Morecare Limited

Vicarage Court Nursing Home

Inspection report

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Tel: 01543685588

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 1 August 2017. This was an unannounced inspection. At the last inspection on 1 November 2016 we asked the provider to take action to make improvements. We found that risks to people were not always managed in a safe way. We could not be assured people were suitably protected from potential abuse. We also found that when people were unable to consent, capacity assessments and best interest decision were not always completed. People were not always given the opportunity to participate in pastimes or activities they enjoyed and people were not always involved with reviewing their care. There was no registered manager in post and the systems that were in place to monitor the service were not always effective in driving improvements. The service was rated as required improvement. We asked the provider to send us an action plan. The provider told us they would meet the legal requirements by 31 January 2017. At this inspection we found these actions had not always been completed.

The service was registered to provide nursing care for up to 39 people. At the time of our inspection 35 people were using the service.

The service did not have 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.

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, it 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.

People did not always receive their medicines as prescribed; there were no systems in place to monitor stock levels within the home. Risks to people were not managed in a safe way. People were offered an

inconsistent approach for management of their behaviours as there was no clear guidance in place for staff to follow. We saw no evidence after incidents had occurred that action had been taken to reduce the risk reoccurring. We could not be sure people were protected from potential abuse. When potential safeguarding incidents had been recorded we did not see these had been reported in line with the provider's procedures. The provider did not have suitable recruitment procedures in place and people and relatives felt staffing could improve.

People did not have care and support that was responsive to their needs as pressure management and weight loss was not appropriately managed within the home.

People were not always treated in a dignified way as staff were rushing to complete tasks. People were not always offered choices. People felt there could be more to do and the home lack stimulation. Food was served cold to people at breakfast time.

The systems in place were not always effective in identifying shortfalls and information was not used to drive improvements within the home. When action was needed to reduce risks it was not always taken.

We saw the provider offered an inconsistent approach to capacity assessments and best interest's decisions. Staff did not demonstrate an understanding of DoLS and risk assessments had not been completed while authorisation considered.

People received access to health professionals and were happy with the staff that supported them. People were encouraged to remain independent and make decisions how to spend their day. Staff received an induction and training that helped them provide support to people. People and relatives knew how to complain and any complaints received had been responded to in line with the provider's procedure. The provider was displaying their rating in line with our requirements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People did not receive their medicines as prescribed. There were no systems in place to monitor stock levels within the home. When incidents occurred we could not be sure action was taken to reduce the risk of reoccurrence. We could not be sure the provider took appropriate action and that people were protected from potential abuse. The provider did not have suitable recruitment procedures in place. People and relatives told us they felt staffing levels could be improved.

Is the service effective?

Requires Improvement

The service was not always effective.
Food was served cold and people were not always offered a choice. The provider did not have a consistent approach to supporting people with decision making. Staff did not understand when restrictions were placed upon people and there was no guidance how to support people with this. Staff received an induction and training that helped them to support people. People had access to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always supported in a dignified way or offered choice. People made decisions how to spend their day and were encouraged to be independent. People and relatives were happy with the staff that supported them. Relatives could visit when they chose.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People did not have care and support that was responsive to their needs. People felt there could be more to do within the home. People and relatives knew how to complain and complaint had been responded to in line with the provider's procedures.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not made the necessary improvements identified at the last inspection. There was no registered manager in post. The systems in place were not effective in identifying concerns and information was not used to drive improvements within the home. When action was needed to reduce risks it was not always taken. The provider was displaying the previous rating within the home.

Vicarage Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection visit took place on the 1 August 2017 and was unannounced. The inspection visit was carried out by one inspector and a specialist advisor. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We also reviewed information we had been sent by the local authority and Healthwatch Staffordshire. Healthwatch are a consumer champion for health and social care. We used the above information to formulate our inspection plan.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with four people who used the service, two relatives, three members of care staff and the manager. We also spoke with two registered nurses. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for eight people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection, we found that risks to people were not managed in a safe way. Where people demonstrated behaviours that put themselves and others at risk, no guidance was in place to guide staff on how to support these people safely. We could not be assured people were suitably protected from potential abuse. These were breaches of Regulations 12 and 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.The service was previously rated as requires improvement in this area. At this inspection we found the necessary improvements had not been made.

