Mrs D Hudson

Spring Bank Nursing Home

Inspection report

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Date of inspection visit: 09 & 10 June 2015
Date of publication: 24/08/2015

Ratings

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

Overall summary

The inspection took place over two days on 9 and 10 June 2015, the first day was unannounced.

Spring Bank Nursing Home provides accommodation for up to 31 people, predominantly older people. It is situated in the town of Silsden and is close to local shops and amenities. The accommodation is on two floors and is made up of single and shared rooms. There are two lounges and a dining room on the ground floor and there is a passenger lift. The home is set in its own grounds and there is parking by the side of the building.

The service has not had a registered manager since November 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection was in November 2014 and at that time we found there were ten breaches of the regulations. We issued warning notices for three of the breaches of

Summary of findings

regulations, there were in relation to nutrition, record keeping and monitoring the quality of the services provided. We told the provider they had to make improvements by 23 March 2015. The other breaches related to safeguarding, the safe management of medicines, the safety and suitability of the premises, consent to care and treatment, staff training and development and respect and involvement.

We told the provider they must submit an action plan with details of how they were going to make improvements in these areas. The provider sent us an action plan. During this inspection we followed up all these areas to check if the required improvements had been made.

We found the provider had not taken adequate measures to meet the requirements of the warning notices in relation to nutrition, record keeping and monitoring the quality of the service which meant there was a continued breach of regulation in these areas. In addition we found the provider was still in breach of the regulations relating to medicines, the safety and suitability of the premises, consent to care and treatment and staff training and development. In addition to the on-going breaches of regulation we identified new breaches of the regulations. They were in relation to staffing, staff recruitment, person centred care and safe care and treatment.

People who used the service and their relatives told us they felt safe. However, we identified a number of concerns which led us to conclude the service was not safe. We found people's medicines were not managed properly and people did not always get their medicines in the way they were prescribed. This was an on-going breach of regulation. The home was not clean and there were unpleasant odours in some areas including people's bedrooms. The home décor and furnishings were showing signs of wear and tear and the home was not well maintained. The standards of cleanliness had deteriorated since the last inspection.

There were usually enough staff on duty but the home did not have enough nurses and relied on a mixture of part time and agency nurses which risked a lack of continuity of care. This was a new area of concern.

We found people did not always receive care and treatment which was appropriate, met their needs and reflected their preferences. This was a new breach or regulation. People were supported to meet their health care needs and had access to NHS services via their GPs.

Some improvements had been made to the way people were supported to eat and drink however there were still areas of concern. For example, when people had food and fluid charts to monitor what they were eating and drinking there was no system in place for checking the charts to make sure they had in fact had enough to eat and drink.

People told us staff were kind and caring and we saw staff were respectful and attentive to people's needs. However, there were some aspects of the service which could compromise people's privacy and dignity, for example there was no lock on one of the communal toilet doors.

There were no restrictions on visiting and people were able to receive their visitors at times that suited them and in private. There was a programme of activities. Opportunities to take part in social activities outside of the home were limited and for the most part people relied on family and/or friends to take them out.

People told us they had no reason to complain. Information about how to make a complaint was displayed in the home.

The required recruitment checks were not always done before new staff started work. This meant people could be at risk of being supported by staff unsuitable to work in a care setting. This was a new breach of regulation. When new staff started work they did not always get any induction training to make sure they were competent to work safety and deliver appropriate care. Staff had received some training on safe working practices but it was difficult to get accurate information about what training staff had received. This risked people being cared for by staff who were not properly training to deliver appropriate and safe care. This was an on-going area of concern and had been identified as a breach of regulation at previous inspections.

Staff did not have a clear understanding of the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards which meant there was a risk they were not always acting within the law. This was an on-going breach of regulations.

Summary of findings

There was no registered manager and there was a lack of consistency and leadership. There were some systems in place to monitor the quality of the services provided but there were not working well. This meant that potential problems or shortfalls in the service were not always identified and acted on which in turn could have a negative impact on the experiences of people who lived in the home.

People who lived in the home and others were potentially at risk because the provider did not have effective systems in place to identify, assess and manage risks to their safety and welfare.

We found the provider was not meeting nine regulations and many of these were on-going. CQC is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. 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, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

On 07 September 2015 we issued a Notice of Proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home. The provider took the decision to close the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People who lived at the home and their relatives told us they felt safe living there.

People's medicines were not managed safely and people did not always get their medicines in the way they had been prescribed.

The home was not clean and was not well maintained and people were at risk because risks to their safety and welfare were not identified and managed.

The numbers of care staff on duty were adequate but the home did not have enough nurses and relied on part time and agency nurses which meant there was a lack of continuity of care.

Is the service effective?

Inadequate

The service was not effective.

People said they enjoyed the food. Improvements had been made but more needed to be done to make sure people were consistently given the right support to meet their nutritional needs.

Some staff training had taken place but more needed to be done to make sure staff received the training and support they needed to deliver safe and appropriate care.

The service was not working in accordance with the Mental Capacity Act 2005.

People had access to a range of NHS services.

Is the service caring?

Requires improvement

Some aspects of the service was not caring

People who used the service and their relatives told us the staff were kind, caring and friendly and this was supported by our observations.

However, some of the bedrooms and communal rooms were not as clean as they should be and there were in unpleasant odours in some places. This was not conducive to people's wellbeing.

There were no restrictions on visiting. We spoke with two people's relatives and they told us they visited at different times and never had any concerns about the care.

