London Residential Healthcare Limited

# Oaklands House Nursing Home

**Inspection report**

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## 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 |

## Overall summary

This inspection took place on the 29 and 30 June 2015. Oakland's House is registered to provide accommodation and nursing care for up to 54 older people who may be living with dementia and / or have a physical disability. On the day of our visit 52 people were living at the home. The home is located in a semi rural location on the outskirts of Southampton, near the village of West End. The home has two large living rooms / dining areas.

People's private rooms are on both the ground and first floors. Four of these rooms are shared. There is a passenger lift to the first floor. Outdoors there is a secure patio area.

The provider is currently in the process of building a 24 bed extension which is due to finish in August 2015. As

# Summary of findings

part of this new development, areas of the existing building will also be improved and new facilities will include new treatment rooms, a secure outdoor garden, games areas, a sensory room and coffee bar lounge.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The current registered manager had previously managed the service but left in June 2014. In the interim another registered manager had been managing the service but had left in May 2015. The current registered manager had returned to the service the week before our inspection, although we have been informed following the inspection that they have resigned. The provider is currently overseeing the service along with the organisations training and development manager whilst a new registered manager is appointed.

We found a number of areas which required improvement.

Our inspection highlighted a high number of unexplained bruises and skin flaps that had not been adequately recorded, investigated or reported to ensure that any possibility of abuse or neglect had been followed up and their recurrence minimised. Risk assessments needed to be updated to include more detailed and specific guidance to support staff to manage risks in a safe and effective manner.

Staffing levels required improvement. People had to wait for support and assistance. Target staffing levels were not always met and staff struggled to meet people's needs in a timely manner.

The management of medicines required improvement. Medicines, including oxygen, were not always being stored safely and securely or in line with recommended temperatures. We found a number of gaps or omissions without the reason for this being recorded. We could not be assured that all of the staff administering people's medicines were trained and competent.

Mental capacity assessments were not being undertaken with due regard to the MCA 2005. When a person lacked capacity to make decisions about their care, we were not always able to see that appropriate best interests consultations had been undertaken.

People's nutritional needs were met but improvements were required to ensure people were supported to eat and drink in a timely and dignified manner.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care.

Staff had not completed all of the training relevant to their role. Staff had also not received supervision in line with the frequency determined by the provider.

People knew how to make a complaint and information about the complaints police was readily available within the home, however, an adequate record was not always being maintained of each complaint, its outcome and the actions taken in response.

Whilst some quality assurance systems were in place, these were not being effective and driving improvements.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People spoke positively about the care provided by the staff as did their relatives. One relative told us, "I have not met anyone who was not caring; they [the staff] are very patient".

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

# 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 always safe.

Staffing levels required improvement to ensure people were kept safe and to ensure their needs were met in a timely manner.

The planning and delivery of care was not always being managed in way which mitigated risks to the health, safety and welfare of people.

People medicines were not managed safely.

Staff had received training in safeguarding and demonstrated an appropriate understanding of the signs of abuse and neglect.

**Is the service effective?**

**Requires improvement**

The service was not always effective.

Staff did not have all of the training relevant to their role and were not having regular supervision which helped to ensure that they understood their role and responsibilities.

Mental capacity assessments had not always been carried out in line with the Mental Capacity Act (MCA) 2005. Where people had been assessed as lacking capacity to make these decisions, we were not able to see that there had always been a best interest's consultation.

People's nutritional needs were met but improvements were required to ensure people were supported to eat and drink in a timely and dignified manner.

**Is the service caring?**

**Requires improvement**

The service was not always caring.

Most people spoke positively about the care provided by the staff as did their relatives. Some however felt that staff were at times too busy to provide person centred care.

Improvements were needed to ensure that people and those important to them were involved in making decisions about their care and support and how this was to be delivered.

**Is the service responsive?**

**Requires improvement**

The service was not always responsive.

Care plans did not consistently contain sufficiently detailed and personalised information about people's needs to help staff deliver responsive care.

Improvements were needed to ensure that each person had regular access to activities that were meaningful to them.

# Summary of findings

People knew how to make a complaint and information about the complaints police was readily available within the home, however, an adequate record was not always being maintained of the complaint, its outcome and the actions taken in response.

**Is the service well-led?**

**Requires improvement** 

The service was not always well led.

Systems in place for assessing and monitoring the quality and safety of the service were not being effective at driving improvements.

During the inspection we found the registered manager and the deputy to be open to receiving our feedback about the service and they both showed a desire to improve. A number of improvements were implemented during the inspection and we were sent an action plan following the inspection which showed some of the immediate action being taken to address the areas of concern.

