IMS Care Group Limited

Winchester House

Inspection report

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Date of inspection visit:
08 February 2018

Date of publication:
27 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Winchester House is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under a contractual agreement with the local authority, health authority or the individual, if privately funded. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Winchester House accommodates a maximum of nine older people, including people who live with dementia or a dementia related condition, in one residential style building which has been adapted for that purpose. Winchester House is a large detached house situated on a main road in a residential area of Kirby Cross, Frinton on Sea, and is close to local shops. Each person using the service has their own individual bedroom and adequate communal facilities are available for people to make use of within the service. At the time of our inspection eight people were using the service.

A registered manager was in post. The registered manager was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

At the last inspection in October 2015, the service was rated 'Good'. At this inspection we found the service had achieved a rating of 'Requires Improvement'' This inspection was brought forward in response to concerns we had received from the local authority. We have detailed these further in the background section of this report.

During this inspection, we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of registration. For adult social services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Although people raised no concerns with us regarding the care they received, we found records relating to people were not sufficiently well maintained and people were not always being cared for by an adequate number of staff. Although the provider carried out pre-employment checks for care staff, we found sufficient checks had not always been completed to ensure they were suitable to work at the service.

Individual risks to people had not been identified and action taken by staff to satisfy themselves that people

were kept free from potential risks was not always carried out. Risk assessments in place did not contain clear guidelines for staff on how to support people and minimise risk levels.

People were protected from the risk of abuse. Staff had received training around this. There were recruitment systems in place however; procedures for these were not always followed consistently. People lived in an environment that, although clean, posed some potential safety risks.

Medicines management procedures were not always followed in line with best practice and the legal requirements in relation to the storage and documentation of medicines. Quality assurance processes in relation to care records and the monitoring of the service being provided were not robust. This included a lack of routine audits on areas such as medicines management.

The service provided to people was effective in meeting their needs, however staff did not all have the relevant skills and had not all received appropriate training and supervision to enable them to support people to meet their needs. Not all staff received good support from management through regular training, supervisions and appraisals.

Although people were cared for by staff who were kind, attentive and respectful to them, the multiple failings in regulation did not reflect a caring service overall and the provider did not ensure that people's care met their needs at all times.

Care plans did not clearly reflect the needs of people or the care provided for them. The design of people's care plans made it difficult for staff to obtain up to date information. The health and safety audits of the service and reviews of people's care plans had not picked up on concerns or ensured people's care plans were up to date. There was no evidence to demonstrate the registered manager and registered provider had oversight of these processes.

Activities for people at the service did not meet the varied needs of people living at the home. People and relatives knew how to raise any concerns and told us they would feel confident to raise issues if they needed to.

The service was not well-led. Quality assurance checks and audits were not completed regularly and therefore did not identify the shortfalls within the service. During this inspection we found that systems and processes to maintain the quality and the standard of care being provided had not been effectively implemented and sustained. Records were basic and did not evidence the most relevant information in relation to the support needs of the person.

Audits systems and checks were not being used effectively as there were not any measures in place to monitor, assess or improve the delivery of care being provided. Audits/checks which were in place did not effectively measure the quality or standard of support being provided. Feedback from people who were being supported or their relatives about the quality of the service provided had not been formally gathered. This meant there were not any systems in place to gather feedback about what the service does well or what areas needed to be improved on.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and have made three recommendations with regard to recruitment procedures, dementia friendly considerations for the environment and social activity provision.

Despite the failings in the service, people felt safe living at Winchester House and staff were aware of their

responsibilities to ensure that if they had any concerns about the way people were being cared for they should raise this. In the event of an emergency people's care would continue in the least disrupted way possible.

People were encouraged to make day-to-day decisions about their life. For more complex decisions and where people did not have the capacity to consent, the registered manager and staff had not always acted in accordance with legal requirements. Where required, people and relevant professionals were involved in planning their nutritional support. People were support to access a variety of healthcare professionals and appointments were arranged.

People and their relatives gave us very positive feedback in relation to the staff and the way they treated them. We observed gentle, caring interactions between staff and people and it was clear staff knew people and their family members well. Staff, people and their relatives spoke positively about the staff and registered manager. There was a united team culture within the service and staff demonstrated a caring and good understanding of the people they cared for.

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

Staffing levels were not always sufficient to meet people's needs promptly.

Risks to people were not always appropriately assessed and managed.

Good medicines management processes were not always followed and people lived in an environment that posed some risks due to a lack of appropriate assessment and action to mitigate risk.

Appropriate recruitment checks were not always carried out to ensure suitable new staff were employed

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment did not always meet good practice guidance for supporting people living with dementia.

New staff had not always completed an induction process and staff had not always received training, supervision and appraisals required to support and develop them in their roles.

Whilst people were supported to make decisions and choices about their care. The registered manager had not fully understood and applied the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and made appropriate referrals to the local authority.

People were supported to eat and drink appropriately. Care records did not include specific guidance for staff to follow to support people in the management of health conditions.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had warm and positive relationships with the staff who supported them.

Staff treated people with dignity and respect.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences.

People and their relatives were satisfied with the care being provided.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not clearly reflect the needs of people or the care provided for them. Guidance for staff was not always clear.

The activities at the service did not meet the needs of all people in a meaningful way.

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People received compassionate end of life care.

Is the service well-led?

Requires Improvement

The service was not well-led.

There were multiple breaches of regulation identified.

There was a lack of robust oversight by the management team to ensure staff carried out the duties they were employed to do.

The registered manager did not always have oversight of the care people received in the service and records of care. This meant they were not able to ensure lessons had been learned when things go wrong.

Quality assurance and audit systems were in place however; their findings were not used to improve the safety of the care delivered and outcomes for people.

