed with diabetes but the care plan did not reflect this, nor was there information about how to manage high or low blood sugar readings. There was also a risk of choking documented, but no care plan identified.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Whilst we saw isolated examples of good practice from individual staff, overall our observations revealed a staff team that were 'task focussed'. Interaction between staff and people who used the service we noted was sporadic and generally not positive. In more than one instance we saw staff say hello to people, but only very rarely staff used their name. People were sat in front of TV for long periods, sometimes with no sound on. One interaction we witnessed was when a member of staff brought someone into a lounge. They spoke to no-one, simply started moving chairs to make room for the wheelchair, and in the process stood right in front of the TV that people were already watching. We did not hear anyone being asked if they wanted to watch TV but rather it appeared to be the default activity for anyone in a lounge.

On one afternoon we witnessed a small number of people, supported by a member of staff, take part in a chair based exercise programme run by a qualified physiotherapist. This consisted of safe upper body strengthening, mobility exercises and lower body workouts. We saw that it challenged people and they had fun. We then asked people about their social and emotional needs and whether these were catered for at Queens Court. People's comments were overwhelmingly negative. One person stated: "There's nothing I really like doing. I spend most of the time in here and read magazines and visiting my friends on the first floor". Another person we asked said: "Nothing to do here. They don't take you anywhere. Not been out". A third person told us: "Very occasionally we go out on a trip". Other than the physiotherapy exercise session, a lack of activities occurred during the inspection. In bedrooms, we saw people lying in their beds or sitting in chairs with no social interaction, other than when staff entered for personal care purposes.

Staff we spoke with provided criticism about the number and extent of activities for people. They felt the lack of a dedicated, trained activities coordinator was a downfall, and said they struggled with other workloads and did not have time to run activities. The provider had not ensured there were activities to meet most people's social and emotional needs on an individual basis. For people who could entertain themselves items like books and puzzles were available, but for those who required more motivation and staff encouragement stimulation had not been provided in a planned manner. We found a programme of activities was pinned to the wall, listing activities such as carpet bowls, quizzes, and a coffee morning. We saw a pet–assisted therapy (PAT) dog visits the home occasionally and pampering sessions were scheduled. The flyer was unclear about how often these activities occurred. People were clearly engaged when they visited the hairdresser on site during the inspection. We observed conversations with the hairdresser and each other, and a light-hearted mood that people clearly appreciated.

We spoke with people who lived at Queens Court to ascertain whether they had previously raised complaints or would feel comfortable in providing feedback if they felt something was wrong. Some people we spoke with were content with their care and told us they "…are not the complaining sort". Other people we spoke with had mixed responses regarding complaints. One person stated that they complained about evening food provided and alternatives on several occasions. The person said: "They won't allow you to change; you have to have the meal when they say". The person told us they had asked for a different time for their meal but that the staff will not let them to change it. They concluded the conversation with us by telling

us they: "…no longer go to meetings as it makes no difference…" Another person complained that they did not get the daily newspaper they paid for. They told us: "I have to fight to get it" and "…I won't get it unless I ask one, two or three times". Relatives also had complaints which the provider failed to pay attention to. For example, one told us their relative was told they would have to go to bed after going to the toilet in the afternoon, and that they would have dinner in bed. The relative explained this was against the person's wishes and that this was far too early for bed. They said they was going to complain as "Why did [X] have to go to bed?" Relatives said they would complain about anything if they felt it was necessary. Another relative we spoke with told us they are all asked their opinions in surveys: "…from time to time". The relative went on to tell us that they had no real concerns and would raise them with staff if they did.

We looked at how the provider encouraged, received, investigated and responded to complaints. We noted an absence of signs around the building which informed people and relatives how they could make a complaint if they wished to. We also saw that service user handbooks or similar were not in people's bedrooms where the content could refer people and their relatives about to whom or where to complain. We looked at the provider's folder containing complaints for 2015. We saw that people and relatives had written complaints which were stored in the folder. However, we noted that the location consistently failed to acknowledge complaints in writing, store investigation documents with the complaint or write to the complainant with an outcome.