The staff were respectful but there were some aspects of the service which potentially compromised people's dignity, for example there was no door lock on one of the communal toilets.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

Summary of findings

People did not always receive care and treatment which was appropriate, met their needs and reflected their preferences.

There was a programme of planned activities in the home. Opportunities to go out were limited and people relied on family and/friends to take them out.

People told us they had no reason to complain. Information about how to make a complaint was displayed in the home.

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager and there was a lack of consistency and leadership.

There were some systems in place to monitor the quality of the services provided but they were not working well.

The provider did not have effective systems in place to identify, assess and manage risks to the safety and welfare of people who used the service and others.

Spring Bank Nursing Home

Detailed findings

Background to this inspection

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

The inspection started on 9 June 2015 with an unannounced visit to the service, the inspection continued on 10 June 2015.

The inspection team was made up of two inspectors, a specialist advisor in nutrition 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, in this case, the care of older people.

We looked at 15 people's medication records, four people's care plans and seven people's nutritional records. We also looked at staff records, a selection of maintenance records and records relating to the management of the service. We spoke with eight people who lived in the home and two people's relatives. We spoke with the manager, the provider, two nurses, three care workers, the maintenance man, the cook and a kitchen assistant. We observed how people were cared for and supported in the communal areas and looked around the home.

Before the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams. Before our inspections we usually ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask for a PIR.

Inadequate

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe. One visiting relative said, "My mother has been here for seven years, and whilst she is not a well lady, and cannot speak up for herself these days, I am very happy with the way she is looked after and I know she feels safe in her room and also I know that she is safe. I have known some of the staff for a long time and they are easy to talk to."

However, during the inspection we identified concerns which indicated the service was not safe.

At the last inspection in November 2014 we found people's medicines were not managed safely and we told the provider they must make improvements. During this inspection we looked at medicines for 15 people who used the service. We found the provider did not have suitable arrangements in place to make sure people received their medicines in the way they were prescribed. We saw nine people were prescribed medicines which had special instructions about how they should be taken in relation to food. We asked the nurse how they managed this and they told us, only one person was receiving their medicines according to the prescribed instructions. We asked the nurse why other people with similar medicines were not receiving them in the same way. The nurse said they had tried giving the medicines earlier but it had not worked. Therefore they had gone back to giving people all their medicines at the same time. This was usually around 10am when most people had already eaten their breakfast. This meant there was a risk people's medicines would not be effective because the instructions said they should be taken 30 to 60 minutes before food.

In another person's records we saw they had been prescribed medicine (Haloperidol) to be taken twice a day. The Medication Administration Record (MAR) for May 2015 showed the medication had only been given on one occasion. The code for omitted medicines was recorded but there was nothing else recorded to show why the prescribed medicine had not been given.

We saw the provider had put a stock balance chart in place for medicines which were prescribed to be taken as needed and in a variable dose. For example, some people were prescribed Paracetamol to take one or two tablets as needed. However, there were no care plans in place to guide staff on the use of medicines prescribed to be used in variable amounts and when needed. This meant there was a risk these medicines would not be used appropriately.

We looked at the medicines classified as Controlled Drugs (CDs) and saw they were stored securely. We checked the stock balance for one of these medicines. We found the number of tablets in stock was the same as the number recorded in the CD register; however it was not the same as the stock balance recorded on the MAR. We found this was because the stock carried forward from the previous month had not been recorded on the MAR. We saw some people were prescribed medication patches for pain relief. There was a "daily record sheet" which staff were required to sign to confirm they had checked the patch was still in place. We looked at two people's records; the charts covered a period of 32 days starting on 7 May 2015. We found one person's record had not been signed on 13 of the 32 days and the other person's record had not been signed on 10 of the 32 days. Because the daily checks were not done there was a risk of people experiencing pain or discomfort and staff not being aware of this to take appropriate action.

When medication charts were hand written they were not signed to show who had written them. When it is necessary to hand write medication charts it is good practice for two people to check and sign the MAR to reduce the risk of transcribing errors.

We looked at the care plans about supporting people with their medicines and found they did not have detailed information about people's individual medicines. For example, the possible side effects staff should look for.

The provider's medication policy was out of date. It had a review date of November 2012. The provider's guidance on the use of covert medicines was a document titled NHS Berkshire East and was also out of date; the review date was January 2015. The nurse on duty told us there were not administering medicines in a disguised form to anyone living at the home at the time of the inspection.

The nurse on duty told us they had attended a training update on medication earlier this year. They said they had done the training in their own time and paid it for themselves. There were four other nurses employed at the service, the training matrix showed one was overdue medication training and there was nothing recorded for the remaining three.

Inadequate

Is the service safe?

The provider had implemented some stock checks but there was no audit which looked at all aspects of the safe management of medicines.

This demonstrated the provider did not have suitable arrangements in place to ensure the proper and safe management of medicines and therefore people were at risk of receiving care and treatment which was unsafe. This had been identified at the last inspection in November 2014 and was an on-going breach of regulation.

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

At the last inspection in November 2014 we told the provider improvements must be made to the environment. During this inspection we looked around the home accompanied by the manager. We saw the bedrooms were comfortable and most people had personal belongings in their rooms. However, we identified a number of concerns about the cleanliness and maintenance of the premises.

In the majority of people's bedrooms we saw the carpets were stained and looked dirty. Much of the furniture was showing signs of wear and tear and there was evidence of damage caused by wheelchairs and/or other equipment. In some bedrooms the bed linen was thin to be point of being threadbare. In a number of rooms we saw counterpanes on the beds; these are covers for the bed and bedding. They were made of a thin synthetic nylon type fabric with a padded backing. However, the padding had either come away or been removed leaving a tatty looking cover on the bed. The painted walls in many of the bedrooms, en-suites and communal bathrooms was stained and looked dirty. There was an accumulation of dust on the louvre doors of the en-suite toilets and the pull cords on the light switches were dirty.

