Eldercare (Halifax) Limited

Ingwood Nursing Home

Inspection report

Stainland Road
Greetland
Halifax
West Yorkshire
HX4 8BQ

Tel: 01422374410

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection of Ingwood Nursing Home took place on 19 November 2015. The home provides residential care for up to 34 people with bedrooms set over two floors. Communal areas include a large dining room and three small lounges. At the time of our inspection there were 10 people living at the home.

Our last inspection of Ingwood Nursing Home took place on 23 July 2014. At that time the service was found to be compliant with regulations and was given a rating of 'Good.' Since that inspection the provider took the decision to cease the provision of nursing care at the service. This meant that people living at the home who required nursing care went to live at other services. Nursing staff, including the registered manager, were transferred to another of the provider's services. The service is referred to in this report as Ingwood Nursing Home as the provider has not informed the Commission of change of name for the service.

The previous registered manager of Ingwood Nursing Home deregistered with the Commission in January 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
There was no manager in place at the home and staff did not know who was in charge. There was a lack of regular quality auditing by senior management.

People who lived at the home told us they felt safe and staff had a good understanding of their responsibilities in keeping people safe. However, staff were unfamiliar with how to report safeguarding concerns. Accidents that happened in the home were not audited which meant staff were not doing everything possible to mitigate risks to people who lived at the home.

Systems for managing medicines were not safe. Staff who had not been adequately trained or assessed as competent were supporting people with their medicines.

Staffing was adequate but better deployment of care staff, including the arrangements for the use of agency staff, was needed to make sure staff were always available to respond to people.
We recommended the provider considers the deployment of staff to make sure care staff are not taken away from supporting people living at the home.

Procedures for recruitment of new staff were safe with thorough checks always completed before staff started work to make sure they were safe and suitable to work in the care sector.

Staff had not received the training they needed to support them in their roles.
Staff were caring and people we spoke with were complimentary about the staff.

Food provided at the home was of a good standard but mealtimes were not managed well and staff had

failed to make sure that all of the people who lived at the home received the nutrition they needed to maintain their health.

Risk assessments were misleading and out of date.

Care plans did not demonstrate a person centred approach to care and were not up to date.

We saw people engaging in activities which they enjoyed although the working hours of the activities coordinator restricted the opportunity for planned activity.

People were restricted in their movements within the home. A series of key pad locks meant that people could not always access two of the lounges and bedrooms.

Complaints made to the service were not managed in line with the complaints policy.

Systems for auditing the quality and safety of care were in place but were not up to date.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.
This means that usually the service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, would be inspected again within six months.

However in this instance the provider took the decision to cease residential care provision at this service and Ingwood Nursing Home is now closed. The provider is in the process of applying to the Care Quality Commission to deregistered this service. In view of this the Commission took the decision not to take enforcement action against the provider in relation to Ingwood Nursing Home.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Accidents and incidents that happened in the home were not being appropriately managed or analysed to assess and mitigate risks to people living at the home.

Systems for managing and administering medicines were not safe.

Staff were being recruited safely and staffing levels were adequate, however, staff deployment needed to be reviewed.

Is the service effective?

Inadequate

The service was not effective.

People's weight and nutritional needs were not monitored effectively, which placed people at risk of not receiving sufficient diet to maintain their health.

Staff had not received the training they needed to support them in their roles.

Mental capacity assessments were not detailed and people were restricted in their movements within the home.

People had access to healthcare services but staff did not always follow professional advice.

Is the service caring?

Good

The service was caring.

We witnessed caring interventions from staff who appeared to recognise and respect people's dignity and privacy needs.

We saw some indication that close relatives had been involved in

care planning. However this was not consistent in all of the care records we looked at.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments of need were not up to date and care had not always been planned or reviewed with a person centred approach.

People told us they enjoyed activities at the home.

People felt they were listened to but complaints made to the home were not recorded or managed.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager. There was a lack of leadership and poor quality assurance systems meant people did not receive safe care.

Systems to monitor the safety of the environment were not up to date or effective.

Ingwood 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We inspected Ingwood Nursing Home on 19 and 20 November 2015 and the visit was unannounced. Before the inspection we reviewed the information we held about the home. This included information from the provider and the local authority contracts and safeguarding teams. On this occasion we did not ask the provider 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.

Our last inspection of this service took place on 23 July 2014. At that time the service was found to be compliant with regulations and was given a rating of 'Good'. Since that inspection the registered manager has left the home and the provider took the decision to cease the provision of nursing care at the home.

