Care Quality Commission

Bupa Care Homes (GL) Limited

Elmridge Nursing Home

Inspection report

19A The Pastures, Coulby Newham, Middlesbrough, TS8 0UJ
Tel: 01642 590038

Date of inspection visit: 03, 10, 11 and 18 August 2015
Date of publication: 21/12/2015

Ratings

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

Overall summary

This inspection took place on 03, 10, 11 and 18 August 2015. The first day was unannounced which meant the staff and provider did not know we would be visiting. We were unable to enter the service on the first day because there was an infection control outbreak. The provider knew we would be returning when the infection had cleared but they did not know when this would be; they did know when we would be returning on the third and fourth day of inspection.

Elmridge provides nursing and residential care for up to 42 adults living with a learning disability; at the time of our inspection there were 34 people who were using the service. Elmridge is a purpose built building in its own grounds within a residential area. The service is split into four units (Ash, Birch, Cedar and Dutch). There is a large communal area within the service where activities take place and there is a sensory room.

At the time of our inspection, the registered manager had left the service and a new manager was in place. They had been in post for three weeks and planned to submit an application to the Care Quality Commission for their registered manager status. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We previously carried out an inspection in April 2014. We found that the service was not meeting the standard for record keeping. Care plans and risk assessments had not been regularly reviewed and there were gaps in the recording of information. We inspected the service again in July 2014 and found that the service and taken action and was meeting the standard for record keeping.

At the time of our inspection there was a high number of safeguarding alerts open for people who used the service. These alerts had been made by visiting professionals and not the service. This meant that the service had failed to identify when a safeguarding alert was needed and take the appropriate action. Accidents and incident forms had not been fully completed which led to a number of safeguarding alerts not being made. There was a whistleblowing policy in place but staff were not confident in using it.

Risk assessments for the overall running of the service were up to date. Risk assessments for people who used the service had not been reviewed regularly. Gaps in employment had not always been investigated.

The service did not use a dependency tool to determine staffing levels. We could see that there were enough staff on duty to provide care and support for people, however we questioned the arrangements in place for the deployment of staff. During our inspection, we found that new members of staff who were meant to be shadowing more experienced members of staff were left on their own. On one unit we found that staff were stretched trying to managing the complexities of people's needs and on another unit there appeared to be more staff than needed.

Record keeping, administration and audit arrangements for medicines required improvement. We found gaps in records and incorrect totals. Some medicines were not available.

Certificates for the day to day running of the service and equipment used by people and staff were up to date. However there not enough hoists in place at the service for people who needed them.

The service had a dedicated domestic team who ensured the service was kept clean. On the first day of our inspection there had been an infection control outbreak. We could see that the service followed the procedures necessary to manage this outbreak.

Staff supervision and appraisals were not up to date. This meant staff had not received regular support and guidance to carry out their roles. Mandatory training was up to date, however we found that staff had not received training in living with a learning disability and autism. We also found that staff had not received training in specialist communication methods [Makaton, picture boards, for example] which are appropriate to the people who used the service.

People had enough to eat and drink throughout the day. Menu's had been created by Bupa which ensured that people received nutritious food. We found that these menus were not always suitable for people who had difficulties with swallowing.

People had regular access with health professionals such as the Dentist and General Practitioner. At the time of our inspection, we saw the Dentist supporting people with their healthcare needs.

We could see from the records and from speaking to people that they were not regularly involved in decisions about the care and support which they received.

Staff provided care which was specific to people's needs; although records did not always have the detailed needed to provide personalised care and support. Staff who had worked for some time at the service knew the people they cared for, however there was insufficient information to support staff who had just started working at the home.

Staff detailed the steps they took to maintain people's privacy and dignity. There was evidence of people being given choice during inspection.

There were significant gaps in all records looked at, which the service had failed to improve the quality of record keeping despite measures put in place by the provider and discussion around how to make improvements with commissioners.

A thorough complaints procedure was in place and all staff were aware of their responsibilities if they received a complaint.

Summary of findings

Poor systems were in place to monitor and improve the quality of the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Risk assessments had not been regularly reviewed. Record keeping, administration and audit arrangements for medicines required improvement.

There were enough staff on duty; however they were not always deployed effectively. There was a shortage of employed nurses; the service had to rely on agency nurses.

Safeguarding alerts had not always been raised by the service. Incident forms had not always been fully completed which meant that some safeguarding alerts had not been raised.

Is the service effective?

Requires improvement

The service was not consistently effective.

Supervision and appraisals had not been carried out effectively for staff. Mandatory training was up to date, however despite the service being designed to provide care and treatment for people living with a learning disability and autism spectrum disorders staff had not received training about these conditions. Staff had not received training in the use of specialist communication methods that were relevant to the people who used the service.

People had not signed consent forms, where people were not able to, a legally appointed representation was not in place to give consent. Photographs were on display but there was no consent to do this. Appropriate procedures for carrying out mental capacity assessments had not been followed. A deprivation of Liberties safeguard had expired for one person, however the service continued to support this person with the safeguards in place.

Healthy and nutritious food was provided, staff knew how to adapt food for people with swallowing difficulties and for people who needed assistance to maintain or increase their weight.

Is the service caring?

Requires improvement

The service required improvements to be caring.

Care plan reviews were not carried out regularly. There was no evidence of people being involved in decisions which affected them.

People were cared for by staff who knew them well. People's dignity and respect was maintained. There was evidence of choice from care staff.

The were no communication aides specific to people who used the service.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

There were significant gaps in all records looked at during inspection. Assessments tools in place were not specific to people with a learning disability and could not be completed.

The gaps in the records led to a significant number of safeguarding alerts being raised by professionals which led to the commissioner reviewing the placements which they made at the service.

There was a good range of activities in place for people. People had choice about the activities they could do at the service; however people could not always go outside when they wanted to.

Is the service well-led?