At this inspection we found that when people presented with behaviours that may challenge, the actions that were put in place were not always effective. For example, we looked at records for one person. We saw incident forms and recording charts were being completed in relation to behaviours that this person had displayed. This included, scratching, biting and hitting themselves and others. We saw there was a behaviour management plan in place. However, there was no detail stating how staff should manage these behaviours or action to take. The staff we spoke with gave differing information on how they would support this person. One staff member said, "We just leave them to calm down" and another staff member told us, "We go and get another staff member to help us". This meant that staff did not have the information available to offer support to this person and offered an inconsistent approach. It was also documented that this person refused interventions including personal care and medicines. There was no clear guidance advising staff what to do when this occurred. Documentation showed us that this person had refused personal care for the previous three days and no action had been taken. As we were concerned about this we spoke with the manager and staff. One staff member reassured us that this person had received a bath and personal care four days earlier. After the inspection and due to our concern we raised this as a safeguarding to the local authority.

Risks to people were not always considered. For example, for one person we saw photographs of significant bruising to a person's arm. The manager told us this was caused as the person would bang their arms on their bedrails. We looked at records and the manager confirmed there was no risk assessment or other information in place for this. Staff we spoke with were unaware of this risk to the person. When an incident or accident occurred within the home, we did not see what action had been taken to reduce the risk of reoccurrence. For example, for one person we saw documented that they had 'been found on the floor'. In the 'action taken' nothing was documented and the manager was unable to confirm what action had been taken. This meant when incidents occurred we could not be sure action was taken to reduce the risk of reoccurrence.

We saw there was a monitoring sheet, wound assessment chart and care plan evaluation chart in place for people who had developed skin damage caused by pressure. For one person it was documented that the dressing should be changed every two days. However, from this information we saw it was unclear when the dressing had been changed. For example, on 31 July 2017 it was documented that no dressings were available and this had not been completed. On 29 July 2017 there was no documentation in the wound care assessment or care evaluation; therefore we could not be sure this wound had been dressed on this occasion. On 27 July 2017 it was documented that the dressing had been changed and on 25 July 2017 there

was no documentation. There had been no evaluation of the care plan since 27 July 2017 and therefore we could not be sure if the wound had increased in size during this time.

Another person also had skin damage caused by pressure. The manager told us it was confusing as to where and how this had occurred and could not provide us with any more information. There was documentation in place stating that this was to be dressed every three days. It was last documented that this was redressed on 27 July 2017. There was no evidence to suggest and the nurses or manager could not confirm that this had been dressed since. This meant we could not be sure pressure areas were being dressed as required placing people at increased risk of further skin damage.

People did not receive their medicines as prescribed. One person was prescribed an antibiotic medication. We looked at the medicines administration record (MAR) for this person and saw there was a missing signature. The provider had not picked up on this and no action had been taken. On counting the stock levels there should have been one tablet left to administer, however there were two. This meant the person had missed a dose, no action had been taken and the person had not received this medicine as prescribed. We found similar concerns for two other people's MAR we looked at.

For another person we saw they were prescribed medicines to help with the management of their bowels. It was documented on the MAR that since 10 July 2017 the person had refused this medicine and no action had been taken. Furthermore, it was recorded on the handover sheet that this person had not had a bowel movement since 24 July 2017 and therefore this missed medicine had had a negative impact on the person's health. This meant the provider had not taken appropriate action. We also found the same concerns with different medicines for this person.

There were no systems in place to monitor the medicine stock levels within the home and therefore, we could not be sure people received their medicines as prescribed. For example, one person was prescribed medicines for pain relief. It was documented that on 10 July 2017 100 tablets were carried forward when the next medicine cycle started. The MAR and manager told us 114 tablets had been administered since then. When we checked stock for this medicine there were 10 tablets remaining. The manager could not provide an explanation for this. Therefore we could not be sure the person had received this medicine as prescribed. We found the same concern for three other people's MAR we looked at.