The inspection team consisted of two inspectors and an expert by experience with experience in older people and older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On the day of our inspection we spoke with seven people who lived at Ingwood Nursing Home and four people who were visiting their relatives. We also spoke with three members of care staff, the domestic, and the manager who had worked at the service for a short time and two area managers.

Some of the people we spoke with had complex care needs and were not able to express their views to us. We therefore spent time observing care in the dining room and lounge to help us understand the experience of all of the people living at the home.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe at Ingwood. One relative told us they had, "Involved social services and safeguarding" because of their concerns about their relation. They told us the issue had been resolved to their satisfaction.

We spoke with the senior care staff in charge. They demonstrated a good understanding of safeguarding but said they were unsure of how to make referrals to the local authority safeguarding team. They were aware of the company's whistleblowing procedure and told us they would report any concerns they had about staff practice.

When we looked at the training matrix for staff we saw only four of the 16 staff employed had received up to date safeguarding training. This did not include the person in charge on the day of our inspection.

We looked at how accidents and incidents had been reported and managed. We saw accident forms had been completed but these had not been checked and signed off by a senior member of staff. The provider had a system in place for all accidents and incidents to be recorded on a monthly basis so they could be analysed to identify any themes or trends which might be helpful in mitigating future risk. At the time of our inspection, due to a lack of management oversight, these had not been completed.

This meant that accidents and incidents that happened in the home were not being appropriately reported, managed or analysed to assess and mitigate risks to people living at the home.

This was a breach of the Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw personal emergency evacuation plans (PEEP's) were in place within people's care files. However the PEEP's did not always provide staff with detail about how people who were unable to mobilise should be evacuated in an emergency.

We saw care files included personal safety assessments. However, these were not up to date. For example, the assessment for one person stated they would be unsure of what to do or where to go if they needed to evacuate the home in an emergency. . This was not appropriate as the person was no longer able to mobilise independently.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored in a safe way.
We observed people being given their medicines on the first day of our inspection and saw staff supporting them with patience and kindness. However, we observed one person ask what the tablets they were being given were for and was told by the member of staff administering medicines, "They're to make you better." When we asked, the member of staff about this they said they didn't know what the medication was or what

it was used for. We were informed later that day, by the home's administrator that, on checking training records, they had found that the care worker administering medicines had not been assessed as competent to do so.

On the second day of our inspection we saw that the provider had made arrangements for staff from another of their services to come to the home to administer medicines. This was not well organised and resulted in some people not receiving their morning medicines until lunchtime.

We looked in the controlled drugs (CD) cupboard and found no controlled drugs were in use. However, when we looked in the controlled drugs register we saw a number of controlled drugs were shown as being on the premises. We looked at the returns book but found not all of these medicines had been booked out as being returned to the pharmacy. This meant there were controlled drugs which could not be accounted for.

We looked at the medicine administration records (MAR) for three people. We saw medicines which were supplied in the MDS had been signed for consistently. We checked the balances of medicines which had been supplied in boxes for three people. In all three cases it was not possible to establish the balance of medicines being held. This was because some medicines had either not been booked in or not carried forward from a previous MAR.

We saw some people had been prescribed 'as required' medicines but there were no protocols in place to inform staff in what circumstances these medicines should be administered. For example, one person had been prescribed medication which can be given as pain relief or to treat diarrhoea. There was no protocol to advise staff why this person had been prescribed this medicine.

This is a breach of the Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a newer member of staff who confirmed a DBS (Disclosure and Barring Scheme) check and references had been taken up before they stated work at the home. They also told us their training certificates had also been checked. We looked at recruitment files for two members of staff and saw that recruitment procedures had been followed to make sure staff working at the home were safe to do so.

We spoke with the cleaner on duty who demonstrated a pride in their work. We found all areas of the home to be clean and tidy.

At the time of our inspection there were 10 people living at the home. Staffing levels were arranged to provide three care staff during the day and two at night. A relative we spoke with said, "I've no concerns about this team of staff. There are enough of them and because there's only a small number of residents they have time to spend with people." However, staff said they sometimes struggled to make sure people's needs were met in a timely manner as a number of people needed two staff to meet their needs. Staff said this was particularly the case at tea time when one member of the care staff had to finish the preparation of the meal and wash up afterwards.

We recommend that the provider considers the deployment of staff to make sure care staff were not taken away from supporting people living at the home.

Inadequate

Is the service effective?

Our findings

People visiting the home told us that staff had the abilities to care for their relatives. One said, "Yes they have but then there's no medical care given." Another said, "Yes they have and they're very caring. They take a real interest in (relative)." A third told us that not all of the staff were able to meet their relative's needs due to their sometimes challenging behaviours. This person told us that they attended the home regularly to assist in their relative's personal care.