Requires improvement 

The service was consistently well-led.

There were poor systems in place to monitor and improve the quality of the service. Where concerns had been raised through internal audits, the registered provider failed to take appropriate action.

There was a divided staff team at the service. Staff enjoyed their roles in the home, however morale was poor.

A new manager was in place at the service. Staff spoke positively of them but remained uncertain about the future of the service.

Elmridge 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 03, 10, 11 and 18 August 2015. During this time, three inspectors, a pharmacist inspector and an expert by experience were involved in the inspection. The expert by experience involved in this inspection had direct experience of caring and supporting someone who lived with a learning disability.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

The provider was not asked to complete 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.

We spoke to people who used the service, however not everyone we spoke to could communicate with us. We spoke to three relatives. We also spoke with the operations director, area manager, home manager, clinical services support manager, deputy manager and two nurses. We spoke with seven care staff, the administrator, the maintenance man, a member of domestic staff and the chef. During the inspection, we reviewed three care records in detail, eight PEG feeding regimes, medicine records, staff files and records relating to the management of the service including policies and procedures. We also observed care and support in communal areas of the home and a daily meeting with senior members of staff.

Requires improvement

Is the service safe?

Our findings

The service did not use a dependency tool to determine staffing levels; staffing was informally calculated based on the number of people who used the service. There were enough nurses, senior carers and carers on duty; however we questioned whether staff were deployed appropriately. We observed a number of occasions where new members of staff [meant to be shadowing] were left on their own. We raised this with the regional manager who took immediate action. On one unit, we could see staff were under pressure trying to effectively support people and their individual needs, this meant that one person who was allocated 1:1 time did not always receive this. On another unit, we could see that there were more staff than were needed because people were in the communal area of the home with activities staff. One staff member told us, "People are safe with the staffing levels we have, however we need the same staff on each unit for consistency." Following our inspection, the service introduced a dependency tool to determine staffing levels.

Many people who used the service required the support of two staff members. There were eight people on Birch unit who required 2:1 support; we found that the two hoists on this unit were insufficient at times. This meant staff had to borrow a hoist from one of the other units which left that unit without a hoist. This meant that they could be a delay in providing care and support to people. One staff member we spoke with told us that another hoist was needed on Birch unit.

We found consistent gaps in all of the care records we looked at including the risk assessments for people who needed them. We found that risk assessments had not always been in place prior to January 2015. We also found that risk assessments had not been reviewed each month [as stated in the care documentation], for example, a bed rails risk assessment for two people had been carried out in May 2015, but had not been reviewed since. This meant we did not know if these people still needed them. We could see that the maintenance person checked the safety of these bed rails each month. A moving and handling risk assessment for three people had only been reviewed once since May 2015. A Waterlow [pressure sores] risk assessment had been completed in March 2015 which showed the person was a high risk of developing a pressure ulcers, however this had not been completed again until July 2015 which showed an increased score meaning the person continued to be at high risk. A MUST [nutrition] risk assessment had not been completed between January and May 2015 for one person.

We looked at the medicine administration records (MAR) for 12 people and talked to staff. All of the people who used the service had their medicines given to them by qualified nurses. People were given time and the appropriate support needed to take their medicines. Medicine protocols were in place and included information about dosage, frequency, administration and potential side effects. This meant that staff had the information they needed to dispense particular medicines. We found medicine records were not completed correctly placing people at risk of medicine errors. For example medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and nurses can monitor when further medication would need to be ordered.

When we checked a sample of current 'boxed' medicines alongside the records we found that six medicines for two people did not match up so we could not be sure if people were having their medication administered correctly. The home had a process in place to record the stock count for boxed medicines and for three people on the previous MAR this showed that medicine had been given at the incorrect dose on a number of occasions. Four medicines for three people were not available. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm. We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had started a daily medicine audit recently it was not robust and had not identified all of the issues found during our visit. Previous monthly audits identified issues in the home and an action plan was in place but this had not been acted upon.

One person who used the service received ten hours funding for 1:1 support each day. We found staff regularly struggled to provide this support with the pressures of the

Requires improvement

Is the service safe?

day to day running of the unit this person was based on. Because of the nature of incidents which arose on this unit, staff were often needed to assist which meant the person didn't always received their 1:1 time.

This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection, there were a number of concerns relating to the service which had led to the local authority and NHS commissioners reviewing the care provided of the people they had funded care for at the service. At the time of our inspection, there were twenty five safeguarding alerts open with the local authority which had been raised by professionals visiting the service and not the service themselves. This meant the service had not raised a safeguarding alert when needed. We also found that the provider had not informed CQC using a specific notification.

All staff had received safeguarding training and were able to give examples of what could constitute abuse including the action which they needed to take. One staff member told us, "I have not seen anything but care here. I think it is a really caring service. I am sure people would report it." On the third day of our inspection the manager made us aware that on the second day of our inspection; a member of staff found a medicine on the floor [on the morning] and took this to a senior member of staff. The senior member of staff had waited until we left at 18:00 to raise this with the manager. This senior member of staff had not carried out any investigation, recorded it or raised a safeguarding alert. The manager raised a safeguarding alert after being informed.

A whistleblowing policy was in place which all staff told us they were aware of and would raise any concerns which involved people they cared for, however not all staff felt confident about raising concerns about other staff members in the team because of fear of reprisal. Some staff spoke negatively about the whistleblowing policy and described the "backlash received after having gone through this process." A small number of staff had been involved in the disciplinary process at the service. Where the disciplinary process had resulted from a safeguarding alert, CQC had been notified. Disciplinary records detailed the reason for each staff member being involved in the process and included all records of meetings. We could see the disciplinary procedure [as outlined in the disciplinary policy] had been followed.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (1), (2), (3) Safeguarding.

Failure to notify CQC of the safeguarding incidents is a breach of the Care Quality Commission (Registration) Regulations 2009, regulation 18. This matter is being addressed outside of the inspection process and we will report our actions in due course.