This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At our last inspection we could not be assured people were suitably protected from potential abuse. At this inspection we saw there were procedures in place to report concerns to the local safeguarding authority, and staff demonstrated an understanding of these, however these procedures were not always followed. We were told by the manager that there was an on going safeguarding investigation within the home. They told us another professional had identified this concern, not the staff or manager at the home. The provider had not notified us, as required, about this. We looked at records which showed us one person had acquired a lump to the forehead. It was documented 'no idea how this was sustained'. The provider had documented that they would conduct an investigation. There was no evidence this had taken place, been investigated or reported. We spoke with the manager who confirmed this should have been reported to the local safeguarding authority. After the inspection we raised two safeguarding concerns that we found during our inspection. This meant we could not be sure the provider took appropriate action and the practice in the service placed people at risk of potential harm.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities)

Regulations 2014.

We found that when information had been received by the provider about staff's lack of suitability to work within the home they had not completed the necessary risk assessments. No action had been taken to ensure people who used the service were suitably supported. We also found for some staff that their disclosure and barring service record (DBS) had been completed from previous employers and no risk assessments were in place to support this decision. The disclosure and barring service (DBS) is a national agency that holds information about criminal convictions. This meant we could not be sure the provider had a suitable recruitment process in place to ensure people who used the service were safe.

We saw there were staff available for people when needed and people did not have to wait for support. However, people and relatives felt further improvements were needed. One person when asked acknowledged they had to wait for support and did not feel there were enough staff. They told us, "Some staff are better than others, sometimes they ignore me and I can be crying with pain, they say be with you soon but that can be anytime". Another person said, "There are enough of them but if I want a little chat then they are very busy with the others so don't always have the time". A relative said, "Most of the time it's okay, but not all of the time". This meant that there were not always enough staff available for people.

Staff we spoke with were aware of people's emergency plans and the level of support people would need to evacuate the home. We saw plans were in place to respond to emergencies. These plans provided guidance to staff and the levels of support people would need to be evacuated from the home in an emergency situation. The information recorded was individual and specific to people's needs.

Requires Improvement

Is the service effective?

Our findings

At last our comprehensive inspection, we found that when people were unable to make certain decisions, capacity assessments and best interest decision were not always completed. This was a breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We also found concerns with how food was served. At this inspection some improvements had been made but further improvements were needed.

At the last inspection we raised concerns that food was not always served warm. At this inspection no changes had been made. We observed, as previously, at breakfast hot food was brought into the communal area. Some of this was wrapped in foil and other food was covered in paper. During breakfast the wrappings remained open and the last person was served their breakfast 35 minutes after the food had arrived. In the communal area upstairs we saw the same concerns. We observed that when the meal trolley arrived, soft diets were pre-plated and uncovered and they were then put on a table by an open window until served to people. At lunch time we observed that people were not always offered a choice of meals. In the communal area upstairs chicken casserole was served to each person and no other choice of main meal was offered. A person we spoke with confirmed that no choice had been offered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had considered when some people were being restricted unlawfully and had made appropriate applications to the local authority for approval. However, we did not see any evidence that risk assessments were completed to ensure people were being supported in the least restrictive way while approvals were being considered. We saw that one approval was in place. Staff we spoke with were not aware of this and did not demonstrate an understanding of DoLS. One staff member said, "It's when people have bucket chairs". When asked they confirmed they were not aware that the person had a DoLS authorisation in place. Another staff member said, "I'm not sure about DoLS".

We checked to see if the provider was working within the principles of MCA. We saw the provider offered an inconsistent approach. We saw some capacity assessments were in place however not all decisions had been considered in people's best interests. For example, best interest's decisions had not been considered in relation to medicines and persona care for one person. It was also unclear how decisions regarding people's capacity had been made. In the records we looked at we saw it was recorded that the lack of capacity was due to their dementia'. Due to these assessments we could not be sure people's capacity had been fully considered.

Staff received an induction and training that helped them to support people. One member of staff who had recently started working at the home told us, "I had an induction; I did moving and handling training. Then I shadowed staff for about a month that was good I found out a lot". Staff also told us that they were undertaking the care certificate as part of the induction. The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. This showed us staff were provided with training that supported them to meet people's needs.

We saw when needed people had access to healthcare professionals. For example, we saw records that people had been seen by the chiropodist and GP. On the day of inspection staff were arranging an appointment for a person to attend the dentist. This meant people had access to health professionals when needed.

Requires Improvement

Is the service caring?