# Oaklands House 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 took place on the 29 and 30 June 2015 and was unannounced.

On the first day, the inspection team consisted of two inspectors, a specialist nurse advisor in the care of frail older people living with dementia, 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 service. Our expert had experience of supporting people living with dementia and of using health and social care services. On the second day, the inspection team consisted of two inspectors.

The provider had completed a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with six people who used the service and five relatives. We also spoke with the provider, registered manager, deputy manager, the training and development manager, a chef, two registered nurses, six care workers and an activities coordinator. We reviewed the care records of 10 people in detail and the records of four staff. We also reviewed the Medicines Administration Record (MAR) for nine residents. Other records relating the management of the service such as training records and policies and procedures were also viewed. During the inspection 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 cannot talk with us. We spent time in the communal areas observing how staff interacted with, and supported people. Following the inspection we sought feedback from five health and social care professionals who had regular contact with the home.

The last full inspection of this service was in February 2014 when concerns were found in a number of areas. As a result we took enforcement action in relation to the care and welfare of people, meeting their nutritional needs, the cleanliness and infection control and the arrangements in place for assessing and monitoring the quality of the service. Follow up inspections were carried out in June 2014 and September 2014 during which we found that the required improvements had been made.

Inadequate

# Is the service safe?

## Our findings

Most people told us they felt safe living at Oakland's House. One person said they felt "Absolutely safe". A relative told us, "I go to bed at night knowing [their relative] is safe". This was echoed by other visitors all of whom felt their relative received safe and appropriate care. However, through our observations and discussions with people and staff we found aspects of the care provided were not always safe.

Staffing levels required improvement to ensure people were kept safe and to ensure their needs were met in a timely manner. A number of people could display unpredictable or challenging behaviour, or were at high risk of falls and so also needed a high level of observation. We found there were frequently periods of five or ten minutes when people were left unsupervised in the communal areas. Three of the six care workers we spoke with expressed concerns about the staffing levels. They told us they did not have time to provide adequate supervision in communal areas of the home and manage people's needs. For example, one staff member told us that on one occasion they were supporting a person to mobilise who was at risk of falls when two other people began having an aggressive argument on the other side of the room. They explained that they had not been able to intervene. Similar concerns were voiced by another two staff members. Another staff member told us they often had too much to do and people had to wait for support which could lead to them becoming frustrated or distressed. We saw that concerns had been raised about staffing levels at a team meeting in April 2015. The records showed that staff felt their concerns were not being listened to. Following the inspection, we also received feedback from a healthcare professional who also raised concerns with us about the staffing levels not always being sufficient to adequately supervise and monitor people to avoid preventable falls.

There were insufficient numbers of staff to ensure that people received the support they required at mealtimes. We observed the lunch time meal. People were gathered at the table at 12.25pm for their meal, but the first person did not receive their lunch until 12.55pm. During this period, we observed that two people became restless and distracted and wandered away from the table. One person who was sat at a table waiting for their meal pulled their tablecloth and spilt their drink across the table requiring staff to replace the cloth.

The shortage of available staff meant that there was a risk of people's dignity being compromised. We saw that one person was dropping most of their food into their lap whilst trying to feed themselves. Another person was eating their meal with their fingers and another was fed by two different staff members. One person had their meal placed in front of them at 1pm, but they were not provided with any support or encouragement to eat this. At 1.15pm their pudding was placed in front of them as well. They were not supported to eat either of these meals for a further 15 minutes. It was 2pm before the last person was served their main meal. Whilst staff were kind and attentive when supporting people, the meal-time experience felt dis-jointed and hectic. We were concerned people did not have a positive dining experience. We were also concerned that there was a risk of people being overlooked and not receiving a meal at all.

The registered manager told us that the current target staffing levels during the day were two registered nurses and nine care workers overseen and supported by them and the deputy manager who were also both registered nurses. The provider also employed dedicated cleaning, laundry, kitchen and activities staff. We found that on at least thirteen occasions between the 8 June 2015 and 28 June, there were only eight care workers on duty which meant this target staffing level was not met. The registered manager told us that they agreed that the current staffing levels were insufficient. They told us they had plans to reintroduce a systematic approach to determining staffing levels based upon the dependency of people using the service to help inform improved staffing levels.

Staffing levels were not organised in in such a way as to ensure that people were safe and that their needs could be met in a timely and person centred manner. This is a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The planning and delivery of care was not always being managed in way which mitigated risks to the health, safety and welfare of people. When walking around the home meeting and speaking with people, many did not have their call bell in reach. We visited another person in their room, who told us, they were unable to move their legs which were resting on a stool. They also told us they were cold. Their call bell was not in reach. We went and found a member of staff who immediately attended to the person. Whilst many people would not have been able to use a call

# Is the service safe?

bell, some could. We were concerned that they would not be able to seek assistance when they needed it. A relative told us, "The bell is always out of reach, I put it on the bed when I leave".