There was a shortage of employed nurses at Elmridge which meant that the service used agency nurses. At the time of our inspection, the service did not request information about the qualifications and experience of agency nursing staff. This meant the service did not know if nurses had training or experience specifically in Learning Disability nursing. Further to this, the service did not know if agency nurses had received specific training in PEG feeding regimes. After the second day of our inspection, the service started to request a PEN profile of all agency staff. This meant that the service would have a photograph of the nurse they were expecting and information relating to their qualifications and experience. Further to this, the service had implemented a new procedure to ensure all new agency nurses would be aware of the layout of the building, relevant policies and procedures and procedures relating to the care and support of people.

During inspection we requested the incident forms for one person using the service for August 2015; we found that there were none for this person [we knew from other records and from speaking with staff that incident forms should have been completed August 2015]. Following a search, a staff member found them located in a drawer. We found that none of the management sections with the incident forms had been completed. This meant we could see that safeguarding alerts had not been put in place for this person.

We found that the service had failed to complete incidents forms which had meant that safeguarding alerts had not been completed.

Requires improvement

Is the service safe?

This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (1) Good Governance.

People who were able to communicate with us, told us they felt safe living at the service. Staff told us they did not have any concerns about the safety of people they provided care and support to. One relative told us, "They feel safe here. They know staff will keep them safe and the building is secure." People could not enter the building without a member of staff letting them in and the outside area was secured by fencing. Another relative told us, "We used to think he was safe but recently we have had issues which are ongoing – he's had one or two knocks and bruises. This is being addressed at the moment."

The records of the last six staff employed at the service showed that references and identification had been sought prior to commencing work at the service; however gaps in employment had not always been investigated. In the case of one staff member, we brought this to the attention of the new manager straight away and they investigated this straight away. Staff had a Disclosure and Barring Services (DBS) check prior to working at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

Each person who used the service had a personal emergency evacuation pack which detailed the support needed to leave the building in an emergency. All staff wore name badges which made them easily identifiable. All visitors to the service were required to sign in. This meant the service could keep track of all visitors to the service and ensure that people were kept safe. All records relating to the safety and security of the building were up to date. There was a maintenance person regularly on duty who ensured any areas in need of attention were carried out. Checks of equipment for people who used the service had been carried out each month and regularly serviced by engineers. Fire drills had been carried out with day and night staff. Daily fire safety checks had been carried out by the maintenance person, however we found that these checks had not always been carried out when they were not at work. We spoke with the management team and they took action to address this.

On the first day of our inspection, we were not able to enter the home. This was because there was an infection control outbreak. We had been informed of this outbreak using a CQC notification. The service had appropriately informed all of the relevant people, such as public health and the local authority. On the second day of our inspection, we could see that the home had followed all the necessary protocols and procedures. This helped to minimise the risks to people.

Domestic staff were regularly on duty and were knowledgeable about the procedures they needed to follow to maintain the cleanliness of the service. Staff had access to the personal protective equipment (PPE) they needed and we observed using it. We saw staff had access to all the necessary controls of hazardous substances to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely. At the time of our inspection, staff had not been involved in hand hygiene competency checks. This had been put in place during our inspection. Generally the home had a pleasant odour, however there was a malodour on one of the units. We raised this with the management team and asked them to take immediate action to address this.

Requires improvement

Is the service effective?

Our findings

The people who used the service lived with learning disabilities and this means for some of the people their ability to make decisions may be impaired because they lack the capacity to think through all of the negative and positive consequences of their choices. Therefore we looked at whether the service was applying the Mental Capacity Act (MCA) 2005 appropriately. These safeguards protect the rights of adults using services who lack capacity to make decisions by ensuring that if there are restrictions on their freedom and liberty.

A mental capacity assessment (MCA) care plan for one person was incomplete. There were 14 activities in the criteria in the care plan [skin care, washing and breathing, for example]. The record stated "Lacks capacity," for each of the 14 activities in the criteria. We knew this was inaccurate, for example, we could see that the person could breathe unaided and from our observations and from speaking to staff could make decisions about what they wanted to wear and what they wanted to eat. The care plan did not show what decisions the person could make for themselves. The MCA requires that staff use every means available to support people who may lack capacity to make choices and establish what aides and supports people would need.

We could see staff observed people for non-verbal cues which included eye contact and hand gestures before care and support was provided. Consent forms had not been consistently signed by people they related to. Of the three care records we looked at in detail, only one of them had consent forms which had been signed. This had been signed by a relative; this person's record did not to show whether relative had become a Court of Protection approved deputy, or if they had enacted power of attorney for care and welfare or finance or if they were appointees for the person's finance. Relatives cannot make decisions about care and welfare unless they have the legal authority to do so and the person lacks the capacity to make these decisions for themselves. Two people had not signed consent form to access care documentation. Photographs were found in people's care records and on display in the home; consent forms to take photographs had not been signed. Care plans had not been signed by the people they related to, this meant that we did not know if people had consented to the care and supported being provided.

Staff were able to provide good examples of how they sought consent from people and we were able to observe this during our inspection. However we found that people were not consistently offered choices, for instance the menus were displayed in written format but there were no pictorial menus, electronic menus or menus in large font to meet the needs of people who used the service. This meant we could not be sure how people could make their dietary preferences known. We observed the drinks and snacks trolley on one morning of our inspection which had a variety of hot and cold drinks, biscuits and fruit. People who used the service were not shown the various options and were not encouraged to make a choice. We saw that a choice of drink was made by the staff member who knew them; staff did not take any fruit or biscuits to people for them to make a choice. At lunch time during our inspection, we did not observe people making a choice about their food; we found staff made a choice for people without asking them. Following feedback, the regional manager informed us that pictorial menu's would be introduced to allow people to make their own choices.