Our findings

We saw that there was often a task focussed approach to supporting people within the home. We saw that this impacted on people's dignity because they were sometimes not fully supported when staff were rushing. For example we observed staff supporting a person with a transfer. They did not observe that during this the person's trousers had slipped down. Staff had lack of understating about people's diversity and human rights and confirmed they had not received training in this area. At meal times in communal areas we observed staff referred to people inappropriately. For example, we saw a staff member come into the communal area and say, "Right I've come to help with the feeders". Another staff member said, "Any more softs?". This was in reference to people's dietary requirements. People were not always offered a choice and staff put aprons on people at mealtimes without asking them, we observed that one person was asleep. This demonstrated the staff's lack of understanding to ensure people's privacy and dignity were maintained.

We observed one person sitting in the communal area who needed support with their meal. As staff were offering assistance to other people they verbally encouraged the person to eat however, did not offer support. When staff offered support to the person ten minutes later, the person ate their meal. When staff interacted with people we saw this was kind and caring. For example, we observed a staff member talking to a person throughout their meal, they were chatting back and smiling throughout. People and relatives told us they were happy with the staff. One person said, "They are a good bunch". A relative said, "The staff are nice".

People told us they made decisions about how to spend their day. For example, one person told us, "I always sit here, I like sitting here so I can look out the window. The staff still ask me but they know I like it". Another person told us they went to the shop to purchase their newspaper daily". Records we looked at reflected what people had told us.

People were encouraged to be independent. One person said, "I can't do as much as I could for myself now, but I still try. The staff let me try myself first". We observed that people were encouraged to be independent. For example, we heard staff encourage people to do task for themselves. A staff member said, "We still try and let people do what they can for themselves, we are there if needed. We have some very independent people living here and we like to promote that".

Relatives and visitors we spoke with told us staff were welcoming and they could visit anytime. One visitor said, "I can come anytime". We saw relatives and friends visited throughout the day meaning no visiting restrictions were placed upon them.

Requires Improvement

Is the service responsive?

Our findings

At last our comprehensive inspection, we found that people were not always given the opportunity to participate in pastimes or activities they enjoyed and people were not always involved with reviewing their care. At this inspection the provider had not made the necessary improvements.

People did not always receive care and support that was responsive to their needs. We looked at records for one person. It was documented that the person had lost 14.1kg in weight since February 2017. The provider had introduced weekly weights for this person. However, we could not see any further action had been taken. On reviewing the person's file we saw a letter from a dietician where a review had taken place for this person in June 2017, the manager told us this was a routine review. Due to the weight loss the dietician had requested a follow up appointment on 13 July 2017. There was no evidence and no one could confirm if this had taken place. Since the review in June the person had lost a further 2.2kg and we could not see that any action had been taken. We looked at the care plan for this person and there was no evidence how the provider was supporting the person with this. This meant when people's needs changed these were not responded to in an effective and timely manner.

There were people living at Vicarage Court who had skin damage caused by pressure. We looked at repositioning records for one person. There was no indication of how often this person should be repositioned however; a member of staff told us this should be every two hours. It was documented on the 30 July; that the person had spent seven hours on their right side. It was then documented the person spent a further four hours thirty five minutes on their left side. On 31 July 2017 it was documented they spent eight hours on their left side and then a further five hours on their right side. There was no monitoring or reviews of these records taking place and therefore no action had been taken. This meant we could not be sure this person was repositioned as required.

We saw documented on 6 June 2017 for one person, due to concerns a swab had been sent to the GP for examination. There was no follow up of these results and no further action had been taken. The manager confirmed this to us. This meant this person had not received appropriate care or treatment.

Staff did not always understand people's support needs. For example, we looked at records for two people who had a catheter in place. Both people were on a fluid balance chart. There was no documentation identifying how much fluid each person should have daily. The staff we spoke with were also unable to confirm this to us. Furthermore, records showed us when people had not received adequate amounts of fluids no action was taken. Staff confirmed to us that the person should have been receiving more fluids than documented. The staff we spoke with confirmed that no action had been taken on this.

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

At our last inspection we found people were not always given the opportunity to participate in past times and activities they enjoyed. At this inspection people told us there could be more to do. One person said,

"There's not a lot going on, we used to have a sing song, I use to like singing, we don't do that anymore". During the inspection we saw no stimulation was offered to people. In the communal area upstairs the television was left on for long periods however people were not watching this. We saw staff only interacted with people when they were completing tasks such as supporting with eating and drinking. In the communal area downstairs a short activity took place. A person commented, "That's for your benefit they don't usually do that". At the last inspection we were told an apprentice would be employed as an activity coordinator. The manager confirmed that this had not been actioned and no activity coordinator was in place.