The fans were not working in the en-suite toilets in six bedrooms and the communal bathroom on the ground floor. There was a lack of storage space and many of the en-suite toilets were cluttered with boxes of incontinence pads and equipment. One of the bathrooms and a toilet on the first floor were being used to store equipment such as bed bases and bed rails. This meant these facilities were not available for use by people who lived in the home. In addition, the doors were not locked which meant there was a risk people could go in there and sustain an injury.

In one of the bathrooms there was an unlocked cupboard which contained cleaning chemicals and a razor which created a potential hazard. The linen room door which had a sign saying it must be kept locked at all times was not locked.

In two of the communal bathrooms there were holes in the floor covering where the bath hoist had been moved and in one of the bathrooms on the first floor there was a crack in the floor covering, just in front of the wash basin, which had been patched with masking tape. In both lounges on the ground floor the carpets were worn, in the main lounge the pattern was barely visible in some places and the carpet in the small lounge was torn in one place. There was an unpleasant odour in two of the bedrooms we looked at. On the second day of the inspection two of the toilets on the ground floor had an unpleasant odour and were not clean. In one of the communal bathrooms there was bin which contained soiled pads which had not been put into plastic bags. The bin did not have a yellow bag which it should have had as it was being used for clinical waste. In one bathroom the cleaning schedule showed it had last been cleaned on 7 June 2015 and in another the last date of cleaning was recorded as 2 May 2015. There was no cleaner on duty on the second day of the inspection. This meant people living in the home were not cared for in pleasant and hygienic environment.

There was a pot hole in the drive and the manager told us they were not aware of any plans to have it repaired. This was a potential risk to the safety of anyone using the drive.

In one person's care records we saw an incident record which stated they had left the building by unlocking a side door and had been seen walking down the drive by the manager. The record stated digital locks would be fitted to all the external doors "asap" to reduce the risk of this happening again. At the time of the inspection the locks had not been fitted.

The records showed portable electrical appliances had been checked in June 2014. They were due to be checked again at the time of the inspection. We saw a television and a bedside lamp in one person's bedroom which the manager confirmed had been brought from the person's home. There were no portable appliance test labels to show a safety check had been carried out when the equipment was brought into the home. The manager said

they would deal with this; however, it indicated there was no proper process in place to ensure electrical equipment brought into the home, which was not new, was checked before use.

This demonstrated the provider did not have suitable arrangements in place to make sure people who used the service were cared for in premises which were clean, well maintained and secure. Concerns about the environment had been identified at the previous inspection and this was an on-going breach of regulation.

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2014 we had concerns about outstanding work to comply with fire safety regulations. Before this inspection we were able to confirm the required work had been completed to the satisfaction of the fire safety officer.

We looked at the fire safety checks and saw the fire alarm was tested every week. We saw the provider had contracts for the regular maintenance and servicing of other fire safety equipment such as the fire extinguishers and emergency lights.

We looked at maintenance records and saw the hoists, slings and passenger lift were serviced and maintained in line with legal requirements and the manufactures guidelines. Water temperatures were checked and the maintenance man confirmed he was aware of the safe temperature range.

At the last inspection the provider had not taken action to deal with shortfalls in the premises highlighted during an environmental health inspection of the kitchens. During this inspection the manager showed us the work had been carried out and said the environmental health officer had been back and was satisfied with the work. The overall rating for the kitchens had not changed and remained at one, the lowest rating.

The home had been inspected by Yorkshire Water to check compliance with water safety regulations. They were due to revisit the service on 11 June 2015 to check the required improvements had been carried out.

The provider had an up to date electrical hard wiring certificate. The gas safety certificate was due for renewal in June 2015.

When we looked around the home we identified a number of risks which the provider had not identified or assessed.

At the end of the corridor on the first floor there was a fire exit door which opened by pushing a bar. This led onto a concrete stairs leading to fire exit door. There was a risk that people could get onto the concrete stairs and sustain an injury. A number of people lived in the home were people living with dementia and as a consequence their ability to identify risks to their safety may be diminished. There was an alarm on the door however, because of the location it was likely to take staff several minutes to respond to the alarm.

There was unrestricted access to the kitchen. Just inside the kitchen door there was a hot water boiler and inside the kitchen there were other hazards such as knives and cleaning chemicals. The back door gave direct access to the outside. This was a concern because some of the people who lived in the home were people living with dementia whose ability to recognise potential risks to their safety and wellbeing may be diminished. When we looked at the accident records we saw a person who lived in the home had been in the kitchen and had fallen, they had been found on the floor by staff.

The top section of the windows in the bedrooms and on the corridors on the first floor did not have restrictors fitted and opened wide enough to create a potential hazard

The main stairway in the entrance hall provided unrestricted access to the first floor, this created a potential hazard for people who were unsteady on their feet or had limited mobility.

We spoke with the manager and provider about these issues and they confirmed the matters raised had not been identified as risks and risk assessments had not been carried out. They said they would take immediate action to assess and manage the risks.

This demonstrated the provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. Following the inspection in November 2014 we told the provider must put an effective system in place to identify, assess and manage risks. We found they had not done this and therefore this was an on-going breach of regulation.

Inadequate

Is the service safe?