For some complaints in the folder, there was no associated documentation that indicated whether the complaint had been dealt with. There was also no analysis log of complaints to show trends or patterns, and common causes of complaints. In one complaint we viewed, the relative had written: "The standard of care they got towards the end…left a lot to be desired. The nurses were very uncaring towards [them]…". We asked to see the investigation and documents that accompanied this complaint handling. The provider was able to produce the minutes of a meeting held with the family members that made the complaint. However, other than this, no other documents regarding management of the complaint were available. Queens Court did not follow their own policy for 'Record Keeping' dated April 2004 in this matter as they had not kept records "required for the protection of service users and for the effective and efficient running of the home".

This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider had clear aims and objectives for the service in their 'principles of care' document which had three principles. The documented highlighted that in order to give people rich and meaningful care; they needed an inspirational environment, inspirational life and inspirational care. The 'principles of care' document also detailed that staff did not wear uniforms out of "a relationship of mutuality". However during our inspection, people and relatives we spoke with felt it was often hard to distinguish staff from visitors because they did not wear uniforms or name tags. When we spoke with staff, they felt they were able to have an opinion about how the service was run, and that managers did listen to what they suggested. We looked at staff meeting minutes for 2015 and found that seven meetings had occurred. In the meetings, topics included training, standards of care, maintenance of the building and care documentation. There appeared a lack of continuity between the meetings and no action plans had been created to capture the areas where the service could improve.

There was no registered manager at Queens Court. Some people told us that they knew the deputy manager and that they have seen them around the building often. However the majority of people we spoke with did not know who was running Queens Court and some residents were worried by this. This was supported by the fact that Queens Court has had a series of managers in charge of the service since the last inspection of October 2014. The last registered manager left work at the home in October 2014 and subsequently deregistered. Since then there have been another two managers, neither of which registered with the CQC as the 'registered person'. People we spoke with also commented on the lack of continued management. As well, staff had concerns about the long term management structure. One said: "Management continuity is poor. I get very little support and there is so much negativism towards carers. We never get a please or a thank you, only 'do this, do that' with little explanation".

For the last four months leading up to the inspection, the person in charge had been the area manager. We were told that other home managers supported the home on weekends to provide extra managerial cover on a daily basis. In addition, in the week before this inspection, the nominated individual who had been supporting the location left the organisation. In the week of the inspection, a new nominated individual and new clinical services manager commenced and were assisting in the home. This had increased the number of managers visible to people who lived there, staff and relatives causing some confusion about leadership. In the week following the inspection, a new interim manager was due to start at Queens Court for a three month period whilst permanent manager recruitment and appointment continued. The deputy manager had worked at Queens Court for approximately four years and was well known to people and staff that we asked.

The provider has a legal duty to inform the CQC about changes or events that occur at the home. When managers of care home change, even if they are not the 'registered person' regulations require that the provider notifies the CQC using statutory notification forms. These forms inform the regulator of who is managing the service and assists with ensuring people are kept safe. Although we had received a notification from Queens Court of a manager's absence longer than 28 days in 2015, the provider had not notified CQC of more changes in managers, as required. In addition, outcomes of two DoLS assessments

had also not been reported to CQC.

This is a breach of Regulation 15 (1) (a) (b) and Regulation 18 (1) (4A) (a) (4B) (a) (b) (c) (d) of the Care Quality Commission (Registration) Regulations 2009.

A robust system of quality assurance was not in place at Queens Court. We asked to see evidence of quality audits and any associated action plans that the provider used to improve care and drive up standards. Before the date of the inspection, there were limited examples of how quality had been assessed or used in the running of the service.

Records we looked at showed that staff had recorded accidents and incidents that people had. Where people had been involved in an incident or an accident, for example a fall, the staff recorded the cause, the injuries and the immediate actions or treatment that had been delivered using the provider's template. Although the accident records were checked by the deputy manager or acting manager, evidence that investigations, where necessary, had occurred was missing. In a series of October 2015 incident reports we looked at for falls, a common response was that the person needed to be reminded to use their call bell. This did not indicate other potential ways of assessing risks and planning care that could present future falls. We saw one person had sustained four falls in a week resulting in bruising to various parts of the body. Although accidents and incidents were tallied by head office on a monthly basis and presented on a grid, the home had completed no analysis on the figures. This meant people with higher risks than others or common themes in the injuries were not detected and used to improve safety.