The person in charge of the home on the first day of our inspection told us they had recently been made 'senior carer' but had not had any specific training to support them in that role. They told us although they were seen as being in charge they were unsure who was responsible for the day to day management of the home.

We looked at the training matrix and saw staff had not received the training they needed to be effective in their roles. For example, the training matrix showed, out of the eight care staff working at the home, three had not received any moving and handling training, only two had up to date fire training, only one had up to date health and safety training, only two had up to date training in person centred care and nutrition and only three had received training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). In addition the training matrix showed that none of the care staff on duty during the two days of our inspection had training in first aid.

We asked staff if they received good support. All of the staff we spoke with said they did not receive any support from higher management and none of the staff could tell us who was taking charge of the home.

This was a breach of the Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff told us one person had a DoLS in place because the home has a number of coded key pads and this person had made several attempts to leave the home, but it was unsafe for them to do this alone. We saw the necessary request and been sent and acknowledged by the local authority but the person had not yet been seen by the assessor.

However, we saw most people were sitting in the dining and lounge area and the doors leading to the entrance hall and the rest of the ground floor were locked by a series of key pads. This meant people could not freely access the other two lounges or other areas on the ground floor. When we asked care staff about the locked doors they told us that sometimes they were open but at other times they were not. This meant that people were not able to leave the area which included the dining room and small lounge.

We saw that care files included Mental Capacity Assessments. We looked at one of these for a person who care staff had told us was living with dementia. The mental capacity assessment included only very brief detail, did not cover the five principles of the MCA and did not include detail of how the person was supported to make decisions. We saw that this person had signed a consent form covering access to care file, medicines and taking photographs. There was no indication of how this had been explained to the person or whether they had fully understood the form they had signed.

This was a breach of the Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed three mealtimes, one breakfast and two lunches. Mealtimes were not made into a sociable event. Tables were not set, people were provided with cutlery as their meal was served but there were no napkins or placemats used. There were condiments on the trolley that carried cereals, milk, yoghurts at breakfast and cold alternatives and desserts at lunchtime but none were offered. We saw one person ask for salt and it was given but no one else was asked if they wanted condiments. Mealtimes were not well organised. People were supported to the dining room for all three meals at different times which meant that some people had almost finished their meals before others were served. Although some people had to wait for breakfast, it was freshly cooked and looked appetising. At lunchtime the meals were ready before all people were at the table and there were instances of hot meals being put onto the table before the person had arrived to eat it. We saw staff put large bibs on everybody, except one who refused. Only one person was asked if they wanted one.

On the first day of our inspection we saw people were offered choice of the main component of the lunchtime meal as the cook spoke to people during the morning to ask for their preferences offering either gammon or spaghetti bolognaise. The cook explained what was on offer but didn't explain that the mince in the bolognaise was meat substitute as this was a vegetarian option. Only one person was vegetarian. We saw some people refuse the bolognaise when it was served as they didn't want meat substitute. People were not given choice about other components of the meal as they were served ready plated from the kitchen. Gravy was provided in a large plastic jug covered with film. This was used for over 40 minutes which meant it would not have been served hot to all of the people. Food looked fresh and appetising, portion size was good and second helpings were offered.

We saw staff support some people with their meals; however, we saw one person sitting in front of the remains of their breakfast for two hours until it was removed. Another person was at the breakfast table in their wheelchair for over five hours. At lunchtime this person was again taken to the table in their wheelchair but was left so far away from it they couldn't reach all their food. The food nearest to the person was eaten quickly. We had to point this out to a staff member who changed the position of the person's chair so they could sit at table comfortably. The person then ate all of their meal.

We saw staff had contacted the community matron in July 2015 because they were concerned one person was losing weight. The community matron asked for the person to be weighed weekly but this had not been done. They had also asked for them to be given extra 'snacks.' Over a period of four months they had lost 15.6kgs. This meant staff were not following the instructions they had been given.

We saw the pre-admission assessment indicated the person only ate small meals and that no care plan was needed as the person had an average appetite. We saw no nutritional care plan had been put in place until 23 October 2015. This was three months after the initial weight loss had been noted. This meant there was no clear plan in place to monitor this person's food intake or their weight.