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

We asked the manager how they decided on the staffing levels and skills required to support people who live in the home. They told us they used a guidance document called the Dependency and Staffing Guidance for Nursing Homes which had been published by the Regulation and Quality Improvement Authority in 2009. The manager said they had done an internet search and this was the most up to date guidance they could find. They told us they also listened to what the staff said and worked alongside the care staff so that they had first-hand knowledge of people's needs.

They told us there was always one nurse on duty. The nurse was supported by four care workers during the day until 4pm, three care workers from 4pm to 10pm and by two care workers overnight. At the time of the inspection the service did not have enough nurses to cover all the shifts, there was a shortfall of 46 hours a week and none of the nurses were employed on a full time basis. Nursing cover was provided by a combination of part time, bank and agency staff. The manager was not a nurse and one of the nurses was designated as the clinical lead. However, the clinical lead worked 20 hours a week, all day Sunday and an evening shift on Monday. Therefore, it was difficult to see how they could provide continuity of clinical care and support. The manager told us agency nurses were arranged on an ad hoc basis, they did not have a contract with an agency to provide regular staff to help ensure continuity of care. The manager said they struggled to get nursing cover and used about six different agencies to supply nurses.

The manager told us they were recruiting two new nurses for bank contracts, which are zero hour's contacts.

We asked the manager if they had a formal process in place for handovers between shifts to make sure information was passed on and people's continuity of care was not compromised by the nursing staff arrangements. They told us there was no formal handover process and there were no requirements for nurses to complete a written handover. We asked about a formal induction for agency nurses and the manager said agency nurses were given a verbal induction but there was no standardised induction format or record. The agency nurse on duty on the second day of the inspection confirmed they had been given a verbal induction which included information about the emergency procedures. They also confirmed there was no written handover. The care staff we spoke with told us information was not always passed on at handover, for example, they said on the morning of the second day of the inspection they had not been told that one of the people who lived in the home had fallen during the night. They found out from the person themselves when they went to help them get up. This meant there was a risk people would not receive appropriate care.

There was a cook, a breakfast assistant and a kitchen assistant but none of the catering staff worked after 1.30pm. This meant care staff were responsible for organising and serving the afternoon drinks and evening meal and this included the washing up and general cleaning after the meal service. This meant they were not always available to deliver care and support to people.

The manager told us the service employed two cleaners who worked approximately 52 hours between them and provided cleaning cover seven days a week. However, on the second day of the inspection there was no cleaner on duty and when we asked why this was the manager said it was their day off.

There was a maintenance man who worked eight hours a week. They told us they did not have set days or hours; it was a flexible arrangement, for example, during the inspection there were decorating an empty bedroom and would compress their hours.

This demonstrated the provider did not have enough suitably qualified, competent, skilled and experienced staff to provide continuity of care and ensure people's needs were met.

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

We looked at the recruitment files of three staff who had recently been employed by the service. The records showed potential candidates had completed application forms and attended a job interview. Checks with the Disclosure and Barring Service (DBS) had been carried out; these are checks to make sure applicants do not have a criminal record which would make then unsuitable to work in a care setting. However, in one of the files there was no evidence that a gap in the person's employment had been explored and in three files there were no documents which provided proof of identity. We also found the process of obtaining and verifying references from former employers

Inadequate

Is the service safe?

was not robust. One of the staff we were with during the inspection confirmed they had been able to start work without providing references. The provider had a recruitment policy which stated recruitment would be carried out in line with the legal requirements but we found this was not the case. This meant there was a risk people were receiving care and support from people who were not suitable to work in a care setting.

We saw that checks on nurses' registration with the Nursing and Midwifery Council (NMC) were done at the time of employment but there was no system in place to check nurses maintained their registration which has to be renewed every year.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection in November 2014 we had concerns about the way the service dealt with safeguarding people who used the service. When we reviewed the information we hold about the service we saw the manager was letting the relevant agencies, including the Commission, know about allegations and/or suspicions of abuse. The information also showed the manager was taking appropriate action in response to safeguarding concerns. During the inspection we looked at the accident and incident reports and did not identify any concerns about safeguarding which we had not previously been notified about. This along with our discussions with the manager confirmed they understood their responsibilities in relation to safeguarding people.

The staff we spoke with confirmed they had received training about safeguarding. They were able to tell us about the different types of abuse and knew how to report any concerns about people's safety and well-being.

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

Inadequate

Is the service effective?

Our findings

At the last inspection in November 2014 we found the provider did not have suitable arrangements in place to make sure people were cared for by staff that were properly trained and supported.

During this inspection we looked at the files of three newly appointed staff and found there was no record of induction training. In one of the files there was a record which showed the staff member had done training on safeguarding and moving and handling since starting work but no other training was recorded. We asked the manager about this and they confirmed there were no induction training records for the three staff in question. Another care worker told us, they had not received any induction training when they started work. They said they had since received training on safeguarding, fire safety procedures including a fire drill and moving and handling and had started their NVQ (National Vocational Qualification) level 2 training. They said they had not received training on infection control, the Mental Capacity Act (MCA) or the Deprivation of Liberty Safeguards (DoLS). This meant there was risk people would not receive appropriate care.

One of the care workers told us, they had completed training on infection control, MCA and DoLS with their previous employer but had not received any training updates since starting work at Spring Bank approximately two years ago. The manager told us staff should have training updates on infection control every year. This created a risk people would not receive care from staff who were suitably trained and competent to meet their needs.

The three staff we spoke with told us, the manager had delivered training updates on moving and handling and safeguarding. One of the staff told us they had completed training on dementia and the training matrix showed seven staff had received training on dementia awareness in November and December 2014.