We spoke with local authority commissioners of care in the home and they were disappointed with the current standard of care and the deterioration the home had experienced in 2015. Commissioners had required a series of weekly meetings with the home to address standards of care that placed people who use the service at risk. Commissioners were also still aware of ongoing areas of improvement the home had to address, for example, staff training and had difficulty viewing evidence that sufficient training had been conducted. The provider had constructed a six-week action plan commencing 17 October 2015 with key priorities and areas to focus on. The action plan included care plans, staff support, staff learning and development and recruitment. We also noted that a flyer had been distributed after week one of the action plan which detailed successes and areas for continued effort.

Other members of the multidisciplinary team we spoke with also felt Queens Court required improvements in order to deliver good care. Two practitioners explained to us that the staffing had a definite impact on the quality of care and that a permanent manager would alleviate some of the issues.

The area manager explained that a quality recording system called 'care home audit tool' (CHAT) was used and that some data was stored in it. These were audits conducted on a rotational basis for different topics each month. Areas that were checked included general environment, health and safety, fire safety and people's finances. A copy was provided of the January, April, May and July 2015 audits. We saw that most questions were able to be marked as 'compliant' but there were numerous examples where the answer was 'non-compliant'. For these items, no action plan had been constructed to deal with the matters that had not passed the audit tool. In addition, there was no clear calendar of which audits should be done in corresponding months and in some months, there were no records of audits completed. Some area manager audits were conducted, but the frequency of these and follow up of these was not satisfactory. We looked at the audit report for 29 July 2015. This demonstrated that appropriate areas for improvement were listed and checked, not always checked at each visit, but that a detailed plan of actions was still needed. We saw some actions had continued from prior reports. The provider could not show us that these actions had been completed or re-examined to ensure that the problem was resolved. We saw one action plan dated 13

October 2015 for health and safety. Out of 17 actions recorded, only 5 had been marked as completed. This meant people were at risk from failure of the location to make corrections where needed.

Other audits and documents that are routinely conducted or completed in care homes were not available. For example, we did not see evidence of infection control audits, care plan audits, personnel file auditing or environmental risk assessments. However, we did look at evidence window restrictors, wheelchairs, bed rails and the call bell system were regularly checked. Although the provider held health and safety committee meetings at head office, the minutes were not readily available at Queens Court and outcomes from the meetings were not always put into practice in the home.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act (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 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 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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (5) Service users were deprived of their liberty by the registered person for the purpose of receiving care without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 (1) (a) All premises and equipment used by the registered person was not clean and properly maintained. Regulation 15 (2) In relation to the premises and equipment, the registered person had not maintained standards of hygiene appropriate for the purposes for which they were being used.

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 Regulation 16 (1) (2) The registered person had not investigated all complaints received and taken the necessary and proportionate action in response to any failure identified by the complaint or investigation. The registered person had not established or operated an accessible system for identifying, recording,

handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activities.

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 Regulation 17 (1) (2) (e) The registered person had not established and operated effective systems or processes to ensure compliance with this regulation. The registered person did not seek and act on feedback from relevant persons and other persons on the services provided in carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

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 Regulation 19 (3) (a) (b) The registered person had not ensured that in relation to each person employed the information required by Schedule 3and that such other information as is required under any enactment was kept and available.

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 15 Registration Regulations 2009 Notifications – notices of change
Treatment of disease, disorder or injury	Regulation 15 (1) (a) (b) The registered person had not given notice in writing to the Commission, as soon as it was reasonably practicable to do so of (a) a person other than the registered person carrying on or managing the regulated activity and (b) a registered person ceasing to carry on or manage the regulated activity.

The enforcement action we took:

We served a fixed penalty notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Regulation 18 (1) (4A) (a) (4B) (a) (b) (c) (d) The registered person had not notified the Commission of the following events, 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; (a) any request to a supervisory body made pursuant to Part 4 of Schedule A1 to the Mental Capacity Act 2005 by the registered person for a standard authorisation and (b) any withdrawal of such requests.

The enforcement action we took:

We served a fixed penalty notice to the provider.

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) (2) (g) The registered person had not ensured care and treatment was provided in a safe way for service users. The registered person had not ensured the proper and safe management

of medicines.

Regulation 12 (1) (2) (h) The registered person had not ensured care and treatment was provided in a safe way for service users. The registered person had not assessed the risk of, or prevented, detected and controlled the spread of infections.

The enforcement action we took:

We served a warning notice to the provider.

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 Regulation 18 (1) The registered person had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the regulation. Regulation 18 (2) (a) Persons employed by the registered person did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they performed.

The enforcement action we took:

We served a warning notice to the provider.