Another person's weight records showed they had lost 14kg in the previous four months. We saw this person had been seen by a speech and language therapist (SALT) in October 2015 but nothing had been recorded in the person's nutritional care plan about the advice from SALT or that the person was losing weight. We saw a letter from SALT which advised the person should be given a pureed diet and thickened fluids. The letter advised staff to contact them again if needed. We looked at food intake records for this person, which included items such as crisps, pork pie and biscuits. We asked the senior care assistant about this and they told us that the person would not eat a pureed diet; however, this had not been referred back to SALT. The senior care assistant in charge said they had thought this had been done by a colleague who had since left the service. The senior care assistant contacted SALT for advice on the day of our inspection. We saw the food intake charts for this person often showed a very poor dietary intake but these had not been checked and therefore the issue had not been identified.

This meant that people's nutritional intake was not being monitored to make sure it was sufficient and appropriate to maintain their health and is a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

In the five care plans we looked at we saw people had been seen by a range of health care professionals, including, community matrons, GPs, district nurses, opticians and podiatrists. However, one visitor told us they had needed to ask staff to contact the district nurse as their relative needed a dressing changing.

Good

Is the service caring?

Our findings

We asked people who lived at the home if staff were caring. One person said, "Staff are kind here," and another told us, "People weren't kind and polite in the past but they've gone now." A relative we spoke with said "(relative) has Dementia. (They'll) lash out, particularly at meal times and bed times but the staff know how to deal with that. They make nothing of it and (relative) settles and it's as if nothing different has happened." Another relative told us, "(Relative) either likes you or doesn't. The senior carer here has worked hard to make a relationship with (relative)."

We saw staff speak to people in a kindly and respectful manner and noted warm and friendly interactions between staff and people who lived at the home. Staff usually explained to people what they were doing and why. We only saw one intervention from staff without proper consultation with the person. This was when staff automatically put clothing protectors on people at mealtimes without asking people if they would like one.

When we asked about how staff protected people's privacy and dignity one person who lived at the home said, "They worry about my modesty more than I do. They do explain what they're doing and I suppose they do ask me before they do anything." One visitor told us, "They treat (relative) really well. I'd say they take good care of their privacy and dignity. I think the care (relative) gets is tailored to their needs. (Relative) has improved noticeably since they came here." Another visitor said, "They do have a caring approach. Yes, they do treat (relative) with respect but then (relative) wouldn't have it any other way. I'm massively involved with (relative's) care plan. Staff keep me well informed and I check (relative's) record all the time."

People looked as though staff had supported them well in their personal care needs and had taken time to make sure people were well groomed and nicely dressed.

Staff appeared to know people well and told us they wanted to do their best for them.

One visitor told us they were fully involved in their relative's care and looked at their care records regularly. However, the care plans we looked at did not evidence involvement of either the person or their families.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home and their relatives if staff were responsive their needs. People's relatives told us, "(Relative's) needs aren't huge as they are mobile and quite self-sufficient but that's supported," and, "They've bent over backwards to meet (relative's) needs." Another visitor told us their relative could make their own decisions and was not restricted in doing so.

The care plans we looked contained confusing and in some instances, out of date information about people's current needs. For example, one file had two different care plans in place for the person's skin integrity and care plans which were no longer relevant to the person's needs were still in place.

Some assessments of need were in place but these were often misleading as they did not refer to the person's current situation. For example one person's skin assessment had not been changed since they had sustained a fracture and become immobile.

We saw the assessment information for one person which had been completed by a social worker. This stated on two previous stays at other care homes the person had left the building and the police had to be called to help find them. We saw on the assessment document the homes staff had completed they had written, "Will try to escape" and "Will try to get out." There was no risk assessment in place on admission to demonstrate what measures had been put in place to keep this person safe. We looked at the daily records from when they were first admitted and saw they were continually looking to find a way out trying doors and six days after admission had managed to leave the building and the police had to be called.

We saw information about The Herbert Protocol on the notice board. This is a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. We asked a member of staff if this information had been compiled for this individual and they told us it had not.

On the day of our inspection there was a fault with the internal key pad locks which meant the doors on the ground floor were unlocked. Twice during the afternoon we heard the alarm on the door going into the back yard sound. Both times this person had gone outside. We noted they had previously tried climbing over the fence in this area.

We saw in the assessment information this person could become agitated if their personal space was invaded and angry when needing assistance with their personal care. There was nothing in the care plan to help staff deal with these situations. We saw staff following the person around because of the problem with the door locks but saw some did not know how to engage with the person.

The senior care assistant told us that they were aware that care plans were not informative or up to date. They told us that a senior member of staff who had recently left the service had been in charge of updating care plans but this had not been done.