A best interest's decision for eating had been made for one person. From the records, we could see that nursing staff from the service, an occupational therapist and a speech and language therapist had been involved and they had discussed the least restrictive options for the person before coming to a decision. However there was no evidence of the person this decision related to or their relative being involved. A best interest's decision for a lap belt for one person was made to keep the person safe. Records did not show any evidence of any alternative least restrictive options and did not show who had been involved in this decision making process. This meant we did not know if there were more suitable options available to the person and if they had consented to this decision. A mental capacity assessment for personal hygiene had been carried out in May 2015; however there was no evidence of a best interests decision.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11.

At the time of our inspection a DoL's authorisation for one person had expired. We could see that an application to continue with the authorisation had been made. The service was supporting this person using the restrictions in place with a DoL's which had expired; this meant they were

doing so unlawfully. When the DoL's authorisation for this person had been made in August 2014, an action was made for this person to have investigative surgery to improve their sight as part of this authorisation had still not been completed one year later. This meant this person had not been given access to the healthcare support they needed. Following our discussion with the service about this, a referral was put in place. A second action as part of this DoL's for this person was to increase their access to the community each week. We looked at the activities records for this person and could see that the conditions of this DoL's had not been met. For another person, we found that no capacity assessment had been completed prior to applying for a DoL's authorisation for this person. This meant the service had applied for a DoL's authorisation without deeming whether the person had capacity.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (5).

Staff supervision and appraisals were not up to date. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. This meant staff had not received regular support and guidance to carry out their roles. Mandatory training was up to date; however we found that staff had not received training in living with a learning disability and autism. One staff member told us, "We need an autism course." We also found that staff had not received training in specialist communication methods [Makaton, picture boards, for example] which are appropriate to the people who used the service. Agency nurses regularly employed to work at the service were not trained in setting up and administering PEG feeding regimes for people.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 (2) (a) Staffing.

New menus had been introduced at the service. This new resource had been created for staff which included a rotating four week menu, recipes, nutritional information and a photograph of how each meal should be presented. There was also information about how to adapt meals to suit the needs of residents, for example, grating vegetables in a cottage pie for people who may need a softer texture. However there was no information specific to people with swallowing difficulties or for people who required 'tasters' of foods. Kitchen staff were knowledgeable about how to adapt food for people with specific nutritional needs and gave examples about how to increase the calorific content of foods for people who needed to put on weight. One relative told us, "Her weight is up right now. They [staff] take notice of what you say." Care staff told us they kept senior care staff up to date when people had not eaten all of their meals. We could see that food and fluid charts were in place to monitor people's nutritional and hydration intake. Care staff showed us records which detailed each person's nutritional requirements. This meant they were aware of the support people needed with their dietary intake. Three care staff we spoke to told us about the options they gave people to make sure they maintained a good dietary intake.

Staff told us, people who used the service were not involved in planning menus. This meant people had no input about the food they were given to eat on a regular basis. One staff member told us, "The menu here is based on an older person's home." The chef told us, "If people can't do tasters, we use trial and error of foods we think will be OK for them. People never go hungry." We also found that kitchen staff were sometimes limited with the alternative options which they could offer people because food was delivered according to the new menu's; staff were not able to amend the menu's or order alternative foods. The chef told us, "Kitchen staff offer whatever is in the kitchen. Recently X told us they wanted 'Pattie and chips' so we took her to the local chip shop in a taxi." One staff member told us, "Menu's need to be more specific to the people here."

Some people received their nutritional intake via Percutaneous Endoscopic Gastroscopy (PEG) feeding. This is a way of introducing food and hydration to people who need it. Qualified nurses were responsible for administering this type of nutrition to people who needed it. Prior to our inspection, safeguarding alerts had been raised for all eight people who received PEG feeds because records did not show whether people had not been given their PEG feeds or whether records had not been updated. We were able to determine that people had received their PEG feeds; however records had not been completed regularly by nursing staff. One relative we spoke with told us, "The new nurses don't seem to know what they are doing with her PEG. They haven't had a lot of training with

Requires improvement

Is the service effective?

it. One of them asked to be moved to a different unit as she doesn't like doing it." Following serious concerns protocol, the service had arranged for all nursing staff to undertake training in PEG feeding regimes.

People had regular access to health professionals. One relative told us, "They tell me straight away if she's poorly and quickly sort her out." Another relative told us, "Twice his food was going into his lungs and they got him into hospital on time. I would have lost him if it wasn't for them [staff]." At the time of our inspection, a Dentist was in attendance at the home providing care and support to people. People had regular access to their General Practitioner and from people's records we could see that Social Workers, Occupational Therapists and Speech and Language Therapists were involved in people's care.

The four units of the home sat within a 'horse shoe' type of design. Access to the inner two units was via the outer two units and access to the dining room in the middle of this design was via the inner two units. We found that this was problematic at times, because people were regularly disturbed and led to some of the units being busier than they needed. There was a large communal space which people used to spend time with each other participating in activities. There was also a sensory room and separate dining room. The design of the building meant that there is an enclosed courtyard in the centre. There was a lack of signage throughout the service, for example, the names of each unit were not always visible. We could see that action had been taken to address this at the end of our inspection. We looked in the bedrooms of some people [with their permission] and could see that they had been individually decorated. We could see that people had been involved in choosing their own colour schemes, bedding and accessories. We found that communal areas of the home were in need of redecoration, we found that paintwork was scuffed throughout the home and could see evidence of damp [wet wall and paint lifting from the wall] in the hair salon.

There were a number of 'double doors' in use at the service which needed to be manually operated. This caused staff difficulty when supporting people who used a wheelchair. We observed numerous occasions during our inspection where both staff and people who used the service had difficulty. Where we observed people experiencing difficulty, we intervened.

