Ashley Down Care Home Limited

Ashley Down Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over two days, 04 and 06 July 2017. The inspection was unannounced.
This was a planned comprehensive inspection to follow up from the previous inspection report when we placed the service into special measures to monitor improvements made. The local authority had visited the service since the last inspection and had raised their concerns that improvements had not been made.

Ashley Down Nursing Home is registered to provide accommodation for older people who require nursing or personal care. The home could provide care and support for up to 19 people. There were 15 people living at the home at the time of this inspection. Two of these people were in hospital so 13 people were actually living in the home. People had complex health needs, including diabetes and stroke. Many people were living with dementia, some at an advanced stage requiring intense support from registered nurses and staff.

The registered provider of the service was also the 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 registered manager was not available on the first day of inspection, however they were available on the second day.

Our last inspection report of this service was published on 20 February 2017 and related to an inspection that had taken place on 22 and 24 November 2016. At the inspection in November 2016 we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to; Regulation 9, people's individual needs were not adequately assessed and regular checks on people were not recorded; Regulation 11, people's care plans did not reflect their basic rights to consent and decision making; Regulation 12, evidence was not available to show that care was provided in a safe way; Regulation 16, the correct information was not available through an up to date procedure to enable people to make a complaint; Regulation 17, effective systems were not in place to monitor the quality and safety of the service and Regulation 18, staffing levels were not based on peoples' individually assessed needs. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, CQC had not been notified of important events that had taken place in the service.

We asked the provider to take action to meet regulations 9, 11 and 16. We also asked the provider to take action to meet Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We took enforcement action against the provider and told them to meet Regulation 12 by 30 March 2017, Regulation 17 by 28 April 2017 and Regulation 18 by 31 January 2017.

The provider sent us a report of the actions they were taking to comply with Regulations 9, 11 and 16 and they told us they would be meeting these Regulations by 28 February 2017. They also said they would meet Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 by 28 February 2017.

At this inspection we found the provider and registered manager had made some improvements to the

service and standard of care. The provider had a new complaints procedure in place and regular checks on people were now recorded. The provider had notified CQC of important events as required. The improvements related to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. However many improvements had not been made and we found continuing breaches of regulations from the last inspection. These related to Regulation 9, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found new breaches of Regulation 19, safe recruitment processes were not in place to make sure only suitable staff were employed to work with people and 20A, the ratings of the previous inspection had not been displayed as required, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments around people's personal and nursing care needs were in place. However, important and serious individual risks had not been identified and risk assessments had not been undertaken to control and minimise those risks to keep people and staff safe. Staff had not had the necessary training to keep people and themselves safe and safety had been compromised.

The premises were clean and suitably maintained and equipment and utilities had been serviced. However, fire evacuation guidance did not give the specific information required to keep people safe. Fire evacuation practice drills had not been carried out to ensure people and staff knew what to do in the event of a fire.

Staff had not been sufficiently deployed to ensure peoples' social and welfare needs were met. People were often left sitting on their own in the lounge or in their bedroom with little stimulation. People were not engaged in meaningful activities that were based on their interests and to create a motivating environment.

People's care plans were suitable for their personal care and nursing needs. However, care plans were not person centred and there was no focus on people's well-being, social and cultural needs based on their preferences and interests. People and their relatives were not involved in reviewing their care plans.

Mental capacity assessments that had been undertaken were not appropriate for the decisions being made. Consent forms had been signed inappropriately on people's behalf. Where decisions had been made on people's behalf, a best interests process had not been followed as determined within the Mental Capacity Act 2005. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local supervising authority.

The provider had asked for feedback of the service from people and relatives. There was no evidence that the comments made had been listened to and actioned.

Although an audit and monitoring system was in place it was not used effectively to identify concerns and act on them to drive improvements within the home.

Some staff thought the provider was approachable and others thought they did not listen to their views and concerns.

New staff had not had the appropriate checks made of their suitability to care for and support the people living in the home.

The provider had not displayed the ratings of the previous inspection in a prominent place as required by the regulations.

Although an up to date complaints policy was in place, the complaints process outlined within the service user guide did not reflect this. We have made a recommendation about this.

People received their prescribed medicines by registered nurses. The medicines administration process was managed well, including the ordering, storage and return of medicines in the home.

Staff had a safeguarding procedure to access the information they needed to protect people and raise concerns. A copy of the local authority procedure with their full guidance for reporting concerns was kept in the home, however, it was an old copy with the wrong information available. We have made a recommendation about this.

Staff had one to one supervision meetings to support their development. Mandatory training and updates had been undertaken since the last inspection. Some training requested by registered nurses for the benefit of their professional development and for the benefit of people living in the home had not been carried out. We have made a recommendation about this.

People said they were happy with the food provided. Where people required a special diet or consistency of food this was documented and appropriate advice and guidance had been sought.

People's health needs were generally taken care of by the registered nurses working in the home and GP practices. Health referrals had been made, however not always suitably quickly and not always pursued and followed up.

Staff had a kind and caring approach to people and made sure they knocked on people's doors before entering their room.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

Risk assessments were not in place to identify and minimise specific risks to individual people. General risk assessments were in place.

Staff continued to not be deployed appropriately to ensure the correct levels of care and support was available to meet people's needs.

Recruitment processes were not robust to ensure staff were of suitable character to work with people living in the home.

Accidents and incidents were recorded by staff but not managed effectively to prevent future occurrences.

The management and administration of people's medicines was managed well by registered nurses.

A safeguarding procedure was in place to provide information about staff responsibilities to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

People continued to not be supported appropriately to ensure their basic rights were upheld within the principles of the Mental Capacity Act 2005.