We found that a number of people were being treated for skin damage and wounds. The records relating to these were not always sufficiently detailed which meant that we could not always be confident that people were receiving appropriate care and treatment. For example, one person was being treated for a grade 4 pressure ulcer to their right heel. We were concerned that the wound care records did not show that a medical review was sought in a timely manner when there was an indication that the wound might be infected. The wound care chart did not include photographs and regular measurements of the wound. These are important as they help staff assess whether the wound is healing. Records showed that the wound should be redressed every three days. The last recorded dressing change was on the 1 June 2015. This person was diabetic which meant that their wounds and pressure ulcers were likely to be more difficult to heal. This made it even more critical that the wounds were assessed, monitored and treated according to clear plans and pathways. We could not be confident that this was happening.

We found examples of unexplained bruising and skin flaps that had not been adequately recorded or investigated to ensure that the risk of their recurrence was minimised. For example, on 9 May 2015, one person's daily records noted that they had a bruise on the lower part of their hand. There was no indication of how it might have occurred. A second person was noted on the 2 May 2015, to have a 'skin flap to their right arm'. On the 8 May 2015, 'skin tears' were recorded. On the 25 May 2015, records said, 'skin tear to right arm'. It was not evident how the skin flaps had occurred or what treatment pathway was being used to treat these. We observed that a third person had a large bruised and swollen area on their left lower arm. We reviewed this person's accident and incident records but could not find a reason to account for the bruising. As a result of the number of unexplained bruises or skin damage identified during the inspection, we asked the registered manager to raise a safeguarding alert with the local authority so that appropriate action could be taken to investigate possible causes and ensure all remedial action was being taken to prevent further occurrences.

Staff were inconsistent in their approach to keeping people safe when undertaking moving and handling. Whilst we saw some good moving and handling practice, we also saw three occasions where people were moved in wheelchairs without footplates which could have caused an injury. One person expressed concern about aspects of the moving and handling. They told us "The girls are good but the men are a bit more tough, they swing you about a bit". We noted from reviewing training records that three care staff and one regular bank nurse did not have current moving and handling training. We spoke with the registered manager about this and they arranged for the training to be undertaken on the 1 and 2 July 2015.

Tools used to monitor and review risks to people's health and wellbeing were not always being consistently or effectively used to manage people's needs. For example, we saw that body maps used to record bruising and monitor skin damage were difficult to interpret as they contained details of multiple marks and injuries on one form. Some people had a post falls assessment tool which included additional observations of their wellbeing for 48 hours following a fall. However this was not completed each time a person had a fall and it was not clear how this tool was being used to plan strategies to resolve or reduce the individual risk factors identified for the person.

A record was kept of incidents and accidents within the home and each month the registered manager or deputy undertook a review of the type, nature and number of each type of incident. This is important as it helps to ensure that appropriate actions are being taken to reduce the risk of further occurrences and helps to identify any trends of patterns which might be developing. However this system was not being fully effective at managing risks to people as we found that some incidents and accidents were only being recorded in people's daily notes or in care plan evaluations. This meant that the registered manager did not have accurate details about the nature and number of incidents taking place. This meant they had not all been investigated in line with the provider's procedures.

The provider had not ensured that risks at service level were adequately identified and planned for. We saw that there was an 'Emergency fire box' located at reception. This contained a 'crisis and emergency plan' which provided guidance about how staff should respond in the event of emergencies such as loss of power or a breakdown of the lift. However some of the information was either out of date

or not sufficiently detailed. For example, the contact details for some staff and the registered manager were incorrect. The map of the building did not identify where people's bedrooms were. The information did not draw attention to the fact that oxygen was stored on the premises. Some people had personal emergency evacuation plans (PEEPS), other did not. These are important as they provide key information about each person which supports the safe evacuation of the premises in the event of a fire for example.

The registered manager was not able to show us that other environmental risks or hazards had been considered or planned for. We were not able to find risk assessments in relation to infection control or the effective control of legionella, although we did see that some checks were being carried out in relation to water safety. We were concerned that a number of sash style windows on the first floor had not been sufficiently restricted to ensure that these did not present a risk of people falling from a height. We were shown a fire risk assessment completed December 2014. This contained a detailed plan with a number of action points that ranged from low to high priority. Some of the actions had been noted as completed but many had not. Neither the registered manager nor the maintenance person were able to confirm that all these actions had been completed. Some regular checks of the safety of aspects of the service were being undertaken, for example, water temperatures were tested regularly as was the effectiveness of pressure relieving equipment, the lifts and the fire system. However, we could not be assured that all the necessary measures were in place to identify, assess and plan for risks that might impact upon the safety of the premises and the equipment within it.