The training matrix was made up of two documents numbered one and two listing different topics. However, we found this did not provide a reliable record of staff training. Some staff who no longer worked at the home were still on the matrix and some new staff were on matrix number one but not on number two. Some of the training which the manager said should be updated every year was shown the matrix as expiring in 2017.

The manager told us they had started to carry out fire drills and the plan was that staff would take part in four drills each year. We saw two fire drills had been recoded. The manager told us the night staff had not taken part in a fire drill. We discussed this with the manager and they said they would address it as a matter of priority.

There was a planned programme for staff supervision and appraisals. Two of the three care workers we spoke with said they had received supervision and completed an appraisal with the manager.

This demonstrated the provider did not have suitable arrangements in place to ensure staff were appropriately trained and supported to deliver safe and appropriate care and treatment. We identified concerns about the training and support provided to staff at previous inspections in June and November 2014. We found the provider had not taken appropriate action and this was an on-going breach of regulation.

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

At the last inspection in November 2014 we had concerns that people were not getting the right support to meet their nutritional needs. During this inspection we found some improvements had been made but more needed to be done to ensure a consistent approach to the management of people's nutritional needs.

We observed the meal service at lunch time on both days. We spoke with five people in the dining room and they all said the food was good and they were rarely hungry. The main meal choice was written up in the lounge but none of the five people we spoke with knew what they were having until lunch was served. They all said they liked the food they were given. The staff knew about people's likes and dislikes and said alternatives were provided if people wanted something different.

The lunch time meals looked and smelt appetising and were well presented on the plate. We saw staff were attentive to people and where necessary people were given appropriate support to eat and drink.

We reviewed the care and support of seven people in relation to nutrition. The records of people who had thickening agents and/or dietary supplements showed improvements had been made. There was a clear process

Is the service effective?

regarding the use of thickening agents and dietary supplements which meant staff were provided with clear and up to date information about how to support people with this aspect of their care.

We saw people had nutrition care plans in place and most of the care plans we looked at were up to date. However, changes to people's care plans were not always signed and dated.

When people were using fluid thickening agents we found the care plans about supporting them with their breathing did not have consistent information about the risks relating to swallowing and/choking. They did not always provide clear guidance for staff on the breathing changes they should observe for. This meant people may not always receive appropriate care.

The service was able to cater for basic diets for example, for people who required a diabetic diet or had the texture of their food altered. At the time of the inspection none of the people living in the home needed a diet to reflect their religion or culture. The catering staff knew how to fortify food and drinks to add energy and protein if needed e.g. additional butter, cream, sugar, skimmed milk powder. Individual requests and preferences could be met and food and drinks were readily available during the day and at night.

There was as clear evidence of improving the nutritional wellbeing in some people. For example, the records of one person who had moved into the home since the last inspection showed they had gained weight.

The service had access to specialists via the GP to assist in delivering appropriate care to meet people's individual needs. We saw evidence of involvement of the Speech and Language Therapy service in people's care.

There were a number of areas which remained outstanding from the last inspection. There were no standard recipes so the nutritional value of the meals offered could not be assessed as providing the nutrition required to meet people's needs. The food offered at the evening meal varied greatly in nutritional content particularly protein content. This meant on some days the amount of nutrition offered was significantly lower than others. This was not true of lunch time menus where dishes were broadly of comparable nutrition. We found most people were having adequate energy intakes but the other nutrients for example protein, Vitamin C and iron would be more variable due to food and drink provided.

The Malnutrition Universal Screening Tool (MUST) was used to assess people's risk of malnutrition. We found the MUST assessments were not always completed correctly which could lead to missing a significant nutritional risk.

The home had sitting scales which meant if people could not use this there was no other way to check their weight, for example the home did not have a hoist scales. At the time of the inspection 13 of the 18 people living in the home were able to use the sitting scales.

People's food and drink intake was recorded using food and fluid charts. However, there was no clear process for checking the charts or monitoring people's dietary intake. This should be done so that the information could be shared with staff and they were told about small but possibly significant changes to look for when supporting people with their dietary intake. For example, if some people were more likely to eat and drink at certain times of the day.

We found there was no clear guidance in place on the actions staff should take when people were not achieving the target fluid intake of 1600mls a day.

This showed that although improvements had been made the provider did not have effective systems in place to ensure a consistent approach to meeting people's nutritional needs. Therefore, this was an on-going breach of regulation.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection in November 2014 we found the service was not working in accordance with the requirements of the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS).

We observed staff asked people for consent before delivering care and there was evidence people's right to refuse care and treatment was respected.

Inadequate

Is the service effective?

Some of the people who lived in the home were living with dementia which meant their capacity to make decisions about their care and treatment was likely to be variable and/or diminished.

The staff we spoke with did not have a clear understanding of how the MCA and DoLS applied to their day to day work. For example, they believed one person who lived at the home had a DOLS in place to stop them going out. When we checked we found an application had been made but the person was not subject to a DOLS authorisation at the time of the inspection. This created a risk the person was being unlawfully restricted.

In two people's care records we saw mental capacity assessments had been carried out which stated they had capacity to make decisions. One person's records stated they were living with dementia and the other persons showed they had short term memory loss. These circumstances would more than likely have some impact on both people's capacity but this was not reflected within the assessments. In both cases people's care plan agreements and reviews had been signed by relatives and not always the same relative. There was no evidence the people themselves had been involved in reviewing and agreeing their care plans or to show their relatives had authority to make and approve decisions on their behalf. This meant there was a risk of people receiving care and treatment which they did not consent to and/or was not in line with their wishes.