People were happy with the food and specialist dietary requirements were met.

Although people's basic health needs were met, referrals to specialist health care professionals were not always made in a timely way or followed up.

Staff received one to one supervision and accessed their basic training requirements. Specialist training required by nurses and staff had not been arranged as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were left alone either in the lounge or their bedroom for long periods of time with little social interaction.

People and their relatives were not involved in reviewing their care plan to make sure all their needs continued to be met.

Staff observed people's privacy by knocking on their bedroom doors before entering. Staff spoke to people in a respectful and caring way.

Is the service responsive?

Inadequate

The service was not responsive.

The care given continued to not be person centred. People did not have their preferences about their care and support recorded. Some people did not have a life history recorded.

People continued to not have an individual plan to make sure their interests were documented so meaningful activity could be provided. Activities were not planned to create a motivational and community environment.

People and their relatives were asked their views of the service provided, however their comments were not listened to in order to make improvements.

A complaints procedure was in place. Differing information was provided in the service user guide about how to make a complaint. No complaints had been made.

Is the service well-led?

Inadequate

The service was not well led.

Quality monitoring and assurance processes continued to not be effective in identifying and rectifying areas that required improvement.

The provider did not have a clear presence in the service when not working on shift. Effective management and leadership were lacking.

Some staff described the provider as approachable and other staff said they did not listen and act on concerns raised.

The provider did not act on feedback to improve the quality and safety of service.	

Ashley Down 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 took place on 04 and 07 July 2017. The first day was unannounced and the second day was announced as we told the provider when we would return.

The inspection team consisted of one inspector, one nurse advisor and an expert by experience. The expert by experience talked to people and visitors to gain their views of the service provided. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the previous inspection report and the provider's action plans. We also looked at notifications the registered manager had sent to CQC. Notifications tell us about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with seven people who lived at the service and two relatives to gain their views and experience of the service provided. We observed the care given to the people living in the service. We also spoke to the registered manager and eight staff including registered nurses, the activities coordinator and care workers. We asked health and social care professionals for feedback about the service.

We spent time observing the care provided and the interaction between staff and people. We looked at ten people's care files, medicine administration records and six staff records to check recruitment processes, supervision and training, the staff rota's and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at feedback given by people and their relatives through questionnaires the provider asked them to complete.

We asked the provider to send us information after the inspection and they sent the information as requested.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 22 and 24 November 2016 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 9, Person centred care. Evidence was not available to show that people who were unable to use the call bell for assistance were checked on regularly according to their individual assessed needs; Regulation 12, Safe care and treatment. Evidence was not provided to support the provision of safe care and treatment; Regulation 18, Staffing. Evidence was not provided to show that staffing levels were based on peoples' individually assessed needs. We asked the provider to take action to meet Regulation 9. We took enforcement action against the provider and told them to meet Regulation 12 by 30 March 2017, and Regulation 18 by 28 April 2017.

Following the inspection the provider sent us an action plan on 23 January 2017 to show how they intended to improve the service and meet the Regulations by 28 February 2017. At this inspection we found that the provider had made some improvements to the record keeping for checks made on people through the day. However, there were no improvements showing how staffing levels were matched to people's needs, or to support the provision of safe care and treatment. Also, at this inspection further concerns around people's safety were found.

Although the provider had introduced a dependency tool to assess the amount of staff support required to meet people's individual needs, these were not used effectively. The dependency tool had been completed for each person and a copy placed in their care file. However, the individual dependency scores had not been used to calculate the numbers of staff required to meet the needs of the current people requiring care and support in the home. We asked a staff member if they knew how staffing numbers were calculated using the tool and they told us the provider did this. We asked the provider to show us how they used the tool to determine the staff numbers required. They told us they did not do this at the moment as there was no need to with the numbers of people they had living in the service. They said they knew the numbers of staff they currently had to be sufficient. However, we saw people sitting in the lounge for long periods without staff attention. People were in their rooms on their own for long periods with staff only having time to chat when they were attending to their personal care needs. Inspectors at the last inspection had found the same issues and the situation had not changed. People's relatives had fed back in a questionnaire that they thought there were insufficient staff. Although people's personal care needs were attended to by staff, they were at risk of being isolated and their social needs not being met. As there were not enough registered nurses employed, the provider did use agency nurses when required. They told us they always used the same agency and tried to use the same agency staff for consistency.

Staff continued to not be sufficiently deployed around the home to make sure people's social and emotional needs were met as well as their personal care needs. People were often sitting on their own or without activity or conversation. Staff were too busy to engage in anything other than attending to people's personal care needs throughout the day. Some of the time two people were sitting in the lounge and other times up to six people were. People were often left alone and unsupervised in the lounge. One person had a call bell placed on their lap even though their care plan said they were unable to use a call bell. Others did

not have a call bell. One person had only one arm they could use following a stroke and banged on the table top when they required help. Others had to shout out. Staff could not always hear them as they were upstairs providing care to people in their rooms. This meant that people were at risk of falling over if they needed assistance or their dignity may be breached if they were not assisted quickly enough. The nurse on duty was the staff member most likely to respond to people's requests for help. We heard one person in the lounge talking and mumbling to themselves. No staff were available in the lounge to hear this and to respond to the person's needs. After 15 minutes another person started to shout "shut up". The nurse heard this as they were in another room downstairs and went into the lounge to find out what the problem was. Once in the lounge, the nurse rang the call bell for assistance from other staff. There was no response from other staff as they were busy upstairs. The nurse called the call bell a second time and continued to receive no response. The nurse eventually had to leave the people in the lounge and go upstairs to find a staff member to assist. This meant that people were at risk of harm and delay in having their care needs attended to.