People and relatives we spoke with told us they knew how to complain. We saw the provider had a complaints policy in place. When needed, we saw the provider had responded to complaints in line with their policy.

Inadequate

Is the service well-led?

Our findings

At last our comprehensive inspection, we found there was no registered manager in post and the systems that were in place to monitor the service were not always effective in driving improvements. This was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.The service was previously rated as requires improvement in this area. At this inspection we found the necessary improvements had not been made.

At this inspection we found that despite concerns raised from our previous inspections, action plans we have received and a meeting with the provider, few improvements to the provision of the service had been made or sustained. This demonstrated the management systems that were in place were weak and inconsistent. Following this inspection we have concluded that we do not have confidence in the provider to make the necessary improvements required for the care and safety of people living at Vicarage Court Nursing Home.

In the action plan we received on 6 December 2016, we were given assurances the provider could meet the legal requirements. For example, under safe care and treatment, the action plan stated, 'behavioural management plans have now been put in place and all staff have been made aware of plan and a copy has been placed in carer's documentation. Challenging behaviour and dementia awareness training has been completed and this will be reassessed for their understanding via 15 minute training times'. We saw this action was completed by 20 November 2016. At this inspection we found concerns with how behaviours were managed. We found staff did not have the guidance they needed and did not offer a consistent approach. Staff we spoke with did not demonstrate or confirm they had their competency checked in this area. Therefore we could not be assured the provider understood the requirements of the regulation to ensure they were compliant.

At this inspection we found there were safeguarding concerns that had not been identified by the provider. These concerns were around the alleged abuse and neglect of people who used the service. The management systems that were in place did not identify these as concerns and the provider had failed to notify us of these events.

There were no audits or monitoring taking place in relation to the management of medicines. The last audit had been completed in December 2016. The manager told us the pharmacy had completed an audit in May 2017 but the provider had not received this report or taken any action to follow this up. Therefore when errors or concerns had occurred, no action had been taken.

The new manager had introduced an audit of care records. The audit monitored if charts were being completed within the home. This included fluid charts. We did not see how this information had been used to address shortfalls and drive improvements within the home. We saw when the chart had not been completed correctly an 'x' had been documented. There was no further information in place stating what action had been taken. The manager told us this was something they would introduce. We also saw a domestic audit was in place. This had been completed in July 2017. When documented 'Are all fire exits

unobstructed'. The response was 'no'. There was no further information stating what action had been taken and if this had been resolved. We discussed this with the manager who checked during our inspection to see if the situation had been resolved.

The provider had sought feedback from people who use the service. The outcome was displayed on posters in the entrance of the home, when areas of concerns had been noted or improvements suggested. There was no evidence any action had been taken with regard to these.

We found that people's records were not kept securely. Care plans were stored in an unlocked filing cabinet in an office. We saw this office was unlocked and frequently unattended which meant that people's personal information was at risk of being breached by unauthorised access.

This is a breach of Regulation 17 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

The service did not have a registered manager in post. The manager who was in place at the last inspection had left the service. A new manager had recently been appointed and was working within the service. The new manager was not aware of the action plan that had been previously completed following our last inspection. People and staff told us the turnover of managers continued to impact on the service. One staff member said, "You can see we have another new one, again". We saw documented in meeting minutes that a person had said they felt, "Despondent and didn't see the point in attending the meeting as it wouldn't make any difference". After the previous inspection we held a provider meeting to seek reassurance over this. However, despite this and written confirmation from the provider, there was no registered manager in post.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have care and support that was responsive to their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could not be sure the provider took appropriate action and that people were protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not made the necessary improvements identified at the last inspection. There was no registered manager in post. The systems in place were not effective in identifying concerns and information was not used to drive improvements within the home. When action was needed to reduce risks it was not always taken.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive their medicines as prescribed. There were no systems in place to monitor stock levels within the home. When incidents occurred we could not be sure action was taken to reduce the risk of reoccurrence.

The enforcement action we took:

We impose urgent conditions in relation to the management of medicines, wound care and unintentional weight loss on the providers registration.