Winchester House

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.

The inspection took place on 8th February 2018. It was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This was an unannounced inspection which we bought forward due to concerns raised with us. These concerns had been raised with us by the local authority following a quality monitoring visit in July 2017 where the outcome of their visit found care management systems to be poor. Further concerns were also raised with us regarding the non-progression of improvement following three subsequent follow up verification visits by the local authority. These concerns related to the lack of information in people's care and risk assessment documentation, staff training and recruitment and supervision of staff. Additionally, other areas of concern highlighted related to, medication recording anomalies, environmental safety checks not completed, inadequate quality assurance systems to monitor the service, and the lack of effective management oversight of the service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. In the planning of this inspection, we gathered feedback from other health and social care professionals who have recently been involved with the service.

On this occasion we did not request a Provider Information Return (PIR) before our inspection. 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. This was because the inspection was brought forward due to concerns we had received.

Whilst most people were able to talk to us, others could not. During our inspection we observed how the staff interacted with people and we spent time observing the support and care provided to help us understand their experiences of living in the service. We observed care and support in the communal areas, the midday meal, and we looked around the service. Some people were able to talk with us about the service they received but others could not. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records at the service. These included four staff files which contained staff recruitment, training and supervision records. Also, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We looked at four people's care documentation along with other relevant records to support our findings. We also 'pathway tracked' people living at the service. This is when we looked at their care documentation in depth and obtained information about their care and treatment at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we spoke with five people, one relative, four staff, and the registered manager who was also the registered provider. We observed the care, which was delivered in communal areas to get a view of the care and support provided.

Inadequate

Is the service safe?

Our findings

Risks to people's health and wellbeing were not always assessed properly, and managed effectively. Each person had risk assessments in place, however the completion of these was noted to be variable, and some were incomplete. One person's risk assessment identified they required a specialist mattress to relieve pressure. The specialist settings for this mattress were not documented and the care plan just stated, '[Person] came here with it as has sores on back.' There was no further information noted for staff to ensure they knew how to mitigate the risk of further skin breakdown or manage the use of the mattress to ensure it was set correctly. Another person's care plan identified they required bed rails to be used on their bed, and the care plan just stated, 'Requires hoisting.' with no further instruction. The manual handling risk assessment was also noted to be very basic with no clear instructions for staff on the actions to take, the size of sling to use or how many staff should perform this task. Another person who also used bedrails had no risk assessment in their plan of care therefore; staff did not have adequate information to enable them to understand when they should be used to keep the person safe.

The risk assessments we saw had also not been reviewed or revised, at regular intervals to ensure current information was up to date. Whilst we acknowledge staff we spoke with were knowledgeable about the needs of the people and were following the guidance from the health professionals, if new staff were required at short notice the current risk assessments would not provide them with accurate information to help keep people safe. We spoke to the registered manager about our concerns, who confirmed they were in the process of reviewing all care plans as part of the concerns raised recently by the local authority visits and were seeking advice directly from them with compiling the same.

Care records documented the risks that had been assessed in respect of areas such as skin care, dehydration and malnutrition. However, where a risk had been identified there was not always a clear plan in place to manage it. For example, one person who was at risk of malnutrition and dehydration last had their weight recorded in December 2017. This indicated a low body weight, however a Malnutrition Universal Screening Tool (MUST) assessment had not been completed fully and it just stated high risk which had been documented on the 5th January 2018. The MUST assessment is a screening tool used to assess people who are at risk of malnutrition. There was no evidence to show this had been followed up or actions taken to monitor this. Although staff had taken appropriate action to seek advice from the dietician in relation to this person, they did not keep a record of this person's food and fluid intake.

A staff member told us about one person, "We do monitor the amount they eat at meals as they don't always eat everything." However, this person did not have a food chart in place. A lack of recording of people's weights and food intake may mean the registered provider will not have records to satisfy themselves that people are maintaining a healthy weight and therefore risk their health and wellbeing. Food and fluid charts enable staff to decide on the most appropriate intervention for a person and provide vital information in the formulation and review of a person's care plan. Fluid records can give information about the pattern of drinking of a person and is important especially for people with poor fluid intake and those who are unable to communicate verbally. Whilst we saw people offered drinks regularly A staff member told us, "We ensure everybody gets enough fluid by offering them drinks regularly, but we don't record the

amount of fluid every person has."

Risks relating to the environment and equipment were not managed effectively. Not all risks to the environment had been identified and some risks we identified during our inspection had not been mitigated against. For example, a four-foot deep fishpond in the garden with a ground level raised step surround was noted to only have portable individual unsecured safety barriers surrounding it. These did not provide sufficient safety measures in the event a person were to lean on them or lose their balance and fall. The registered manager told us the safety barriers were placed there on the preceding Sunday before our inspection and subsequently permanent safety measures were still to be progressed. People told us the pond in the garden had been like this for some time and the registered manager in the interim had told people not to access the garden. The registered manager told us they were still in the process of sourcing an appropriate fencing surround. There was no risk assessment in place at the time of our inspection relating to the pond, and how to keep safe.

We also noted that a Health and Safety assessment of the service had not been carried out. The last environmental audit of the service was last completed on 04 July 2017, however this just focused on whether the service was clean and tidy. It stated 'In process of reviewing emergency evacuation procedures and practice'. We saw no evidence to demonstrate this was completed. Additionally we noted the last fire risk assessment for the service was not current and was dated September 2006 and had last been reviewed in July 2011. Whilst staff were provided with fire safety training via e- learning, not all staff had completed this and we saw no evidence of practical fire extinguisher training or fire marshall training.