People were not sure if there were enough staff. One person said, "I suppose so, it's difficult" and another said, "No, not enough staff. There is no launderette so night staff do the washing". When asked if they thought there were enough staff a relative said, "As far as I know, yes". Staff told us they thought there were enough care staff to meet people's needs. However, staff did say that they thought there would not be enough staff if any more people were admitted to the home.

The failure to continue to not be able to demonstrate that staffing levels were based on individual needs, were responsive to people's changing needs and to deploy sufficient staff to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had general risk assessments in place. For example, each person had risk assessments to identify the risk of malnutrition, pressure sores and moving and handling. Environmental assessments of people's bedrooms and the use of bedrails were also in place. Diabetic risk assessments were in place for people who were diabetic; however these were general and not individual to the person. Some risk assessments had identified other associated risks but these had not been risk assessed separately. For example, one person had a moving and handling assessment as they required the use of a wheelchair. As they transferred themselves in and out of the wheelchair, they were at increased risk of falls and had in fact fallen on more than one occasion. A falls risk assessment had not been completed to enable the person and staff to minimise the risks of their falling over. Another person had a falls risk assessment which was a general scoring tool to assess the risk of falling. The person scored 19, which was classed 'high risk' (the score of 20 was classed as 'very high risk'). No further risk assessment was carried out as a result of this to identify the control and management measures that were required for the person to minimise the risk of falls. Although no falls had been recorded since 2016, the risk was recorded as high and therefore required further measures.

Individual risk assessments to identify control measures to minimise the potential harm from specific risks were not in place. Two people had behaviour that others may consider to be harmful and challenging, to themselves and those around them. There were clear and significant risks to people and staff yet no risk assessment was in place to guide staff how to manage the situations they faced with specific techniques to diffuse the situation. For example, staff recorded many times that one person swore at them, threw their water bottle - often hitting them with it and physically assaulting staff on the arm or the chest area. Staff recorded that another person often swore at them, spat, and tried to kick at and punch them. 'ABC' charts were being completed by staff to record each incident, however it was clear most staff did not understand how to complete these charts correctly. 'ABC' charts are an observational tool used to record; What

happened leading up to an incident, the 'Antecedent', a description of the behaviour observed, the 'Behaviour', and what the consequence of the incident was, for example what action was taken or how others responded, the 'Consequence'. Most staff were writing across the length of the chart and not following the separate columns of A, B and C. This meant the intention of the recording was lost. Some staff's writing was illegible which meant it was impossible to read what they had written on the chart. There was no evidence the provider monitored the ABC charts in order to check for patterns or how staff responded, collectively or individually, to be able to manage the risks more appropriately. The data would also serve as important information to access support and advice from external agencies and to tailor staff training. We asked the provider if they did monitor the ABC charts and they said they did not.

After day one of our inspection a staff member was injured by a person. They were assaulted in the chest area resulting in them having to take time off sick from their duties.

Positive behaviour strategies were not used to support staff to provide consistent care and support. Staff had not received any challenging behaviour training. The training matrix showed that this training was not booked until December 2017. We spoke with the provider about this. They said they would try to change the date. They told us before the end of the second day of inspection that this training had now been rearranged for 18 July 2017. Staff were clearly struggling and did not have the skills or experience to deal with the situations they were faced with. Some were wary of entering the rooms of people whose behaviour others may consider challenging as they were unsure of what they would be facing. On days where the challenges had been difficult staff became tired and demotivated by the end of their shift. One staff member said, "I find it difficult to face by the end of the day". Staff told us they could not cope with the situation as it was. They told us they had told the provider this. At the request of a nurse working at the home, a referral had been made by the GP for one person, to the local community mental health team in June 2016. The community mental health team had rejected the referral stating as the person did not have a diagnosis of a mental illness the referral was not accepted. No further attempts were made to gain support, advice and guidance from specialist health and social care professionals for the person. Serious incidents had occurred that had not been appropriately dealt with by the provider to prevent further incidents and to keep people and staff safe.

Personal emergency evacuation plans (PEEP's) were in place to be used to assist people to safely evacuate the premises in the event of a fire or other emergency. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the care home in the event of a fire. The PEEP's contained general information to be aware of but did not include specific detail about personal barriers to evacuating the premises. All PEEP's had the same guidance even though people had differing support needs. For example, guidance to assist people who required support with mobility to descend the stairs with the aid of evacuation chairs and mats. Or guidance to support people whose behaviour may impede their ability to evacuate safely.

Fire alarm tests were carried out weekly by staff. Although areas that needed attention were recorded, no action was evidenced as having been taken. For example, 11 times out of 19 weeks, the record stated, 'Lounge door did not close'. No action was recorded as having been taken to rectify this safety issue for each of these weeks. No fire evacuation practice drills had been carried out in order to test the response of people and staff. An evacuation drill is required to check the staff's competence and knowledge of their training if such an emergency took place. We asked the provider and they confirmed no evacuation drills had been undertaken.