We looked at the induction records for the last six staff members who had started working at the service. A comprehensive induction programme was in place for staff. Staff spent time shadowing staff within the team to become familiar with practices within the home and to get know people who used the service. The induction program included the role of the care worker, staff development, communication, equality and inclusion, safeguarding and duty of care, person-centred care and health and safety. Training records showed that staff training was up to date.

Each person who used the service had a hospital passport. This provided important information about personal details, allergies, medicines, capacity to consent and behaviours which could challenge. There was a section about 'things which are important to me' which included information about any assistance needed with communication, pain, eating and drinking and how to keep the person safe for example. There was a section about likes and dislikes, such as how the person likes to spend their time. This information is particularly important for people living with a learning disability; this information allows hospital staff to provide care and support to the person with minimal distress to them.

Requires improvement

Is the service caring?

Our findings

Care plans, reviews, risk assessments and best interests decisions did not show if the person they related to had been involved in making decisions about things which affected them. In one person's care records, there was documented information that the person liked to be included in all aspects of care however we could not see evidence of their involvement in decision making and reviews. Care plan reviews did not detail if the person or their relative had been involved in reviewing care or making changes. Where care plan reviews had taken place, limited information had been recorded. This meant the records did not show if all aspects of people's care plans had been discussed or updated.

An epilepsy care plan for one person [dated May 2015] did not reflect an epilepsy protocol [dated December 2014]. From reading the daily notes we saw that an epilepsy nurse had visited this person in July 2015 and reviewed the epilepsy protocol. However no updated copy of this protocol could be found. We also found that this person's epilepsy seizure chart had not been completed since February 2014. From speaking with staff, we knew this person had experienced seizures since this time. A behaviour plan for this person stated that they must have specific items close to hand to reduce anxiety; however during our observations we did not see these items with this person. On the behaviour plan, the record stated that the person should be given Haloperidol PRN. We found that this person was prescribed Lorazepam PRN, not Haloperidol; the records had not been updated to reflect the changes to PRN medicine.

Communication care plans did not detail how to communicate with people. For one person, communication methods specific to the person were not linked with the behaviour support plan to ensure that staff were aware of the triggers and be able to distract them when needed and to engage in meaningful communication. We saw that one person had a pictorial board because they could not communicate verbally, however we found that one person who used the service was visually impaired and there were no communication methods in place for them. From speaking with staff, it was clear that there was a reliance on long term members of staff to determine what this person wanted, rather than communicating with the person themselves. Some people who used the service had difficulties communicating. People did not have the communication devices needed. For example, Picture Exchange Communication System (PECS) were not in place for people with autistic tendencies or behaviour which could challenge. There were no pictorial choice and feeling cards or single switches on wheelchairs for 'yes' and 'no' options and there was no evidence of Makaton signing in place by people who used the service and staff.

We found activities on each of the individual units much more limited; we could see that activities centred around person care and support tasks. Some staff told us that staffing levels meant that people could not always go out into the community. A staff member told us, "One person asked to go to the pub, but we couldn't take them because there was not enough staff. I felt staffing was safe but we were told 'no.'"

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (3) (c) and (d) Person- centred care and regulation 12 (1) Safe care and treatment.

Prior to inspection, a safeguarding alert had been made because a nurse was observed shouting across the home that "X was on antibiotics." This meant that this person's privacy had been not been protected. During our inspection we observed this again. There were several occasions during our inspection when we observed staff referring to one person who lived with Down's Syndrome as the 'Down's.' We fed all of these observations back to the manager who told us this behaviour was unacceptable and planned on speaking with the staff members involved.

We observed a session in the sensory room. The two people in the room appeared to be enjoying the session, however we saw two members chatting to one another during this session. This appeared to be disruptive to the people enjoying the session. We spoke the area manager about this because the two staff members should have been shadowing more experienced members of staff. We saw that action had been taken. When we returned to observe the session again, we found a member of staff writing in people's care records and not participating in the session with people. On one of the units at the service, we observed a new member of staff left on their own with three people they did not know. We found that the two experienced members of staff had left the communal area to provide support to one person. We raised this with the manager straight away who took appropriate action.

Requires improvement

Is the service caring?

We found that when people were given medicines during breakfast, this interrupted their mealtime experience and for some people their breakfast was left untouched or unfinished. Staff used a quiet and gentle voice to talk to people whilst eating. Where assistance was provided, this was carried out in a dignified manner.

One person who used the service received ten hours of funding each day for 1:1 care. We saw little evidence [from the records] that this person went outside. Staff we spoke with told us that this person enjoyed going outside. We observed a mixed response from staff. We could see that some staff actively engaged with this person and we could see that they knew this person well. However this was not the case for all staff. During a twenty minute observation of one staff member, we could see them holding the person's hand. There was no interaction during this time and the person was staring out of the window

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 (1) Dignity and respect.

We could see that staff knew the people they were caring for. Staff were able to tell us about the support people who used the service needed, including more personalised information such as how and when people who used the service like support to be offered. Staff had knowledge of the people they cared for, including more personalised information relating to their background which helped them to establish conversations about life histories and life experiences. Relatives spoke positively about the staff employed at the service. One relative told us, "It's one hell of a home, much better than others." Another relative told us, "They [staff] are lovely in here. I can say that hand on heart." From speaking with care staff, we could see that they enjoyed working at the working at the service, one staff member told us, "I think the care here is superb and the residents are well looked after." Another staff member told us, "I love working here. The residents are my main concern, I want to make sure things are right for them."

We found that staff often made the choice for people at mealtimes, however we could see that people were given choices at other times. One staff member told us, "We give a choice, explain and provide options. For some people, we make the choice if they can't indicate. We do it with them and see their reactions. We try to give variety." Another staff member told us, "We give choice with clothing and personal care. Those people with capacity will chose and those without will give non-verbal signs such as a shake of the head. If they can't we act in their best interests. It's the same with food and activities." We could see that people who used the service required staff who knew them well to care and support them because it was only by knowing the person well that you could understand what people needed. For example, one staff member told us, "X will scream until he gets showered." Understanding this, meant staff could provide support straight away. The staff member also told us, "X waits until specific carer is on duty to ask for assistance to shave. X chooses who to 'cast on' [knitting] with and X will grind her teeth if they are not happy."