We spoke to the registered manager about our concerns, who informed us that due to some recent personal circumstances they had not been as organised with ensuring the maintenance and upkeep of the service was attended to. They advised that following the recent local authority visit they would ensure urgent risk assessments would be carried out for the areas identified.

Medicines were not managed well and in line with current National Institute of Clinical Excellence [NICE] and Royal Pharmaceutical Society (RPS) guidelines. When we arrived we noted the keys were left in the medicine cupboard in the office which anyone unauthorised could access. We removed these and returned them to the person in charge. We also noted a carrier bag full of used medicines for a person who had recently passed away five days earlier, and a full months stock of medicines just placed behind an open door and not secured appropriately. When we asked staff why they were there they told us, "They came in last week and we have not had time to check them yet." This meant that staff would not know if they had the correct medication for people as it was still in unopened bags, it may not be stored at the correct temperature to ensure the efficacy of the medication.

We also checked a sample of people's medication administration records and noted anomalies such as controlled medication stocks not correlating correctly on documentation. Some ampoules of one medication had also not been recorded in the controlled drugs register and had just been left in a bag to return to pharmacy as the person had passed away. Whilst the actual stock of medications was correct, the documentation of the same was confusing and this medication had not been stored securely. Additionally one controlled medication did not denote which form it was in on the chart and another chart stated the person was having patches applied. The patch chart for this had gaps and did not clearly state when the patch had been changed and the location of the site applied. We further found some opened eye drops just left sitting on top of a bookcase in one person's room. The care plan stated, '[Person's] eyedrops to be kept in medication cupboard in office.' We were told this must have happened when the night staff went off shift and they must have forgotten, however this was not safe practice. MAR charts were noted to have been handwritten but there was no evidence of two signatures being present for checking of transcribed

medication. This meant people might be at risk of receiving the wrong medicine should this have been documented incorrectly.

We observed medication being given to people in the service. Whilst this was done with due care and attention one person told us, "They [staff] usually wait for me to take my pill but sometimes they [staff] leave it with me." The relative of a person who had a sight impairment told us, "They used to give [relative] their pills to take but after a while we found they hadn't always been taking them so after that they would watch them take them. I think [relative] was just forgetting."

NICE and Royal Pharmaceutical Society (RPS) guidance for care homes was not being used. Staff had only received basic on line medication training. The service medicine policy was generic and not service specific and did not include relevant elements as identified in (RPS) guidance such as storage, ordering and recording to guide staff on the correct procedures to follow. We spoke with the registered manager about all of these areas during and at the end of our inspection and they advised us they would ensure that best practices in relation to medicines processes are followed at all times.

We identified the above evidence and failure to safely manage risks in the service as a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.– Safe care and treatment.

The registered provider did not have robust systems to plan and review staffing levels and did not ensure a safe level of staff for the needs of people using the service. We noted that the 'Statement of Purpose' for the service stated that to maximise residents' welfare they will: 'Employ staff in sufficient numbers and with the relevant mix of skills to meet residents needs' and, 'Provide at all times an appropriate number of staff with qualifications in health and social care.' The Statement of Purpose also stated, 'There are a minimum of two staff available in the waking hours and one awake, night staff plus one sleeping, on-call night staff in sleeping hours.'

Following a review of the last four weeks rotas we noted the registered provider did not base staffing levels on the needs of people and did not review staffing levels in light of peoples changing needs. Staffing numbers were historic and had remained the same as identified in the 'Statement of Purpose'. Staff told us as people had aged and their support needs had changed; they were more dependent and less able but staffing levels had remained the same. For a few people living with dementia had become a real issue in terms of the level of support they needed to maintain their wellbeing. The registered manager was unable to demonstrate how staff numbers were calculated in line with people's assessed needs.

We observed there were two staff on duty throughout the day, one staff member at night with one staff member on-call. Two people we saw on the day of inspection required support from two staff to move and transfer, another two people needed support from a staff member to eat. In addition to their caring role, staff were also responsible for the cooking, serving of food, cleaning and laundry, which meant eight people were supported and supervised on most occasions by one staff member. Whilst we recognise that extra staff were called in on the day of inspection and the registered manager was on duty, we were told this was unusual. This meant there were insufficient staff to support people should unforeseen events occur such as emergency visits to hospital.

One staff member told us extra staff on duty was, "not normal practice." One person said, "I think there's enough staff here." This was the response we had from most people although another person said, "Sometimes I have to wait, if they're busy. Last week when the paramedics came to take [person] away I think they forgot I'd asked for help, they (carers) were very busy dealing with the ambulance." They went on to say the impact of having to wait was, "Well I had asked for a cup of tea and I had to wait quite a long time

but they were very busy." We were advised the service had 48 hours per month, which still required permanent staff cover. This was currently covered with existing staff doing extra shifts, which sometimes exceeded their contracted hours.

We identified the above evidence and failure to ensure sufficient staff were deployed in the service as a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – Staffing.

Recruitment processes were not robust enough to ensure new staff recruited were suitable for the role. Appropriate checks had not always undertaken before staff began work. Criminal records checks had not been undertaken with the Disclosure and Barring Service (DBS), for some staff working in the service. We reviewed four staff files and found that two staff had DBS checks for a previous employer, one staff member had not had one renewed since 2012, and a fourth member of staff had no evidence of a DBS check on file. This meant that staff who may have access to people's confidential or financial information had not had appropriate checks completed to ensure they were safe to work with people who used care services. We discussed this with the registered provider who advised us that all staff would have their DBS check updated to address this.