In one person's records we saw a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) form which showed it had been discussed with their relative and they did not want to be resuscitated. A capacity assessment had not been carried out and there was no evidence to show the person's relative had any legal authority to represent their views.

This showed the service was not working in accordance with the requirements of the Mental Capacity Act (MCA) 2005 or the Deprivation of Liberty Safeguards (DoLS). This was identified at the last inspection in November 2014 and was an on-going breach of regulation.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People had access to a range of NHS services. Visits from external health and social care professionals such as GPs, nurse practitioners and speech and language therapists were recorded in people's care plans. The home had a "Telemedicine" link with the local hospital. This was provided via a video link and meant that when people sustained minor injuries they could be assessed by a medical practitioner to determine if they needed further treatment. This helped to reduce unnecessary visits to Accident and Emergency departments which could be distressing for people.

People told us there were regular visits from the podiatrist, optician and dentist when required. The relative of a person who lived at the home said**,** "My mother became ill and the staff called the doctor." They added the doctor had wanted their relative to go to hospital but the person had declined saying they felt safer at Spring Bank. The person's wishes were respected.

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

Requires improvement

Is the service caring?

Our findings

A relative we spoke with said their relatives funding had been reduced because they no longer met the criteria for nursing care. However, they said the level of care had remained the same and added, "I really don't have to worry about anything."

A person who used the service said, "The staff are extremely good." They said the only thing they did not like was the "mashed up" food but explained this was necessary because of a medical condition. We saw the person had their breakfast in their room which showed people's individual preferences were respected.

We spoke to another person who used the service at approximately 9.45am; they said they had not had their breakfast yet because they had wanted to have a lie in. They said the staff were "kind" and always responded quickly when they used their call bell. They told us they had been in a room on the ground floor when they first moved in but had been asked if they would move to the first floor. They said they had been happy to move.

We spoke with two people who lived at the home; they were sitting together in the lounge. One said, "Everyone is nice here. I have my eyes tested and my nails done, and the hairdresser comes every week." The other person said, "The food is good here and I feel safe and happy in my room."

The staff we spoke with knew about people's needs. For example, the cook was able to tell us about people's food preferences and dietary needs. Care staff were able to tell us about people's preferences, for example, they told us one of the people who used the service often liked to move to the small lounge in the afternoon because they found it too tiring to stay in the big lounge all day.

We observed good interactions between staff and people who lived in the home and saw staff were attentive to people's needs. For example, we heard staff asking people what they wanted to wear and where they wanted to sit. We saw staff addressed people by name and involved them in what they were doing. At lunch time we observed staff provided discreet and sensitive support to people who required help to eat and drink. However, we saw the cold drinks were served in sharp edged plastic beakers which did not promote people's dignity. There were no serviettes for people who did not require a protective apron.

We saw people were dressed in clothing which was well looked after and when we looked around we saw people's clothing had been put away neatly in their wardrobes and drawers. This showed staff respected people's personal possessions.

There were no restrictions on visiting and people were able to receive visitors at times that suited both parties.

We saw there was no door lock on one of the toilets on the ground floor which created a risk people's privacy and dignity could be compromised.

On the first day of the inspection we observed the handover at 4pm was carried out in the dining room within earshot of a person who lived in the home. Staff were discussing the care needs of other people living in the home and made no attempt to lower their voices in order to protect people's confidentiality.

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

Requires improvement

Is the service responsive?

Our findings

A relative of a person who had lived in the home for many years said, "I know that the staff have adapted to mother's needs as her circumstances have changed over the years."

We looked at four people's care plans in detail. We saw people's needs were assessed before they moved in and again when they moved into the home. The information obtained during the assessment was used to develop people's care plans. However, we found the care plans did not always provide detailed information to guide staff on how to meet people's individual needs which put people at risk of receiving inappropriate care.

Some of the information about the person's preferences was inconsistent. For example, one section of the care record stated the person liked to get up at 8am and another section stated they liked to get up at 8.30am. In the same person's records we saw there was no formal falls risk assessment. When risks to people's safety are not assessed there is a risk they may not receive safe care and treatment. When we spoke with the person they told us they had fallen the day before. They said they had lost their balance when reaching for something.

There was no bed rails risk assessment in the person's records. Bedrails are potentially a form of restraint and an assessment should always be carried out to make sure they are only used when it is had been established they are in people's best interest.

We saw one person had old bruises on their face. The bruising was recorded in the care records but there was no information to indicate the cause had been investigated. By failing to try to find out the reason for the bruising the provider was missing the opportunity to identify and act on potential risks to the person's safety and welfare.

When we looked around we saw two people had pressure relief mattresses on their beds to help reduce the risk of developing pressure sores. In both people's records we saw assessments had been competed to assess their risk of developing pressure sores using the Maelor assessment tool. Both people had been assessed as having a high risk of developing pressure sores and had care plans in place. However, the care plans did not have any information about the correct setting for the pressure relief mattresses. When the mattresses are not set correctly there is a risk they will not work effectively to reduce the risk. This meant people were at risk of receiving unsafe and/or inappropriate care and treatment. We asked the manager about this and she said she didn't know what the setting should be, she said the nursing staff were responsible for this aspect of people's care.

This showed the provider did not have suitable arrangements in place to assess risks to the health and safety of people receiving care and treatment and to do all that was reasonably practicable to mitigate such risks.