The home had a dignity champion in place. One staff member told us, "We went through privacy, choice and care during our induction." We could see that staff respected privacy. When personal care was given [providing medicines and taking people for lunch] explanations were given and care was given in a timely manner. People who used the service were not rushed. One staff member told us, "We protect people's dignity after having a shower but covering them with towels." We observed staff asking people's permission before any care and support was given. Staff were discreet when asking people whether support was needed, such as whether the person needed to use the toilet, for example. Where people were not able to give a verbal response, we could see staff observing non-verbal cues.

During our observation of activities in the communal area provided by the activities team, we saw staff actively participated in sessions with people. Staff gave people lots of support and encouragement to participate. Staff gave people lots of direction when they needed it. People were given choice about the activities they wanted to participate in and choice about what colour pens they wanted to use, for example. The activities sessions were relaxed and there was music in the background. There was lots of chatter and laughter from people. When staff were reading to people, we saw that they used animated voices to bring stories to life; we saw that people particularly enjoyed this. During all of the activities we observed, people were not rushed and could spend as long as they wanted on their chosen activity.

We observed proactive and caring care staff during out inspection. Domestic staff were singing and encouraging people to join in. Staff were complimentary to people, for

Requires improvement

Is the service caring?

example, we heard one staff member telling one person, "You are looking very smart today." We saw an agency nurse taking the time needed to ensure they took their prescribed medicine. This person initially refused their medicine, however the agency nurse sat with the person and chatted with them until they felt ready to take their medicine.

We observed one care staff asking for a person's permission before assisting them to eat. The staff member waited for a response before providing the supported needed. During our observation of breakfast, we saw staff interacting with people about their plans for the day. We could see people speaking animatedly about where they were going and upcoming plans.

We saw a carer providing reassurance to one person who appeared distressed because a different bus and driver had turned up to the home. The carer quietly reassured him that the same escort on the bus was there and provided distraction by engaging them in conversation about what music they would play on the bus. When this person moved their electric wheelchair, the staff member asked for permission to take over the controls to guide them through the double doors. We saw that one person had fallen asleep outside in the garden. The staff members carefully moved the person in their wheelchair out of the sun.

We observed a healthcare professional visiting a person who used the service to carry out an assessment for a specialist chair. After this visit, staff took the time to talk to the person about this assessment and what the health professional had advised. Staff asked the person for their thoughts and if they were ok with the advice from the health professional.

Advocacy is a means of providing independent advice and support. An advocacy poster was on display at the service in the communal area of the home. This poster was A4 in size [this made is difficult for some people to read] and was not in a format for people living with a learning disability. Following our inspection, the service contacted the local advocacy service who did not have one in the format needed. The service developed a poster which included pictures and large font, which was approved by the local advocacy service.

Inadequate

Is the service responsive?

Our findings

We looked at the care records of all eight people who received (PEG) feeding. There were large gaps in the records. The nurses employed at the service had failed to record information in relation to the administration of all eight people's PEG feed. We spoke with one nurse about their gaps in the PEG records. We wanted to know why the nurse had failed to record appropriate information and sign to say that PEG feeds and fluids had been given. The nurse failed to take responsibility and was not concerned with the possible consequences of this. We reported this to the management team immediately. On the third day of our inspection, the management team at the service had introduced a new PEG feeding regime record. This record was not personalised and did not match people's individual feeding regime. We found that staff still failed to complete this record at times.

We looked at the weight records of these eight people and found that the weights recorded in care plans did not match the monthly weight record which was used to keep track of people's weights. We also found that a monthly nutritional review of people's weight had not been completed regularly. We looked at eight weight records of people who did not require PEG feeding and found that records had not been completed between January and July 2015. This meant people had only been weighed in August 2015.

We looked at the care records of three people in detail. We found care records were incomplete. In some care records, there was a lack of personalised information, for example, in a senses and communication care plan for one person there was a lack of information about what the person could do and what they needed support with. Care plan reviews for all records looked at were inconsistent. We saw that some care plans had not been reviewed regularly. We found that little evidence of care plan reviews between January and May 2015. Care plan reviews following this time were inconsistent. We continued to find gaps in reviews, for example, a care plan review for a happier life for one person had not been carried out in May 2015. Two epilepsy care plans looked at were very detailed and contained specific information about each person's presentation during a seizure, what staff needed to do and how and when to use the rescue medicine pack. However reviews had not been completed for July and August 2015 for one person and in August 2015 for another person. However a care plan for safety, including the use of a lap belt [to keep the person safe] had been regularly reviewed. A sleep system for one person contained lots of guidance about how to implement the sleep system and ten staff members had signed the care plan to say that they had been shown and had understood how to use the sleep system.

A PRN protocol for Lorazepam for one person detailed the types of behaviours which could be displayed and the timeframes when this medicine should be given, however this was not reflected in the daily notes or incidents forms checked in July 2015. In August 2015, we noted that a body map had been completed which was cross referenced in the person's daily notes however no incidents form had been completed. On another occasion in August 2015, we saw another body map had been completed and an incident form had been dated to correspond with the body map but the incident form was did not show what actions had been put in place to minimise the risk of harm to the person.

A record about the person's day, life and story had been written in April 2015 for one person, we could see that the person it related to had not been involved. The information contained in this record was limited, for example "X will join in on good days and on bad days is lethargic." The record did not indicate what this person liked to do on good and bad days and how staff would know it was a good or a bad day. Including the person or their relative could have increased the level of information contained in the record.