We also found that the registered provider had not always obtained appropriate references for people as one person's references were not dated or signed. We noted these to be a tick box format and they did not indicate in what capacity the staff member being employed was known or employed. We did however see other relevant recruitment documentation, including employment history and declaration from staff to say they were fit and well enough to carry out their role was in staff files to show that staff were suitable to work in the service. The registered manager informed us that DBS applications had been submitted for all staff prior to starting work. Care staff confirmed they had been asked to provide references and had a DBS check carried out before they started work, however most had been working at the service for some time and could not remember when this had last taken place. The registered provide must ensure they meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to employment of staff.

We identified the above evidence and failure to ensure staff were recruited safely as a breach of regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – Fit and proper persons employed.

Despite these failings, people told us they felt safe living at the service. One person said, "There are different ways of thinking about it but I do feel safe living here. I use this [pointing to walking frame] when I walk but if I had a fall I know there's someone here who would help me. Also, at night they check on me to make sure I'm alright which makes me feel safe."

People told us staff treated them well and we found staff understood their roles and responsibilities in safeguarding people. Staff were able to list categories of abuse and confirmed they had received training. One staff member told us, "I would definitely report anything I felt was abusive and if someone was at risk I would not be too shy to say anything." Another staff member said, "I know the people here well and would report any concerns to the senior staff." Staff were clear about the need to report any safeguarding concerns. They told us they would report abuse to outside agencies if necessary and knew where to find the contact details for these.

The service was clean with no offensive odours. The last infection control audit had been completed on 6th June 2017 and no issues were found. A monthly deep cleaning rota was displayed on the wall in the office dated December 2017; however this was blank and had not been completed. The registered manager told

us they were not sure why this was however, it had not been completed recently. Soap dispensers, paper towels and hand sanitisers were accessible in appropriate locations around the service and that plenty of gloves and aprons were freely available for staff personal protective equipment [PPE].

Routine checks of fire safety equipment were completed as well as fire drills. In the event of an emergency people's care would continue with the least disruption and staff would know what action to take in the event of a fire. People all had individual personal evacuation plans in place (PEEPS). Staff had undergone fire training and there were routine fire drills held. We also noted equipment such as hoists had been serviced appropriately. Where accidents and incidents had occurred, action was taken in response to these. For example, an incident had recently occurred whereby someone had let themselves in through the front door uninvited. A relative told us, "It's secure, the door is always locked now and even though they know us we have to ring to be let in, we (the family) have been quite happy with that." CCTV had also been installed following this incident in an effort to improve security.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments were in place for people, which recorded whether they could make decisions relating to day-to-day tasks. However, there were no further assessments in relation to any specific decisions that needed to be made that could restrict people's freedoms, or were needed to ensure their welfare. The service had not always reviewed peoples' DoLS applications to ensure they remained relevant, and ensured they were using the least restrictive methods possible. One person did not have an authorised DoLS application in place. We were told this person needed supervision to go out. The care record for this person stated a mental capacity assessment was carried out but this was undated, another person had details in their care plan that a DoLs application had been submitted at the previous service they resided and they were awaiting a response. No follow up actions to this were evident therefore, it was not clear if the information had been followed through and was current. Records showed that not all assessments were up to date and evaluations did not indicate a thorough reassessment of a person's capacity to ensure there was no change.

The records we looked at did not demonstrate a thorough understanding of the MCA. There were no records of capacity assessments to determine whether people were, for example, capable of deciding for themselves whether to take their medicine. And it was not clear if the registered provider had involved the relevant people in decisions as most of the care plans we reviewed had no consent documented. For example, one care plan stated 'family members' had been involved; however, there was no further information about who they were. This meant that the provider could not be assured that they were making decisions in the best interests of people or giving the opportunity to make them themselves.

We identified this as a breach of the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. - Consent.

We also identified as part of this inspection that staff were not provided with appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to do. Whilst we acknowledge staff told us they felt supported and spoke positively about their role and their work at Winchester House, they were unsure about the frequency or purpose of professional supervision and could not tell us how regularly they received it. Staff records we sampled indicated that the practice of individual supervision had not been completed regularly and staff appraisal, and annual performance monitoring processes, had not been carried out for some staff.

Systems were not in place to identify gaps in staff knowledge and staff were not provided with additional learning and development opportunities in areas such as dementia and end of life care. Whilst we acknowledge that all new staff had commenced the Care Certificate as part of their induction process and training, and staff completed a workplace specific induction in addition to ensure they were aware of policies and safety procedures, we found gaps in four of the five files reviewed. For example, staff undertook learning in key mandatory subject areas via e-learning and with a knowledge test, however records showed for some staff the e-learning was out of date, and for others there was no evidence to show it had been undertaken.

One member of staff had no record of a service-specific induction but had commenced The Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. They had also mandatory subject certificates, which related to their previous employment and these were dated for 2012, there was no evidence to show their knowledge and skills had been further assessed or refreshed since. Another staff file showed whilst they had achieved National Vocational Qualification [NVQ] qualifications in care there was no evidence of mandatory training completion. We discussed this with the registered provider and advised it was best practice to ensure that even competent workers went no longer than three years without some form of refresher training or opportunity to develop their knowledge and skills further. Another staff file evidenced they had not completed any mandatory training and a fourth file showed a staff member had not completed medication training, however a record of assessment of competency only had been carried out for medication administration.

Staff had insufficient training and support to manage medicines effectively. Staff received basic on line medication training only. Furthermore, staff carrying out competency assessments for others had not received further training to support their supervisory roles and their competency had not been assessed to ensure they were competent themselves in the intended learning outcomes. The registered manager told us practical moving and handling and face-to-face first aid training was being addressed. The 'Statement of Purpose' for the service states to maximise residents' welfare they will: 'Offer our staff a range of training, which is relevant to their induction, foundation experience, and further development', and 'We are aiming for a progressive improvement in the standards of training at all levels of our staff and management.' We were not assured of this on the day of inspection which meant people may receive ineffective care as staff had not been subject to consistent relevant training and support in their roles.