This was a breach of Regulation 12The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

In one person's care plan relating to continence there were no details about how often they should be supported to go to the toilet. The person had a DNACPR (Do Not Attempt Cardiopulmonary Pulmonary Resuscitation) form dated 18 May 2015 which had been completed when they were in hospital prior to moving into the home. The form stated the DNACPR decision had been discussed with them and was against their wishes. The form also stated the decision was valid until the end of life. There was nothing to suggest the person lacked the capacity to make this decision and there was nothing to show the decision was to be reviewed when they moved into the home in acknowledgement that it was against the person's wishes. This was discussed with the manager who said they would deal with it as a matter of urgency.

In the care records of a person who was living with dementia there was no care plan for dementia to guide staff on how best to support the person. The records showed the person sometimes behaved in a way which challenged the service but there was no care plan to show how staff should manage this. In the daily care records we saw staff described the person as "moody". This suggested staff were judging the person on their behaviour rather than trying to understand what they were experiencing. This meant there was a risk the person would not receive appropriate care. In the same person's records we saw they had not been able to have a shower before going to bed, they were told it was too late (at 22.40) and they would have to wait until morning.

One person had a care plan about meeting their needs in relation to their diabetes and we saw their blood sugar levels were checked. However, there was no information in the care plan to tell staff what the acceptable range of

blood sugar levels was for this person. In the records of another person who also had diabetes there was no care plan to show what support they needed and no information about monitoring their blood sugar levels. This meant the person was at risk of not receiving safe and appropriate care and treatment.

One person had a DNACPR form which showed they did not want to be resuscitated. However, DNACPR form was not signed and therefore not valid which meant if the person had a cardiac arrest they would have to be resuscitated. This was discussed with the manager who said they would deal with it urgently.

In another person's records we saw they had frequent falls and also presented with some behaviours which challenged the service. There were no care plans in place to show how staff should support the person with these aspects of their care.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

In the records of another person one of the care plans referred to the person having a plaster cast on their arm following a fracture. We asked care staff about this and they told us the cast had been removed several months ago. The care plan had been reviewed every month but there was no information in the reviews about the cast being removed. We observed the person sitting in the lounge, they had a pressure relief cushion in place but their feet were not on the floor, the chair with the cushion was too high for them. The person had recently been moved to a different bedroom. Staff told us this was because the person needed to have regular checks and said it had been discussed with the person's relatives. There was nothing in the records to support this or show the person had been consulted about the decision. This showed the persons care was not planned and delivered in a way that was responsive to their individual needs.

We asked staff how they identified people who had a DNACPR in place. They told us the only way to do this was by looking in each person's individual file. This created a risk of staff not being able to access information quickly in the event of an emergency and was of particular concern because of the number of part time and agency nursing staff working in the home.

The care workers told us the home did not have a key worker system, where staff are given particular responsibilities for small groups of people who live in the home. They told us they completed charts such as the food/fluid charts but had no involvement in developing people's care plans. It is important the care workers are involved in the development and review of people's care plans so that they get to know and understand people's needs and share information about people's individual needs and preferences.

Care staff told us the quality of the information provided at handovers varied and said they were not always told about changes in people's needs. On the first day of the inspection we observed the afternoon handover. When the nurse said they had finished the handover one of the care workers reminded them that they had not mentioned a person who had moved into the home within the last few days and pointed out that another of the care workers had been on leave and would not know anything about the person's care needs. This created a risk of people not receiving appropriate care and support.

This showed the provider did not have suitable arrangements in place to make sure people who used the service received care and treatment which was appropriate, met their needs and reflected their preferences.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

One person told us they liked, "The man who sometimes comes to sing." There was a weekly plan of activities on display in the lounge. It showed arranged of activities such as hairdressing, bingo and musical entertainment. There was a table and chairs outside at the front of the home but we did not see anyone sitting outside although it was warm and sunny at the time of inspection. There was an activities diary which showed a range of activities during the week, there was no evidence of any activities at the weekend and no evidence that people had been given the opportunity to go either individually or in groups. We saw some people went out with relatives or friends. The home had a cat and several of the people who lived there enjoyed having him around.

The provider had put a new complaints procedure in place since the last inspection in November 2014. We looked at

Requires improvement

Is the service responsive?

the complaints records and saw action had been taken when people had raised concerns. This included letting people know what the provider had done in response to their concerns. The people we spoke with during the inspection told us they were not aware of the complaints procedures however, they added they didn't feel they wanted to complain about anything. When we looked around the home we saw there was information available about the complaints procedure in the entrance hall and in people's bedrooms.

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

Inadequate

Is the service well-led?

Our findings

The registered manager left the service in November 2013. A manager was appointed in April 2014; however, they left in September 2014. The manager who was in post at the time of the inspection took up their post on 3 November 2014. They confirmed they were in the process of applying to the Commission to be the registered manager.

The lack of a registered manager for over 18 months meant there was a lack of consistency in the management and leadership of the service. The registered provider spent time in the home most days but this was limited because of other commitments.

The staff we spoke with told us they had seen improvements since the new manager started in November 2014. However, they said they did not always feel supported by the nursing staff. They said many of the nurses just did the medicines and did not provide leadership and support by taking charge of the shift. They said it was sometimes difficult working with agency nurses who did not know about people's needs.

The new manager was not a nurse. The service is registered to provide nursing care and we asked the provider what arrangements were in place to make sure the clinical aspects of people's care were managed by a registered nurse. The provider told us one of the nursing staff was nominated as the "clinical lead" and they also told us they had a background in nursing and could provide support in this area. However, the clinical lead was employed to work 20 hours a week and did compressed hours which meant they worked all day Sunday and Monday evening. We had concerns this was not a suitable arrangement because it meant there was no clinical oversight and support five days a week. The home did not have enough nurses to cover all the shifts and relied on part time and agency nursing staff and this combined with the absence of clinical oversight created a risk people would not receive appropriate care. Our findings as detailed in the responsive section of this report show that people were at risk of receiving inappropriate care and treatment.