Daily notes were not completed every day. For one person we found three days between 19 June 2015 and 27 July 2015 where records had not been completed. For this person we found that entries were not always contemporaneous, this meant we saw records dated 7 June, 8 June, 6 June and 7 June 2015. We also found that daily records did not match the specific care needs of people. They were vague and repetitive, for example "X was received in bed" was frequently used in the records. We made reference to this style and phrase of recording during our last two inspections in April and July 2014. Activities records were not completed regularly, for example in one person's records an entry was made on 22 May 2015 and then nothing until 01 July 2015. In July and August 2015, we found 31 days where no entries had been recorded.

Inadequate

Is the service responsive?

Prior to our inspection, we found that one person had not always received their 1:1 hours funded by the local authority. We could see [from safeguarding meetings] that the service had taken action to ensure this person received their 1:1. We looked at the 1:1 records for this person between 31 July and 10 August 2015. A record to check that activities and supporting records had been completed had only been signed 19 out of 39 times. An activities timetable for this person was in place; however we found that this was inaccurate. This timetable showed that the person went out for five hours three times per week with a relative; however during our inspection we found that this was not the case. We spoke with the manager and they told us that activities were usually determined on the day. We could see that records did not support this and the manager told us they would amend the records. The activities records did not show what kind of activities this person liked to be involved in and they did not reflect all of the activities this person was involved in each day. We could see that limited activities were provided, for example, one entry stated that "hand cream had been put on" to the person, another entry stated that the person had "requested their wireless and had been given it." Terminology used to record activities was not always appropriate, for example "X demanded their headset" and "X demanded to go to bed." Activities records for June and July 2015 had not been completed every day; however they had for August 2015. Activities records for two people had not been completed each day. We looked at the activities records from 25 June 2015 to 17 August 2015 and found gaps of up to fifteen days where records had not been completed. There was no information about what activities this person liked to participate in

Rating scales used to check the health and well-being of people were not suitable. The geriatric rating scale is a 30-item self-rating report to determine depression in older people. Most of the people who used the service were of working age and would not have fallen into the 'older person' age category. This rating scale was not a learning disability specific rating tool; this meant that people who used the service would not have been able to complete the rating on their own. This meant the rating scale would have been invalid [and therefore inaccurate] if they had been completed. A cognitive behavioural rating tool was also found in people's care records; again this was not specific to the needs of people who used the service. Both records were incomplete. This was because they were not suitable for people who lived with a learning disability and staff had not received appropriate support and guidance to complete them. We spoke with the management team and found that there were no learning disability specific rating scales were in use at the service.

We looked at position change charts for four people over two days on one unit. The records showed that people were assisted to move position every two hours which reflected their care plans. However the records showed that 13 out of 16 positional changes for people [on the same unit] regularly occurred at the same time, for example, the records showed that three people were assisted to move at 22:00 on 09/08/15 and four people were assisted to move at 08:00 on 10/08/15. We could see that there were not enough staff on duty throughout these two days to facilitate these positional changes at the same time. This meant that the records were not accurate. We also looked at the records of 'half hourly checks' for four people on one unit over five days. We found gaps of up to twelve hours where staff had not recorded. This meant that we could not be sure if people had been regularly checked to make sure that they were safe.

Recruitment records for six people looked at showed these were incomplete. Full employment history was not available for three people. Interview records for all six people were incomplete and had not been signed. Induction records for two people were unavailable for inspection.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) Safe care and treatment 17 (1) Good Governance and 18 (2) Staffing.

Throughout our inspection we regularly saw people in the communal areas of the home involved in activities with activities and care staff. We spoke with a life skills member of staff, they told us, "We do a huge range of activities such as gardening, arts and crafts and cookery in house. But we also bring in musical entertainment and we have just booked a Pantomine." We also saw people attending a local day centre and going into the community to go shopping and to visit the hairdresser. The service had its own hair and beauty salon where we observed people had their hair washed and styled and their nails painted. Staff encouraged people in the gardening group to smell and touch plants. From speaking with relatives, we could see that they were welcome to participate in activities with

Inadequate

Is the service responsive?

people. One relative told us, “I love coming int. I help them by sewing labels onto clothes.” We saw a staff member reading to one person and another staff member involved in a craft session with a group of people; there were some people who were watching a film and others who were making use of the sensory room.

People had personalised sensory boxes which had their photograph on the front of the box. One staff member detailed the support the team had given one person to manager their anxiety which meant they were able “to go out for the first time in years. This was a major breakthrough.

An up to date complaints policy and procedure was in place at the service. Complaint forms were available in easy read, pictorial format and written format. Staff told us any complaints would be directed to the management team. Staff were knowledgeable about the procedures they needed to take following an inspection.

Requires improvement

Is the service well-led?

Our findings

Daily checks of medicines and PEG feeding regimes had been put in place as part of the service's improvement plan. These systems were put in place to improve the quality of records and minimise the potential risks to people who used the service. We found that the responsible staff members for these checks had missed errors when checking records. For example, we found incorrect totals of medicines, missing signatures and gaps in the recording of information. This meant these errors went undetected to the manager and regional manager, who had been assured that accurate checks had been carried out and improvements were being made. This was identified during inspection where we made the senior management team aware of our findings.

Prior to our inspection, we had asked [via a serious concerns meeting] for the service to investigate the concerns relating to PEG feeding regimes. Safeguarding alerts had been put in for people who received these feeds because they could not determine from the records whether people had received them. We specifically wanted to know whether people had not been given their PEG feeds because the care records were incomplete. The service was not able to do this because of the poor systems in place; the manager informed us that there was no way of checking this from the care records or from the order system delivery of PEG feeds. This meant that we brought our inspection forward because we needed to make sure that people had been given their PEG feeds.

A high number of assaults on staff had been recorded between January and May 2015.We could see that staff had received training in managing behaviours which challenged, however no analysis had been carried out to identify the causes of assaults on staff and to identify ways prevent these assaults on staff.