We identified this as a breach of the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. – Staffing

Some people using the service were in the early stages of dementia; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and in keeping with best practice. At this inspection we found throughout the service there was little evidence of a dementia friendly environment. For example, there was no pictorial or directional signage, use of contrasting colours on grab rails, and no use of memory boxes, coloured doors or other ways to help people identify their rooms. Such adaptations would support people to remain independent for as long as possible. There were heavily patterned carpets throughout the home; this can cause potential confusion to some people with visual impairments or who are living with dementia.

We recommend the service reviews current guidance, and seek advice from a reputable source in relation to dementia friendly environments and incorporates dementia friendly adaptations. This should be done in consultation with people using the service.

Staff asked for consent first and explained what they were doing before providing support for people. People told us staff explained the process when they were providing care. One person said "I need help to get around; they [carers] use that [pointing to the hoist by their bed]. When they use it they explain when they're about to lift me, you know, they warn me first." We asked what it was like to be hoisted and they told us, "Well, it's ok actually, it's not uncomfortable if that's what you mean, and it has to be done." We observed staff moving and handling people appropriately on the day of inspection.

Staff supported and enabled people to practice their faith and one person described how the service helped them with this. People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination. Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act, were considered in people's care plans with them. This helped to ensure people did not experience any discrimination. For example, where people had a particular faith this was recorded. Equality and diversity training was included in the provider's basic training programme however this training had not been completed recently by staff.

People were supported to eat and drink sufficient amounts to meet their needs and their dietary requirements were detailed in their care plans. Fresh meat and vegetables were used and all food was home cooked. People were provided with opportunities to have hot and cold drinks throughout the day. People when asked about the food commented positively. One person said, "I'm a vegetarian, although I will eat fish and they're very good, there's always something I can have." We noticed it was chicken or lasagne for lunch and asked if they would have something different and they told us, "I know, I eat chicken so that will be fine." Another person said, "I like the food here, it's very good, home cooked you know, and tasty."

The mealtimes we observed were relaxed and friendly. People received any help, support and encouragement they required to eat and drink promptly. We saw people were offered a choice of meal and were asked if they had had enough to eat. We visited the kitchen and saw there was a list of people's dietary requirements displayed. This included information on people's weights and any nutritional risk. This would help ensure kitchen staff were able to provide people with appropriate nutritional support. People told us they were able to get a drink or snack when they wanted, and we saw drinks were offered regularly throughout the day. People told us they were provided with enough to drink. One person told us, "They bring round tea or coffee during the day, and you can always ask for a drink if you're thirsty," We spoke with three people in their rooms and all three had a drink in a small glass or beaker.

Whilst no one raised any concerns regarding mealtimes and some people chose to eat in their rooms, we observed there was one communal lounge and dining area; with only one dining table to seat up to six people. If everybody chose to sit at the dining table to eat there would not be enough seats. The service also had no system to support people to access food independently; there were no finger foods or fresh fruit readily available for people to eat if they were hungry. Staff told us this would be readily supplied upon request.

Records in people's care files showed a range of health professionals had been involved in their care. This included GPs, district nurses, opticians and chiropodists. People told us they were confident staff would arrange for them to see a GP or other health professional promptly in response to any health concerns they had. One relative told us, "Because we [her relative and I] were in most days, we would take [person] to the hospital or doctor for appointments so we knew what was happening and would update them [care home]. Equally, if the doctor had been in to see [relative], they would tell us, we were both providing information so everyone knew what was happening." A person using the service told us, "The doctor's just next door which is very handy. If I need to see someone they get the doctor round, they are very nice." Another person said, "Well, the opticians came to see me a little while ago and I got new glasses." We saw staff monitored most

people's weights where a need had been identified. This would help ensure any change in that person's health would be recognised and acted upon. Whilst we recognise this staff told us they did not escort people to hospital or healthcare appointments as there were not enough staff to do this. We also noted there were no hospital information grab sheets to assist hospital staff in the event of an emergency admission.

We discussed with the registered manager the red bag pathway, which looked to improve the way services worked together. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital episode and is returned home with person. The standardised paperwork will ensure that everyone involved in the care for the person will have necessary information about the person's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications in the red bag. This meant the service would have systems in place to ensure a person's needs were met when they moved between services. We also checked the care records for people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. There were DNACPR forms in place for some people. These should be kept under regular review in case a person's needs changed and they required review.

Requires Improvement

Is the service caring?

Our findings

People told us staff treated them kindly. One person said, "They are lovely staff." During the day we saw care staff talking with people in a very natural and relaxed way. For example, we saw two people spoken to in a caring way as they could become anxious. Staff reassured them and spoke very kindly to them. At lunchtime one person started to stare towards the front window of the lounge, the staff member asked them if they were alright and the person said, "There's someone out there, I can see someone standing outside the window." The staff member looked and said, "It's alright [name of person], I can't see anyone, I think that's just my car you're seeing, it's parked outside." The person smiled and seemed to be satisfied with the explanation. Staff had developed positive and meaningful relationships with the people they supported and knew them well. They had a good rapport with people and interactions were patient, warm and respectful.

The caring nature of the staff, was also reiterated by the relatives we spoke with. One relative told us," As [Name of relative] got worse they were very caring, and it was important to me. [Name of relative] had always been very smart, you know, they liked to look their best. Whenever we came to visit, their hair would be brushed and they would be well dressed, I think that's very important even if [Name of relative] didn't really know any more, it was important to us."