At the last inspection in November 2014 we found the provider did not have effective systems in place to assess and monitor the quality of the services provided. During this inspection we found that although some checks had been put in place they were not effective in identifying shortfalls in the service. For example, the manager had started to carry out checks on medicines. However, the checks which had been completed were stock balance checks and there was no auditing of the overall process. When we looked at how people's medicines were managed we identified a number of shortfalls. These are detailed in the safe section of this report and included an out of date medicines policies and a lack of staff training. These concerns had not been identified by the provider.

Similarly when we looked at people's care records we found concerns which the provider's check list had not identified. When concerns had been identified they had not been followed up. For example, in two people's records we saw DNACPR forms which should have been reviewed in March 2015 and had not been reviewed. The manager had picked this up in an audit on 27 May 2015 and put it in the GPs visit book to be acted on but at the time of the inspection the DNACPR forms had still not been reviewed.

When we looked around the home we identified a number of concerns regarding the cleanliness and maintenance. These are detailed in the safe section of this report. These concerns had not been identified by the provider and there was no evidence of a planned approach to the repair, maintenance, upkeep and renewal of the fabric and furnishings of the premises.

The manager told us they were finding it difficult to make progress as there were so many areas that needed to be addressed. They said they felt they were, "spread too thin." They added they did not always feel supported by the provider.

This demonstrated the provider did not have effective systems in place to assess and monitor the quality of the services provided which meant they were not identifying areas where improvements were needed.

At the last inspection we found shortfalls in relation to record keeping. During this inspection we found similar concerns. For example, in the records of people who lived in the home we found gaps in recording, missing dates and signatures and in some cases an absence of care plans for identified needs. In relation to the staff records we found there were documents missing from the staff recruitment files and the training matrix did not provide a reliable and accurate record of staff training. Other examples are included in the other sections of this report. This is an on-going breach of regulation.

Inadequate

Is the service well-led?

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

People who used the service and their relatives had been given the opportunity to share their views of the service by completing questionnaires at the end of last year. The findings had been analysed and showed 12 people had completed questionnaires. The topics covered were; catering and food, personal care and support, daily living, premises and management. The feedback was positive with all 12 people indicating they were 'satisfied' or 'very satisfied' with the services provided. Comments included, "Cannot fault the care received. All staff are first class and couldn't be improved." And "All the staff seem pleasant and caring and there is usually somebody there whom we can approach." Some people mentioned specific areas where they would like to see improvements and the providers report included a note of action taken to address individual issues. One person said they would like to see more memory provoking activities for people living with dementia. The provider's action plan indicated more meaningful dementia activities had been purchased and implemented. However, we did not see any evidence of this during the two days of the inspection.

The manager told us they had tried organising meetings for people who used the service and their relatives but this had not been successful. They had put other measures in place to give people the opportunity to comment on the service, these included one to one interviews with people living in the home, a short questionnaire for people who used the service for respite care and a suggestion box in the reception area.

The manager understood the requirements in relation to notifying the Commission about things that happened in the home. However, when the manager was not there notifications were not always done. For example, in May 2015 the manager sent in a notification for an incident which had happened in December 2014. The manager had found when checking the records that the notification had not been completed at the time of the incident. The manager told us they had been off work due to ill health at the time of the incident. This demonstrated the provider did not have suitable arrangements in place to make sure they complied with the law in relation to notifications.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Health and Social Care Act 2008 Care Act.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Person centred care** The registered person did have suitable arrangements in place to make sure people who used the service received care and treatment which was appropriate, met their needs and reflected their preferences.

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Need for consent** The registered person was not working in accordance with the requirements of the Mental Capacity Act (MCA) 2005.

The enforcement action we took:
Need for consent
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment**

This section is primarily information for the provider

Enforcement actions

The registered person did not have suitable arrangements in place to ensure the proper and safe management of medicines and therefore people were at risk of receiving care and treatment which was unsafe. 12(1) (2)(g)

The registered person did not have suitable arrangements in place to assess the risks to the health and safety of people receiving care and treatment or to make sure everything possible was done to mitigate any such risks. 12 (1) (2)(a)(b)

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Meeting nutritional and hydration needs** The registered person did not have effective systems in place to ensure a consistent approach to the management of people's nutritional needs.

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and equipment** The registered person did not have suitable arrangements in place to make sure people who used the service were cared for in premises which were clean, well maintained and secure.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance** The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. 17(1)(2)(b) The registered person did not have effective systems in place to assess and monitor the quality of the services provided which meant they were not identifying areas where improvements were needed. 17(1)(2)(a) The registered person did not have suitable arrangements in place to ensure they maintained accurate and complete records in respect of each person who used the service, staff and the management of the service. 17(1)(2)(c)(d)

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing** The registered person did not have enough suitably qualified, competent, skilled and experienced staff to provide continuity of care and ensure people's needs were met. 18(1)

This section is primarily information for the provider

Enforcement actions

The registered person did not have suitable arrangements to make sure staff were appropriately trained and supported to deliver safe and appropriate care and treatment. 18(2)(a)

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Fit and proper persons employed** The registered person did not have effective recruitment procedures.

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Notification of other incidents** The registered person did not have effective processes in place to make sure notifications were sent to the Commission without delay.

The enforcement action we took:
Notice of proposal to cancel the provider's registration to carry on the regulated activities accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening procedures at the location Spring Bank Nursing Home.