The failure to assess and mitigate individual risks and provide safe care and treatment is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff recruitment files we looked at did not evidence that safe recruitment practices were in place. One staff member had ticked 'yes' on their application form to a question asking if they had any criminal convictions. The staff member had moved to England from another country. Although the provider had completed a Disclosure and Barring Service (DBS) check to check if the person had any criminal convictions, this would not show criminal convictions from another country. We asked the provider if they had asked the staff member about the answer given on their application form before appointing them and they said they had not. Another staff member had previous criminal convictions evidenced on their DBS check. We saw no evidence that this had been discussed further with the staff member or assessed by the provider. We asked the provider if they had carried out a further assessment of the applicant's suitability before employing them and they said they had not. Previous criminal convictions may not preclude staff from working with people, however it is crucial further assessment takes place with the applicant to find out more about the applicant and their convictions. This would enable the provider to be assured of their suitability before employing the staff member. One staff member's recruitment file had no evidence that an interview had taken place to test their skills and character before employment was offered.

The failure to ensure all necessary checks are carried out to ensure only suitable staff are employed to care for people living in the home is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Ashley Down Nursing Home. The comments we received included, "Very safe", "Perfectly safe" and "Yes, I feel safe".

Staff had access to guidance about abuse through the provider's safeguarding procedure. A copy of the local authority safeguarding policy, protocol and procedure was kept in the nurse's office. However, it was not the most up to date copy of the procedure as it was dated January 2014. The local authority policy had been updated in April 2015 with changed guidance and telephone contact numbers. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. We spoke with the provider about this and they said they would download and print a copy. Relatives knew who they would speak to if they had concerns about their loved ones safety. One relative said, "I would talk to staff or [The provider]."

We recommend a copy of the up to date Kent and Medway Safeguarding protocols are put in place for staff to refer to should they need it.

People received their medicines as prescribed from nurses that were suitably trained. Medicines were kept safe and secure at all times when not in use within a medicine room. Systems were in place for the ordering, obtaining and returning of people's medicines. Registered nurses administered medicines and had a good understanding of the policy and procedures for administration. People's records contained up to date information about their medical history and how, when and why they needed their prescribed medicines. Some people had 'As and when required' (PRN) medicines, for example pain relief medicines. Systems were in place to ensure people received these medicines when they needed them. Nurses checked with people if they were in pain and needed pain relief before administering the medicines. Medicines administration records (MAR) were kept in good order, neat with legible writing and signatures. No errors were seen or reported. Some prescription medicines are under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. A controlled drug was prescribed for one person living in the home. Their controlled drugs were stored and accounted for appropriately.

The home was clean and well maintained. The provider employed a handyperson who carried out odd jobs

around the home as they were needed as well as looking after the gardens. Essential servicing of equipment and installations were undertaken regularly to make sure items were kept in good order.

Inadequate

Is the service effective?

Our findings

At our previous inspection on 22 and 24 November 2016 we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was in relation to; Regulation 11, Need for consent. Restrictive practice was used without evidence to show this was in people's best interests. Care plans were not reflective of people's rights within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice.
We asked the provider to take action to meet Regulation 11.

Following the inspection the provider sent us an action plan on 23 January 2017 to show how they intended to improve the service and meet the requirements of Regulation 11 by 28 February 2017. At this inspection we found that the provider continued to not work within the principles of the Mental Capacity Act 2005. Capacity assessments were lacking, consent gained was not appropriate and there was no evidence to show that decisions were made in people's best interests.

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Some capacity assessments had been undertaken with people for less complex decisions. However, these were not individual to the person, as exactly the same wording was used for each assessment. This meant capacity assessments were not decision specific. There were few records of appropriate best interest's decisions having been made on behalf of those people who lacked the capacity to make particular decisions. Those that were in place had not been completed correctly and there were no recent records. One best interest's decision record dated 26 October 2015 regarding the person's freedom to move around the home did not record who had completed the form or who else had been involved in the decision made.

One person had a friend who acted as Lasting Power of Attorney (LPA) and this was recorded in their care plan. A LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lose mental capacity at some point in the future, or if you no longer want to make decisions for yourself. There are two types of LPA; an LPA for financial decisions and an LPA for health and care decisions. This was a long standing arrangement and the person now lacked the capacity to make their own decisions. We found no evidence of the LPA in the person's care file. We asked the provider if they had a copy or had seen a copy of the LPA and they were unable to say clearly that they had seen a copy but did say they did not have a copy in the home. We asked if the LPA was to support or make decisions for the person's finances or health and care as this would determine the decisions the friend with LPA could make. The registered manager told us the LPA was for finance decisions. The friend with LPA had signed many declarations and consent for health and care decisions. For example, the friend with LPA had agreed for the person to have sedation at night to help them sleep and also that they were happy with the security arrangements in the home. These were clearly health and care decisions and not financial. The registered manager had not fully checked the legal arrangements to ensure the person's basic rights were upheld.

Consent forms had been signed by people and sometimes relatives. The consent forms were not appropriate as people were asked to sign their consent to a number of very different decisions on one form. For example, one consent form that was signed by every person or their representative was to gain consent for; 'bedrails, wheelchairs, safety belts, reclining chair, administering medicines and delivery of care'. The consent form went on to state, 'I fully understand the reasons and the need for the above safety equipment'. Not all of 'the above' were actually safety equipment so the consent form that people had been asked to sign was incorrect with misleading information. Many of the items listed required separate consent forms and separate capacity assessments and best interest decisions if people may have lacked the capacity to consent. One person's relative had signed the consent forms on their behalf, even though they had no legal authority to do so and no evidence of a best interest decision having been made. The care plan stated, 'Next of kin has agreed to make decisions on [their] behalf' and 'Staff to refer decisions to next of kin'. This misunderstanding of the basic principles of the MCA 2005 undermines people's basic rights.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There was no clear process for carrying out mental capacity assessments prior to a DoLS application being made. Applications had now been made by the registered manager to the supervising authority to deprive people of their liberty. Four applications had been made on 10 May 2017 although no authorisations had yet been granted by the supervising authority.