People were treated with kindness, dignity and respect. During the medicines round we observed staff knocking on people's doors and crouching down to people's level to speak to them. Staff spoke clearly and gently to people and where they had to speak louder to someone because they were a little hard of hearing they did this in a gentle way. A relative told us, "There were occasions when they needed to hoist someone in the lounge and they asked us to step outside the lounge while they did it (for their dignity)." Another person told us, "The carers are kind, of course they are and although they're busy they are patient." During the day, we became aware that one person pressed their call bell frequently. Their room was located adjacent to the lounge and staff members responded promptly. This happened quite often throughout the day and the person just needed a little reassurance each time.

Different care staff would go in and talk to the person in a calm and patient manner. One person told us this could cause some frustration with them sometimes however we saw no indication that staff became irritated or frustrated by the repetition of calls responding appropriately each time. One person told us, "Well sometimes I have to wait but it's not very long. I don't like to press my bell because I know they're busy, unlike other people who I understand are always calling for help." Staff spoken with were committed to providing good quality care but recognised the shortfalls in the care they could provide to people due to the lack of time for social and caring interaction. We have addressed this in the safe section of this report.

Staff were attentive to people and showed concern. We watched as a staff member assisted someone to sit in a chair. We heard the staff member say to the person, "Be careful get your balance first." We observed staff knock on people's doors or asking if they could enter when people's doors were open. As staff entered they greeted people, using their preferred names, by saying, 'Hello' and telling people what they were there to do. Staff spoke fondly about people and we observed caring interactions from staff. There was a very friendly exchange between a member of staff and two people in the lounge.

People were cared for by staff who knew them. One staff member was able to describe people in good detail, what they did for a living, their medical conditions, family, etc. They knew people's allergies, what support they required and how they required their food to be prepared. They could also describe what they used to do as a job, their past times and information about their families. We did however note that people's care plans did not reflect this level of detail, and the registered manager told us they were reviewing all care plans presently to ensure they complied with concerns raised by the local authority regarding the lack of essential detail in the same.

People were enabled to have privacy if they wished and to make their own choices. One person we spoke with chose to remain in their room most of the time. They told us this was their choice and staff respected this. Another person said, "I can make my own choices, my son comes and takes me out sometimes which I enjoy, we go to Clacton. Also, I decide when I want a bath, I can ask or sometimes they'll say, 'Do you want a bath today?" and I'll have one if I feel like it and won't if I don't." Some people liked to eat their meals in their room and again they said staff respected their wishes. People return to their rooms during the afternoon for a rest or to spend time with visitors and relatives in the privacy of their rooms. Visitors were welcomed politely, and they confirmed visiting was open and they were always greeted warmly.

The staff took into account any cultural or religious needs people may have. Most people did not have any, but one person told us they observed a particular faith. They told us, "Well I get [specific faith publication] regularly which I read. The trouble is there isn't a [specific place of worship] near here so I can't go but, I can listen to a service on my phone." We asked how this worked and they said, "Well, if I phone a number at the right time, I can hear a service, it's live not a recording."

Requires Improvement

Is the service responsive?

Our findings

Plans of care for people were not personalised. They did not identify each individual person's strengths and abilities in full. For example, where people had needs which related to dementia they did not state how these affected their day to day living or the level and type of support people needed. Some care staff also told us they did not read and follow care plans. One staff member told us, "The care plans are done with people and their family members". In people's care files there was no evidence of family involvement.

People's care files were audited monthly. Care plans contained brief information on people's likes and dislikes, including food, their interests and their preferred routine. There was a document containing people's personal information including emergency contact details. Assessments of people's needs had been completed before people moved into the service. Risk assessments were completed for falls, nutrition and skin integrity, however these were not completed sufficiently well to mitigate the risk.

When we case tracked some people's care files. There were sections and a different page of each care plan for relevant areas of a person's care. These included mobility, bathing, skin, eyes, communication, nutrition and diet, medication, continence, cognition, night checks and social needs. We found that up to date and relevant information was hard to find or differed from the care and support the person was receiving. Care plans contained very brief personalised information and there was little information in care plans to guide staff on how to support people's specific health needs appropriately and effectively. For example, one person who suffered with diabetes had it documented in their care plan to check the person's blood sugars. There was no further guidance on the correct range of blood sugars, what the levels of blood sugars mean or signs and symptoms to be aware of if blood sugars are too high or too low and what action to take. Another person had a sight impairment. When we reviewed the plan of care it did not clearly identify arrangements in place on how to promote their independence or support them to lead a meaningful life. Additionally they had not had their Malnutrition Universal Screening Tool [MUST] completed since January 2017. Their weight chart identified a loss of 7kg in weight since April 2017, [from 51kg to 44kgs]. Although we note they had been referred to a dietician in January 2018 there were no care planning arrangements in place on how to promote, tempt and encourage eating; which included things like fortifying food or offering drinks such as high calorie shakes, their food of choice or regular snacks.

Other examples included people being hoisted who did not have individual slings and there was no information in their care plans to advise staff on what size they should use or the mechanism of use. This meant staff did not have appropriate guidance to enable them to safely move people and as people did not have individual slings, incorrect sizes may cause injury and discomfort to people, and also increases the risk of cross infection. Where people were using incontinence aids, these were also not detailed in the same way identifying size, type of use, and which aid they were using. These people were receiving appropriate care on the day of inspection; however, people's care plans did not clearly record this. It is possible that a lack of clear recording could have a future impact on a person's care and support. The design of people's care plans made it difficult to gain or understand up to date information. At times care plans had been added to without the new information being also transferred to another relevant part of the plan. People's changing care needs had not consistently prompted the completion of a new relevant risk assessment.