Regular audits had been carried out and action plans identified. A quality team had been supporting the home since December 2014, following concerns with record keeping at the service. We could see that the quality team had raised concerns and developed action plans. Supportive action had been carried out with the manager in place at the time; however no improvements had been made. Following the retirement of the manager, records were unclear about what actions had been put in place to improve the quality of record keeping at the service.

We could see that concerns regarding record keeping and medicines [lack of care plan reviews, poor documentation, missing signatures, inconsistent tallying of medicines and lack of medicines] had been raised over a number of months by the quality team. Action plans had been developed and allocated. Records showed that the quality team found that no improvements to care records had been made. We could see that three care records were given average scores of 86% in January and February 2015, however in June 2015, scores of nine care records ranged from 11% [lowest] to 59% [highest].The quality team had recorded that the "quality and content of care files is a significant and serious concern" in their June 2015 audit. In this review, they had also recorded, "Actions given to specific staff to complete have not been actioned. There are no improvements in them, despite feedback being given in April 2015."

It was difficult to identify why staff had not followed the instructions given to them to improve care records. We could see that concerns to care records had been discussed with the manager at the time and they had been supported to make the changes needed, but we could see that problems with records had continued. Concerns with record keeping had been raised by the quality team at the service, by health professionals raising safeguarding alerts and in the serious concerns forum. We could not see how the service had been proactive in addressing continued concerns with record keeping.

Information about infections, ulcers, bedrails, complaints, hospital admissions, accidents, nutrition, medicine reviews and annual health checks was sent to Bupa head office each month. We could not be sure about the accuracy of this recorded information because risk assessments, reviews of care plans, medicine reviews and incident forms had not been regularly completed.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) Safe care and treatment.

The service had a registered manager in place however they had not worked at the home since June 2015 and had not ensured they had been removed from CQC register. A new manager was in place at the start of our inspection and was in the process of applying for registered manager status. It is a condition of the provider's registration that a registered manager is overseeing the operation of the home and the provider must also notify the CQC of any

Requires improvement

Is the service well-led?

changes in management arrangements. Failure to adhere to these requirements are breaches of the Care Quality Commission (Registration) Regulations, which we are following up outside the inspection process.

Staff were supportive of the new manager but lacked confidence that they would stay. This appeared to stem from the perceived high turnover of managers previously. One staff member thought the manager and regional manager had "a clear vision for the service and put their expectations across in a positive way." Other staff told us, "The manager is doing a fab job. He is firm and sticks to his guns. Staff ran the place previously." And "The new manager has made a positive impact at the service."

Staff talked about there being a "Split between care and nursing staff" and the lack of communication and team work which took place between them. One staff member told us that nurses were making many errors which were concerned with medicines and PEG feeding regimes. This staff member told us, "Care staff feel penalised and are 'tarred' with the same brush." We heard mixed reviews about working at the service. All staff spoke very positively about the people they cared for, one staff member told us, I'm really happy working here." Staff were aware of some of the concerns about the service resulting in the service being placed into the serious concerns protocol with the local authority. Staff described feeling frustrated and disappointed at being in the protocol for the fourth time in three years. Staff also described their sadness of being accused of intuitional abuse in a safeguarding meeting following a safeguarding alert [which was upheld]. Some staff members felt that the registered provider blamed previous managers when things went wrong with the service and felt that this was the case now. Staff told us that morale at the service was poor and they desperately needed consistency. One staff member told us, The care team all pull together. Even in times of stress, we all work together."

Daily meetings with a member of staff from each area of the home were carried out with the manager. Key issues for the day were discussed and any areas which required action were addressed. This meeting gave staff the opportunity to raise any concerns about people who used the service. We found that this meeting was not always carried out every day.

Two staff meetings had been carried out since April 2015.None had taken place between August 2014 and March 2015.We could see that staff had been informed of changes taking place at the home, the new manager and concerns about the service which had placed them into the serious concerns protocol. Three separate meetings for nurses had also taken place. We could see that concerns about medicines, records and leadership had been discussed. During the last year, only one meeting for people and their relatives had taken place. This meant we were not always sure if people and their relatives had been kept informed of any changes and updates which had occurred at the service.

We saw a 'barriers' board in the staff room. This encouraged staff to identify things which were stopping staff from doing their job and state how it was causing them a problem. Staff were also asked to identify how they could make it right.This helped staff to become proactive in making improvements to the service.

The registered provider had regularly visited the service between January and July 2015; action plans had been identified. A service improvement plan had been developed and tasks had been colour coded [in terms of importance]. We knew that the area manager was regularly attending the home following concerns raised within the safeguarding and serious concerns arenas. They had introduced daily meetings with senior staff as well as a weekly clinical risk meeting. Audits for medicines and infection control and champions for dignity and infection control had also been introduced

Some areas of feedback given during inspection were acted upon straight away. Painting and plastering of areas of the home had been started. Pictorial menus were ordered to support people to make their own meal choices and health and safety checks were allocated to staff when the maintenance person was not on duty. Hand hygiene training had been arranged for all staff and competency checks would be put in place once training had been completed.

This is a breach of Health and Social care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 (1) Good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved in making decisions about things which affected them. Regulation 9 (3) (c) and (d).

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent MCA and DoL'S had not always been carried out appropriately. Consent forms had not been signed by people or their representative. Regulation 11 (1).

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding alerts had not always been made by the service when needed. Staff would not whistle blow because of fear of reprisal and staff provided care to people with deprivation of liberties safeguards in place when they had expired Regulation 13 (1) (2) (3) and (5).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Supervision and appraisals were not up to date. Staff had not received training in PEG feeding regimes or in communication methods specific to people living with a learning disability and/or autism. Regulation 18 (2) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not consistently provided in a safe way for people. Regulation 12 (1).

The enforcement action we took:
A Warning notice was issued.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems and process were not in place to ensure the quality of the service. Regulation 17 (1).

The enforcement action we took:
A Warning notice was issued.