Staff had a basic understanding of the MCA 2005 but did not appear to read people's care files to check the records. One member of staff said, "People are assessed at their initial assessment so we are told then". When asked how they knew if changes in people's capacity occurred after they moved in to the home, they said, "We are told at handover by the nurse, verbally". The staff we spoke with did not know who a DoLS application had been made for and if any DoLS authorisations were in place. This meant that people's basic rights within the principles of the MCA might not be upheld if staff did not have a full and up to date knowledge of each person's status.

The failure to uphold people's basic rights and non-compliance with the Mental Capacity Act 2005 is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many people were not able to express their views to us about the choices they were given and if they had the right support to make decisions. When asked if they made their own decisions, one person said, "Most of the time, yes".

The registered manager had changed the format of daily records and where they were kept and this had led to improvements. Staff told us they found it easier to record the care given since the changes had been made. They told us all recording charts that required regular updating throughout the day were all kept together in one place. This had not been the case before, leading to gaps in recording.

Health care professionals had been contacted for advice and treatment, such as the GP or district nurse. However, where people's needs were more complex and required further intervention this was not always followed up and pursued. For example, a request had been made to the GP to make a referral to the community mental health team in June 2016. This referral had been not been accepted. However, serious concerns continued and no follow up referral was discussed with the person or followed up with community mental health team.

People sitting in the lounge were given the choice if they wanted to go to the dining room to eat their lunch. Only three people ate their meals in the dining room. Each of these people required assistance to eat their meal. One staff member and the housekeeper supported people to eat their meal. This meant that one person had to wait for their meal until the other two people were finished. No explanation was given to the person that they would need to wait or for how long. The person was not given the necessary respect of explaining why they were not given their meal along with other people and how long they were expected to wait. People were happy with the food, no one said they did not enjoy their meals. Food and fluid charts were recorded where necessary and kept up to date. Nurses checked if people were at risk of malnutrition by regularly completing a recognised tool to determine the risk level. Referrals had been made to dieticians if concerns were raised about people's loss of appetite or difficulty swallowing. Some people had been advised to take a pureed diet if the risk of choking had been identified.

Staff had the opportunity to have one to one supervision meetings with the registered manager. Prior to March 2017, all staff had supervision with an administrator employed by the provider. Registered nurses also had their supervision with this member of administrative staff which would not have addressed their clinical supervision and training needs. The administrator left the service of the home in March 2017. The provider had been responsible for supervision since then. As the provider was a registered nurse, this meant the registered nurses had the opportunity to receive clinical supervision from a professionally trained nurse. All staff whose files we looked at had received one supervision by the provider since March 2017.

Staff had attended updates of all the basic training required to carry out their role since the last inspection. Some training refresher courses remained outstanding; however, dates for these had been booked. The training still to complete included first aid, booked for 12 July 2017, nutrition and hydration, 21 September 2017 and dementia, 16 November 2017.

Registered nurses had not been supported to develop their skills further. They had attended the same training course as the unqualified staff. One person had a catheter in place which required changing every 12 weeks. The district nurse came to the home to change the catheter. When we asked the nurses why they did not carry out this nursing task they told us they had not received the update training despite asking for this. They had also asked for update training to enable them to carry out blood tests and this had not taken place either. They said this was because systems needed to be put in place to keep their skills and practice up to date following the update training and this had not been done.

We recommend the provider researches and puts into effect the appropriate training and continuing professional development to keep the professional competency of registered nurses updated.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection on 22 and 24 November 2016 we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach was in relation to; Regulation 9, Person centred care. People's continence needs had not been adequately assessed in order to provide appropriate care and treatment. We asked the provider to take action to meet Regulation 9.

Following the inspection the provider sent us an action plan on 23 January 2017 to show how they intended to improve the service and meet the requirements of Regulation 9 by 28 February 2017. At this inspection we found that the provider had made some improvements such as the care plans now addressed people's continence needs and regular checks on people were recorded better. However, we found that further improvements were required because concerns were found around the person centred care and the support people received.

Staff were now evidencing that they were checking on people regularly to assist with their personal care needs. However plans of care were not person centred and focused on people's nursing and personal care needs. People were observed sitting with little stimulation and consideration for their well-being. Those people who were not in a position to be able to choose whether to watch TV or listen to the radio, or neither, in their room, tended to have a pop music radio channel playing all day. On the first day of our inspection, one person who was nursed in bed was making loud high pitched noises on a regular basis throughout the day. This could be heard clearly downstairs when the person was upstairs. Staff could not tell us why the person was making the noise and said they did this often but not every day. We could find no evidence of interventions that had been tried by staff to find reasons why or to help the person to settle. Although staff were attending to the person's personal care needs, we did not see any staff sitting with the person spending social time with them. Another person was sitting in a chair very close to the person who was making the loud high pitched noises, for the whole day. The staff attended to the person's personal care needs, however, they did not sit and spend time with the person. The person was living with dementia and was not able to stand up and walk away from the chair to move elsewhere away from the noise. Staff did not appear to consider the situation would be distressing for the person and may have a negative impact on their well-being. We spoke with the provider about this and they said they were surprised because the person sitting in the chair spent all their time in the lounge, seven days a week. We told the provider that the person had not been in the lounge the whole of the first day of inspection and only for two to three hours in the morning of the second day. People were at real risk of social isolation and there were no care plans to address this or risk assessments in place to minimise the risk.

Staff told us they did not have time to sit and chat with people or spend any sort of one to one time. One staff member said, "But I always chat with people when I am doing their care and checks". The home was very quiet with very little in the way of banter and laughter between people and staff.