We identified this as a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person Centred Care

Assessments of people's needs were completed before they moved into the service. This was done to ensure that the service could meet their needs. Before people moved in they were also encouraged to visit the service, look around and meet the other people currently using the service. This ensured people had a good understanding of how the service operated before choosing to move in. It also gave people an opportunity to observe staff interacting with people and gain an understanding of how the service operated, its rules and procedures. Staff knew people well and most staff members had worked at the service for some time and this did mitigate some of the risks related to the lack of training

People were not consistently provided with regular access to meaningful activities and stimulation, appropriate to their needs, to protect them from social isolation, and promote their wellbeing. Care and support plans needed improvement to reflect how staff should support people, to lead fulfilled and meaningful lives, through activity, therapy and social inclusion. For example, activity records stated: 'relaxing in chair' or 'had visitors' or 'chatted' and people did not go out into the community during the day.

Some family members commented that the service could improve in the activities being offered to people. There was not a dedicated activities co-ordinator and we did not see a list of weekly or organised activities. One relative told us, "[Relative] used to love puzzles and quizzes and sometimes they would do one. I used to take them to a day centre twice a week and they nearly always had a quiz which they enjoyed." We were told that people watched the television or read. One person said, "I like to stay in my room and watch the television, that's what I do most of the time, I don't get bored." This person had patio doors leading out onto the rear garden and went on to say, "When it's warmer I can go outside, I quite enjoy that." Another person told us, "I quite enjoy listening to the television sometimes, there isn't much I can do now"

There were some activities and stimulation for people happening at the service, with occasional events that people attended. However week-to-week the activities lacked structure and there was no evidence these were tailored to the needs and preferences of the people living at the home, to encourage more involvement. There had not been any development of activities that focused on people who maybe living with dementia. For example, one person who was visually impaired was sitting in the lounge next to another person chatting for most of the day. There was no evidence that the person joined in on any activities, used any services for the visually impaired or adapted activities had been offered to them.

We therefore recommend that the provider seek appropriate support and guidance in order to develop the activity provision at the service to protect people from social isolation and to support them to live full and meaningful lives.

We observed that staff talked to people about what was important to them. One person told us, "They know I like to make things, I used to sew a lot. There are some animals in my room I made." One staff member told us, "[Person] is very talented; they made those animals in their room and the bedspread (patchwork quilt)". At lunchtime two carers described how one person had a relative and they had run a farm together. This was confirmed a little later when we spoke with the person who told us, "We had cows and some sheep, I come from a farming family."

People told us they thought the care they received was specific to their needs. For example, one person said, "They help me to get up, they help me to go to bed. If I need a bath, they help me because I cannot get about on my own anymore. They do everything for me because that's what I need."

Relatives told us they would feel comfortable raising any concerns, although they had not felt the need to. There had not been any recent complaints recorded by the registered manager at the service. One relative told us, "I never had to make a complaint, all the time [relative] was here (nearly 3½ years). There might be the odd time when an item of clothing got lost in the laundry but that was about it. We feel very lucky [relative] came here, they are well looked after and used to say how fortunate they felt they were." Other people we spoke to said they had not made a complaint and were quite happy with the way things were.

The service had a complaints procedure which outlined what people could expect from the provider in response to any complaints or concerns they had. We noted that the complaints policy was on display on the noticeboard and was available in an appropriate easy read format

No-one at the time of the inspection was receiving end of life care. People's care plans confirmed discussions held with people and any decisions they might have made relating to their wishes. Whilst these were in place, a few were incomplete and required more detail to ensure a clear record was kept.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager employed at Winchester House. They were also the registered provider. 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.

At this inspection we found improvements were required to the arrangements for assessing and monitoring the quality of service provision. During this inspection we identified five breaches of regulation in relation to risk management, staff recruitment and training, safe management of medicines, consent and ineffective oversight and monitoring of the service. This demonstrated that the arrangement for assessing quality and safety at the home was inadequate in identifying concerns and ensuring they were rectified in a timely manner. An example of this was recruitment files not containing the relevant documentation being fully checked as part of the recruitment process. A monthly health and safety audit had not been carried out and the last environmental audit was completed in 2017 and previously September 2017. The audits carried out by the registered manager had failed to recognise the premises safety issues we had identified such as the fencing surrounding the external pond and also did not identify that the induction, training, support and supervision for the staff was not carried out appropriately. All these issues had resulted in breaches of regulations, and are described in more detail in the body of the relevant sections of this report.

Prior to this inspection the local authority had raised concerns with us and despite those concerns being raised with the registered provider there had been little progress noted in follow up visits. We inspected as no significant improvements to the provision of the service had been made or sustained. This demonstrated the management systems at Winchester House were ineffective. We concluded there had been a decline in the quality of the service and care provided and the registered provider had failed to recognise the concerns we identified at this inspection and make the necessary improvements required for the care and safety of people living at Winchester House.

We looked at how the registered provider demonstrated they continuously learned from incidents and their checks, improved, innovated and ensured sustainability in the service. We found there was a lack of consistent quality auditing and governance processes. Formal audits had not been completed in areas such as health and safety, care plans, medicines management and people's experiences. Whilst we acknowledge the registered provider advised us they were having a difficult time currently and a few audits had been completed the systems in place were still failing to adequately identify shortfalls and areas where the care was not safe and to drive improvement.

We looked at people's care records and found there was a significant amount of inconsistent and /or inaccurate information about people's needs and levels of risk. We found records of actions that had been identified as required to monitor people's safety were not completed. There were gaps in records of people's medication and weight charts. In addition, care records had not been reviewed on a regular basis. There was no managerial oversight of the safe management of medicines and medication audits were ineffective, as

they also did not identify the concerns found on the day of inspection. The medicines audits completed in the home had not identified the concerns we found in respect of the safe storage of controlled drugs, other medication, and stocks of medication. This meant people may not receive their medicines as prescribed and this was due to the monitoring of this not being adequate.