This demonstrated a breach of Regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

On the first day of the inspection when we arrived at 7:30am the television was on in the lounge, but no one was sitting in this area. There was a children's programme on which none of the staff noticed until we brought it to their attention. The senior care staff came and turned the television off.
We saw the activities co-ordinator engage a group of people in a game of skittles. Time was spent with each individual and there was a lot of laughter and people were enjoying themselves. However, time to engage people in activities was restricted as the activities organiser worked between the hours of 10am and 2pm which meant a large period of that time was taken up with lunch.
We saw one person had a toy dog which they got a lot of pleasure from. We saw them talking and smiling to 'Spot.' Staff told us they had a 'spare' just in case 'Spot' needed a wash. We also saw them include 'Spot' in their conversation with this person.

People we spoke with felt staff usually listened when they expressed their views. One person who lived at the home said, "I can speak out and I think some listen - some don't." A visiting relative told us, "If I raise something they listen and respond as well as they can." Other people who lived at the home in group discussion said they could say what they wanted to and that the staff listened to them.

We saw the complaints policy was displayed in reception. During the course of the inspection we became aware of two people who had raised concerns and complaints. However, when we looked at the complaints file there was no record of these. This meant that complaints had not been managed in line with the provider's policy and procedure.

This was a breach of the Regulation 16(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Since our last inspection of Ingwood Nursing Home the provider took the decision to cease the provision of nursing care at this service. This meant that people who needed nursing care had to move to other services. Additionally, nurses who worked at the home were moved to another of the provider's services in the local area. Because of this there had not been a registered manager at the service since January 2015.During this time, a manager from another of the provider's homes spent a short time at Ingwood Nursing Home but there had not been any consistent management arrangements.

People we spoke with were not aware of the management arrangements at the home. One visiting relative told us, "I can bring anything up if I want to but we don't know who's managing now. We used to know." Another said, "We're aware that different people manage things in different ways. They need to get hold of that because I think records have gone missing, or they (the carers) just can't find them. It matters when people need to go to hospital or the doctor."

Staff we spoke with were not aware of the management arrangements and when we asked who was in charge they said they weren't sure. The senior care assistant told us they assumed responsibility for delivery of care when they were on duty but told us they had not had any training to support them in their role as senior care assistant. Some of the staff we spoke with thought the administrator might be in charge and one described the situation to us as "diabolical". They said they only continued to work at the home as they cared so much for the people who lived there.

We did not see any evidence of on-going support from senior managers within the company. The last provider visit conducted by two senior managers had been recorded in June 2015.

We asked the senior care assistant who was in charge of auditing of care and safety within the home they said they didn't know. They told us that the domestic audited mattresses and standards of hygiene in the home.

During our visit a manager from another of the providers services came to assist with the inspection process. They told us that they had done some auditing during the period of time they had spent at the home.

None of the audits we looked at were up to date. For example auditing of people's weights and medication audits had not been completed since August 2015, Accident audits had not been completed since June 2015 and the last pressure sore audit was dated July 2015.

We saw that first aid kits and the burns kit in the kitchen had not been checked since January 2015. When these had been checked it was noted that a large number of items were missing. When we checked them we found the same items missing. This meant that even though they had been checked, nothing had been done to rectify the issues identified. We saw the' weekly first aid box check' recorded as not checked on the provider visit in May 2015.

We saw the provider visit reports for April and May 2015 included a section titled 'Quality Focus' with the description 'including a full100% audit on the quality focus for the specified month.' The section included 12 areas of audit including medication, weight loss, pressure sore, care plan and accidents. All of the 12 areas were recorded as 'Audit not available for inspection' on both the April and May 2015 reports.

We were able to see copies of some safety certificates including hoist and sling checks but other safety checks such as the passenger lift certificate were not available to us.

On the first day of our inspection an area manager arrived at the home shortly before we were due to leave. We told them we would return the following day at 10.30 so they had time to locate records of safety checks. However, when the operations manager arrived during the afternoon, they told us they had not been told this and therefore was unaware of our request.

This demonstrates a failure to ensure appropriate management of the home and a failure to ensure the safety and quality of the services provided.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have up to date assessments or care plans in place Regulation 9 (3) (a) and (b

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's nutritional intake was not being monitored to make sure it was sufficient and appropriate to maintain their health Regulation 12 (2)(a) (b) Accidents and incidents that happened in the home were not being appropriately reported, managed or analysed to assess and mitigate risks to people living at the home. Regulation 12 (2)(a) (b) Service users were not protected by the proper and safe management of medicines. Regulation 12 (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not being followed to make sure that service users were not restrained or deprived of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not have systems in place to manage complaints effectively. Regulation 16 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) and (2) (a) & (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support and training to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).