There was one double room in the home and two people were sharing this. A staff member told us the two people began to share the room as the home was full when they first moved in and this was the only available room. This meant that it had not been a preferred choice by either person when they first began to

share. We asked if either person or their relatives had been given the opportunity to move to a single room as there were a number of vacancies in the home. The provider told us they had not offered people this opportunity, but said that one person's relative was happy for their relative to share. There was no evidence of any discussion having taken place about continuing to share when other options were available. We asked if there had been a best interests discussion about the interests of either person to determine if it continued to be in their best interests to share a bedroom. The provider said this had not happened.

There was no evidence that people or their relatives were involved in planning and reviewing their care. Care plans did not show that this was the case. We asked people if they were involved and people said, "No" and "That was done when I came, nothing has changed". A relative said, "I leave that to the staff and the GP".

The failure to ensure person centred care was provided to meet all the needs and preferences of people is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they thought the staff were caring and they thought they were. The comments we received included, "I am looked after well, you get some care from staff better than others", "Yes, oh yes, I insist on it" and "They are OK".

We observed some kind and caring exchanges from staff to people. Staff made sure people knew what they were going to do before they assisted them. For example, staff supported people to move from their chair in the lounge to the dining room for their lunch. One person required a hoist to move from their chair to a wheelchair. Staff told the person what they intended to do and when the hoist was starting to move so they did not get too anxious. Staff chatted with people while they assisted or encouraged them with their meals.

Staff knocked on people's bedroom doors before entering. Bedroom doors were closed when personal care was being delivered, maintaining people's dignity and respect. Staff knew people well and were able to describe the care each person required.

The provider gave people a guide to the home when they first moved in. This included the information people would need to know about the services provided within the home.

Inadequate

Is the service responsive?

Our findings

At our previous inspection on 22 and 24 November 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 9, Person centred care. People were not given the opportunity to take part in meaningful activity that focused on their needs or preferences; Regulation 16, Receiving and acting on complaints. The provider had not updated their complaints procedure so that people had the correct information available to them should they wish to make a complaint. We asked the provider to take action to meet regulations 9 and 16.

Following the inspection the provider sent us an action plan on 23 January 2017 to show how they intended to improve the service and meet the requirements of Regulation 9 and 16 by 28 February 2017. At this inspection we found that the provider had made the necessary improvements to the complaints procedure. However, people continued to not have the opportunity to take part in meaningful activities to suit their individual needs and interests.

We asked people if they could choose to do different activities and those people who could speak to us were quite vague about this. The responses we received included, "Anything you like, I watch a lot of TV, mainly news programmes", "You can if you want to, I like sitting on my own" and "No". A relative said, "[They] listen to music on the radio on the telly".

Of the ten care plans we looked at, two people had a 'Daily / social activities' care plan. One was completed on 17 January 2017 and stated, to offer the opportunity to participate or to choose what they want to do. The plan said to 'record monthly'. No other record had been made. The other care plan said to, 'play old music or old movies on TV'. We only saw the person's TV with a pop music radio channel playing all day. An activities coordinator had been employed since the last inspection and had commenced in post on 20 March 2017. They were on duty in the afternoons between 13.30 and 16.30. Activities were taking place in the lounge in the afternoon of the first day of inspection with three people who were taking part in art and craft activities. These were the same people who had been in the lounge most of the day. On the second day of inspection games were being played including target practice. There was no evidence that the activities on offer were relevant to individual people's interests. Activities were not offered to encourage people to take part and join in together as a group to increase stimulation and social involvement. Activities to motivate people such as singing together, armchair exercises or bingo were not evident as taking place through the week. The activities coordinator said they tried to get around to people in their rooms every other day to have a chat and tried to encourage people to come into the lounge. A coordinated plan consisting of people's interests and motivational group activities was not evident.

Many people stayed in their rooms, some because they were nursed in bed or they chose to stay in their rooms. Some people were sitting in their rooms and it was unclear whether they had made a choice to do so. Most bedroom doors were closed at all times. We looked in people's care plans to see if people had made a choice to have their bedroom doors closed. We checked to see if a best interest decision had been made when people had been assessed as not having the capacity to make the decision. We found no evidence of people being asked what their choice was as part of the care planning process. This was raised

at the last inspection on 22 and 24 November 2016 as an area of concern that needed to be addressed and rectified. We asked the provider why most people had their bedroom door closed and why they had not been asked to give their preference. The provider was unable to give an explanation but did say it was due to fire regulations, an answer they had given to the previous inspector in November 2016. This was not the case as all doors had fire 'door guards' fitted to them to safely keep the doors open. This is an approved method of propping doors open as they close automatically if the fire alarm sounds. People were at risk of social isolation by having their bedroom doors closed when they had not been asked their preference about this.

The failure to provide care that took account of people's individual preferences or to provide meaningful activities based on people's individual needs and interests is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had care plans in place recording information of the personal care people required. Care plans included personal hygiene, oral hygiene, reduced mobility, skin integrity and sleeping. Either the provider or the senior nurse completed the care plans detailing the person's assessed care needs. Care plans were clinically led and focused on people's nursing and personal care needs. Although covering the basic information, care plans were generalised and not relating to the person as an individual. People did not have care plans to reflect their social, emotional and psychological needs based on their preferences. People's names were used through some of their care plans and at other times they were referred to as 'the resident'. Other areas of people's lives, their social and cultural needs, that were fundamental to their well-being and comfort within their home environment were lacking. This could have a potentially significant impact on people's mood and behaviour.