The evidence we saw showed that the registered manager had not had oversight of the audits completed. There was a lack of evidence to show how the registered manager provided oversight to staff in the service to ensure they received training and support and completed their delegated tasks and that they were recruited safely. We concluded that there was a lack of robust oversight and accountability by the registered provider who was also the registered manager. After the inspection we were informed us that they were going to work with the Local Authority who had introduced additional oversight to monitor the running of the service and support the registered manager.

We found the service had maintained some links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local health care agencies local pharmacies, district nurses and local GPs. However, the provider had not established a robust a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Winchester House. For example, there were no grab-sheet hospital passports in place for when people needed to be admitted to hospital in an emergency. We also noted that the staff and the registered manager had not joined local initiatives with the local authority and local clinical commissioning groups in areas such as PROSPER which monitors the incidence of falls and pressure ulcer development, and localised medication training. These initiatives are promoted by the local authority and local health services to share best practice and to improve the way services meet people's needs and introduce preventative measures. This meant that the service was not always taking opportunities to learn from best practice designed to improve people's outcomes. The provider/registered manager informed us they had not participated in local initiatives recently however they were aware of them. Following the inspection they informed us that they would be contacting the Local Authority and join in the initiatives. One relative told us there were relatives meetings held occasionally but, "They were rather ad hoc." All of the people we spoke to using the service, could not remember having been asked to fill in a feedback questionnaire.

We asked for a copy of the service's statement of purpose, however the one that was given to us included some information that was incorrect and not up to date. It identified the previous provider as one of the persons registered to carry on the home and officially to manage the home. They were in fact now employed by the current provider as a part time senior carer. The information should be current and specific to Winchester House and we could not see that this had been identified and corrected since the original statement of purpose was compiled. This meant the document held was not factually correct for the service.

The service did not have a culture of continuous improvement. A director of the provider company also held the registered manager position for Winchester House. They did not live locally to the service and spent three to four days a week there, this did not provide effective day-to-day management of the service. The service did not have a deputy manager employed to provide support and leadership to staff in the registered manager's absence. People told us they knew who the manager was. One person said, "Yes, she's a nice lady but she's not here all the time." Another person also said, "Well I think her name is (name of manager), she isn't here every day, but a few days every week. I think (name of carer) runs it really." The registered manager did not have clear and effective oversight and had failed to recognise and act on the deterioration in the managerial elements of their role.

The registered manager had failed to continuously monitor and review where necessary the effectiveness of risk assessments in relation to health and safety, fire safety, and risks to individuals health and wellbeing. The impact of staff's task based duties had not been considered against how they met people's individual care and support needs and how they spent their day.

Whilst we acknowledge records of staff supervision showed that the provider recognised, acknowledged and valued the wellbeing of staff, reflecting praise and thanks and that staff told us that they felt well supported by the provider and were comfortable to raise any concerns they may have with them. The provider did not operate a planned and structured supervision process to support staff and reflect on their day-to-day practice and professional development. They told us that it was a small staff team and they worked closely with staff, for these reasons they had not developed a formal practical structure for supervisions.

The provider told us that staff meetings were not regular because it was a small home and they communicate regularly. There were no minutes of meetings and the last one recorded took place in November 2017, the evidence for this was an agenda only. Staff unable to attend were given agenda only and content of meeting was communicated verbally from other attendees and not directly from the minutes or registered manager themselves. The provider/manager said they were waiting for next meeting booked at the end of month to discuss with staff what improvements are needed, how they can be implemented and staff training.

The service did not actively seek to engage people who need care and support in activities or support groups within the local community. For example local Sensory Services for a person who was blind. A staff member told us that they used to have talking books but doesn't know why this had stopped.

Our previous inspection in 2015 rated the service 'good' but this inspection found that the provider had not sustained the infrastructure within the service to ensure compliance with fundamental standards and drive improvement. There were no consistent systems in place to effectively monitor the standards of the service and inform improvement strategies. For example, falls and incidents were not analysed to identify any themes or trends that could be addressed to try and prevent further falls. One person had had seven falls in two months and another person who had sustained a black eye in November 2017 due to unknown cause had no evidence of an investigation being carried out.

We identified this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

Despite these widespread issues, everyone we spoke to told us they thought the service was well run. One person said, "I think it's very well run. They got my sister here you know. She's been quite poorly but she's here, a little way away from me but I'm hoping I'll see her a bit more when she's better." Another person said, "I think the staff know what they're doing, well most of them do, but there's not many of us here so perhaps that's why, you know, it's easier for them."

When we asked people if they were told about any planned changes happening at the service we were told they were, although one person said, "Well I don't think a lot changes really. I knew the pond was being worked on of course because I could see them doing the work but those (barriers) only went up a few days ago, I didn't know that was going to happen."

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and those related to people who used the service. Notifications had been submitted and the

registered manager knew their regulatory responsibilities for submitting statutory notifications to the CQC. A notification is information about important events that the service is required to send us by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records we reviewed were not person centred and did not provide staff with adequate information about the person who was being supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider has not always ensured that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. The provider must ensure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not effectively assess and do all that is practicable, to mitigate the risks to the health and safety of service users. Care plan documentation, associated risk assessments and those of the environment did not always sufficiently detail robust information to enable staff to minimise any risks associated with people's care and support needs. The management of medications was also not done

safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was failing to ensure that there were systems and processes in place to provide a safe, effective and well-led service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not ensure that persons employed at the service were recruited safely to ensure they were suitably qualified, competent and skilled to care for the people in the service. Also that staff received appropriate training of a sufficient standard to enable them to carry out their duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed in sufficient numbers and did not receive appropriate training and professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.