Care plans were in place for people whose behaviour could be challenging. However, although a basic plan was in place, given the nature and extent of people's behaviour the essential individual step by step detail and guidance for staff to follow was not in place. A detailed person centred plan would assist staff to care for each person appropriate to their individual needs and wishes. For example, there was no reference to the ABC charts in use, although care plans stated, 'Document any misbehaviour (sic) on [person's] records'. One person's 'Anger and aggressive' care plan stated that the person, 'does not like to be disturbed' and '[person] then try to be difficult and can get angry'. Although it was stated in their care plan that the person did not like to be disturbed, records showed that staff continued to wake them very early morning to carry out personal care tasks such as changing an incontinence pad. This often caused real anxiety to the person resulting in extreme upset. Although the care plan stated, 'If [Person name] does not calm down, try again in 15 – 20 minutes'. However, staff often recorded that they continued until they completed the task even though the person was clearly distressed, causing greater upset. One staff member had recorded, 'kept punching me, managed to change pad with nurse help'. Many staff recordings of the person getting upset were very early in the morning when they did not want to be disturbed, as stated in their care plan. For example, staff had recorded at 06.00 on 23 March 2017, 'Came to give personal care to [person] also to wash and shave' then 'Due to personal care [person] was physically aggressive, hitting with arms and kicking with legs' then 'Only able to wash top half, unable to shave'.' It was not clear why staff considered washing and shaving the person at 06.00 as the person's recorded response showed it was not their choice and it was not documented as a preference in their care plan. People were not receiving person centred care that took account of their individual needs, wishes and preferences.

Although monthly evaluations of people's care plans were carried out by the provider or the nurses, there was no evidence of changes being made to care plans in light of incidents. People and their relatives were not involved in reviewing their care plans. This meant that care plans may not capture how the person wanted their care delivered. Where people had been assessed as lacking the capacity to share their views of their care, relatives or friends who knew them well were not consulted about suggested changes to their

care plan to ensure it remained in their best interests.

Staff told us the provider and registered nurses completed the care plans. Staff said that if they needed an update this was verbally given. There was little input from the care staff into people's care planning. One member of staff told us, "We can read them [care plans] if we want to, or just ask the nurse if we want to know anything".

The failure to provide person centred care plans that reflect people's individual needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An initial assessment was carried out with people and their family members (if appropriate) to determine what their needs were and if their needs could be met at Ashley Down Nursing Home. People's medical diagnoses were considered and if they needed the assistance of specialist equipment such as a hoist, a wheelchair or pressure relieving equipment.

The provider had a new complaints procedure. How to make a complaint was included in the service user guide, a copy of which was given to people when they first moved into the home. People were advised to take their complaint to the registered manager and if they were unhappy with the response from the registered manager, they may write to the director of Ashley Down Nursing Home. These were actually the same person. The telephone number for the Local Government Ombudsman (LGO) was included but not their address. As the service user guide was the document that people may refer to if they wished to make a complaint, it should have been correct and reflect the provider's actual complaints procedure which had differing information. No complaints had been made since the last inspection.

We recommend the service user guide is reviewed and updated to include a complaints procedure that provides the correct information for people and their relatives to follow when they wish to make a complaint.

Residents meetings were held regularly. At a meeting on 03 March 2017 five people attended and the registered manager asked for their feedback on particular aspects of the home. For example, a Valentine's day party had been held and three people said they enjoyed it. Two people said the meals were good. One person said they wanted a TV in their room. When asked if staff were kind and helpful, one person said staff were 'sometimes abrupt'. An action plan was in place alongside the notes of the meeting, however, actions were not evidenced as completed. The action plan stated the provider would approach the son of the person who requested a TV in their room to ask if they were able to purchase a TV. However, the action plan did not say when the action should be completed and did not report if this had actually happened. There was no record made of the action taken, if any, regarding the comment about staff being abrupt.

People had been asked their views in a survey carried out in April 2017. Of the 16 people living in the home at the time, five were not able to give their views, therefore 11 questionnaires were returned completed. The majority of the feedback was positive. Two comments were made about activities, 'I would like to take part more' and 'I would like to while in bed'. One person said about staff, 'I have to wait a long time for them to come'. We asked people if they felt they were listened to and most people said yes, although didn't make any further comment. One person told us, "I think it depends". People's relatives were asked to complete a survey in May 2017 to gain their feedback of the service. Five completed questionnaires were returned. Four relatives took the opportunity to make a number of comments on the questionnaire. Three of these commented that people were left on their own too often – either in the lounge or in their bedroom. Comments included, 'I do not like the way residents are left in the lounge on their own', 'Residents left for long periods unattended, no interaction with anyone' and 'I sometimes think [Name] is left on [their] own

too long. I appreciate staff are very busy, but would like more contact'. People and their relatives had made comments about how the service could improve and there was no evidence their views had been listened to and acted upon by the provider.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 22 and 24 November 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 17, Good governance. The provider did not have effective systems in place to monitor the quality and safety of the service provided; Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify CQC of important events that had taken place in the service.

We asked the provider to take action to meet Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We took enforcement action against the provider and told them to meet Regulation 17 by 28 April 2017.

Following the inspection the provider sent us an action plan on 23 January 2017 to show how they intended to improve the service and meet the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 by 28 February 2017. At this inspection we found that the provider had made improvements to this regulation. The provider had notified CQC of important events as required since the last inspection. However there continued to be serious concerns and many further improvements were required to meet the requirements of Regulation 17 by ensuring that effective systems and processes were put in place to monitor and improve the service.

Although the provider had invested in purchasing a whole set of policies and procedures and a quality monitoring system, these had not been used effectively to improve the service. A range of audits to complete were filed in a 'Quality audit' file. The audits included; care plans, documentation, accidents and incidents, falls, staff training, complaints and various environment audits. In February 2017 all the audits were carried out by an administrator employed by the provider. All audits undertaken by the administrator were detailed and recorded. They picked up many concerns and issues, thoroughly documenting and completing an action plan for the provider to work through to make improvements. For example, the administrator looked at 14 care files and people's documentation as part of the February audit. Looking through in detail they produced an action plan and although some of these actions had been completed by the time of this inspection, not all had. The administrator also carried out the audit of accident and incident records in February 2017. They picked up many of the issues around ABC charts and incident recording that were found on this inspection. They highlighted that ABC charts were not being completed correctly even though the provider told us they were unaware this was the case. No action had been taken by the provider to improve and monitor accordingly.

The administrator left in March 2017 so the provider was responsible for completing the audits. Not all audits were undertaken each month and those that were did not pick up any issues. For example, the provider had recorded that they had audited five care files in May 2017, however there was only documentation for one file. The audit stated that changes were required but there was no action plan to ensure the changes were made. The provider completed the accident and incident audit in May 2017. It was unclear how many incidents there had been. Although they had recorded that there was a theme to the incidents, they did not record what, only that ABC charts were used to identify triggers. No action plan was

completed and the audit was not signed or dated. Although the provider had audited accident and incident records they failed to identify the seriousness of the incidents and decide on a course of action to prevent further similar incidents.

We asked the provider if they used feedback received and from questionnaires and residents meetings to identify areas for improvement. They said they did not do this as they had only received five completed relative questionnaires and they, "thought there was no need". We pointed out the comments made around people being left on their own for periods of time and relatives being unhappy with this. Two people had also responded in their questionnaire that they would like to have the opportunity to participate in more activities. The same concerns had also been highlighted in the last two CQC inspection reports. Local authority staff had carried out a contract monitoring visit in 2016 and reported many areas that required improvement. The officers had returned in April 2016 and had found none of the action they requested had been taken. As a consequence they had restricted admissions to the home from their local authority area.

The provider was on the rota as a registered nurse for generally two shifts per week. Their two days off were added to the rota, however all other days were left blank. Staff told us that when the provider was not on shift they were not often in the home. When we asked the provider how many days they were present in the home to carry out their registered manager duties their answers were vague. They eventually said four times a week. Sometimes they stayed a few hours after their shift and other times came in for a few hours, sometimes at weekends. Staff told us that the provider was not generally in the home on the days that were blank on the rota sheet. Staff said they sometimes popped in for an hour or so unplanned, usually at the weekends. A member of staff said, "[The registered manager] is not here much, only when on shift".

The provider was also the registered manager of the home. The provider also owned another nursing home where they were also the registered manager. After the last inspection they told CQC they would be employing a registered manager for their other home. There were clear concerns around the management of Ashley Down Nursing Home and the lack of presence of the registered manager in the home at that time. The same concerns remained at this inspection. After this inspection we asked the provider by email if recruitment to the registered manager position had been completed. They responded saying they had not yet been successful in recruiting to the registered manager position at their other home. Staff knew the provider had another home but did not know anything about it and had nothing to with it. There was no relationship between the two services that could be used for peer support and sharing good practice and ideas.

Staff meetings had been held. One meeting on 15 March 2017 was led by one of the registered nurses. The nurse raised a number of issues with staff around care that was not being delivered to the standard they expected. For example, issues were raised about the timeliness of answering call bells and infection control concerns. The nurse also raised concerns with staff around their responses to behaviour that challenges. They said they would request challenging behaviour training. We were told the training had been requested and had been planned for December 2017, this was felt to be too long for staff to wait and this had been raised with the provider. However, the date of this training was not brought forward until the second day of our inspection. Staff told us they had raised their concerns with the provider, however, no action had been taken. Another staff meeting, led by the provider, on 30 June 2017 was held to discuss the new daily records folder to make sure all staff understood the folder and the reasons for the introduction.

Although some staff told us the provider was approachable and they thought they were a good manager, they were vague about the smooth running and management of the home. One member of staff told us, "The registered manager is very approachable and professional". Another said, "They [The provider] do not give the support required". When asked if the home was well managed, the comments we received from

staff included, "No I don't think it is, changes are not made when they should be. When we raise concerns they are not listened to or actioned", "I can't comment on that as I have never managed a home before". When questioned further, they said, "I do my job, [the provider] is a good manager but I don't know what [they] are like with paperwork".

The failure to ensure effective systems were in place to regularly assess and monitor the quality of the service and to take action to make the required improvements is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report rating 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 not displayed their rating in the home.

This failure to display ratings of the most recent inspection is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people living in the home were under 65 years of age. The provider was registered to provide personal and nursing care to older people. Providers are expected to notify CQC of any changes to their statement of purpose. We asked the provider about this who told us they were aware they must notify CQC of changes such as this. However they said they were unaware two people under the age of 65 years were living in the home.

Although records were kept secure, some records such as staff files, meeting minutes and safeguarding files were kept locked in the provider's office. Only the provider had the key so the nurse in charge did not have access when the provider was not available.

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 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to support people to maintain their basic rights by not ensuring mental capacity assessments for particular decisions had been carried out. Decisions had not been made within the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out adequate employment checks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed the rating of the last inspection on their website so that people, visitors and relatives could view the rating given by CQC following the previous inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to suitably deploy staff to ensure people's needs were met.