People told us they were happy with the way their medicines were managed however, we found some improvements were needed to the storage and administration of medicines. Medicines were stored in locked trolleys in allocated rooms on each floor. Whilst these rooms were kept locked, they were also used for the storage of care plans and other records which meant that all staff had did at times have access to these areas. One of the medicines rooms had a medicines fridge which was used for storing medicines such as insulin. This fridge was not locked. This meant that these medicines were not being stored safely as the arrangements in place did not ensure that only designated and authorised staff had access to people's medicines. Arrangements were in place to monitor the temperatures of the rooms being used for storing medicines. Throughout June 2015, the temperature of the downstairs medicines room was being recorded as 26 C. This is in excess of recommended temperatures for the storage of medicines. Storing medicines at incorrect temperatures can affect their effectiveness. No action was being taken to address this.

One person's oxygen cylinder was being stored in a box next to their radiator. This was not in keeping with the guidance on the person's wall which clearly stated that oxygen cylinders should not be stored next to a radiator. Oxygen is a hazardous substance and exposure to heat sources can affect the integrity of the cylinder.

Medicine rounds were split in the morning between night staff and day staff. The registered nurse administering people's medicines was careful to ensure they were administering the correct dose of the medicine to the right person. They showed consideration of people's wishes and spent time encouraging and explaining about the medicines to people who were reluctant to take them. We were told that the night staff had started the morning medicine round and that the day staff would then continue this until it was completed. This meant that there was potentially as much as a three hour gap between the start and end of the round. The registered nurse told us that they made allowances for this, ensuring that the lunchtime medicines were not administered until later. However, we were concerned that this could mean that people were having their prescribed medicines too close together and therefore not in line with pharmaceutical guidelines.

Nutritional supplements were poorly timed. Following the end of the medicines round, the registered nurse told us, their next task was to provide people with their nutritional supplements. We were concerned that having a nutritional supplement so close to a meal time, could mean that people did not want their meal, negating the benefits of taking nutritional supplements. For example, we visited one person in their room at 1.15pm. Their meal had not been eaten. They told us they were not hungry. We saw that there was an empty bottle of food supplement on their table. A member of staff told us they had received the supplement between 11 and 11.30am. We spoke with the registered manager about this, who agreed to review how the provision of supplements was managed.

Nurse's competency in medicine management was not consistently assessed. National Institute for Health and

Inadequate

# Is the service safe?

Care Excellence (NICE) Managing medicines in Care home guidance states designated staff should administer medicines only when they have had the necessary training and are assessed as competent. The deputy manager told us that staff's competence to administer medicines was assessed every six months or when medicines errors occurred. We were able to see that three of the registered nurses were in the process of having their competency assessed, but there was no record for another two registered nurses who were administering medicines. This meant that the registered manager could not be assured that these staff were competent to manage people's medicines.

We found a number of examples where there was a gap in the person's medication administration record (MAR) but no code had been used to indicate the reason why. Records suggested that one person had not received a medicine used to manage their epilepsy for three days. There was not reason documented. We saw two examples where people's medicines were recorded as being out of stock; one had been out of stock for a week and remained so. MAR's lacked supporting information for 'variable dose' or 'if required' (PRN) medicines. The information available only replicated the medicine label and did not provide sufficient guidance for staff about when these should be given. For example, there was no detailed guidance available to assist staff in reaching a judgement about when to give a person their PRN oxygen, nor was there information about how often their oxygen levels should be tested. The deputy manager agreed that clearer guidance was needed in relation to this.

Body maps were in place to record where staff should apply topical creams, however these did not always contain clear guidance about how often the creams should be applied. The application of the creams was recorded on topical cream administration records (TMAR's) however we found gaps on five of the TMAR's viewed. We could not therefore be assured that people were receiving their creams as prescribed.

People were at risk of receiving unsafe care and treatment. The planning and delivery of care was not always being managed in way which mitigated risks to the health, safety and welfare of people. We found examples of unexplained bruising and skin flaps that had not been adequately recorded, investigated or reported to ensure that any possibility of abuse or neglect had been ruled out and their recurrence minimised. We could not be assured that all the necessary measures were in place to identify, assess and plan for risks that might impact upon the safety of the premises and the equipment within it. People medicines were not managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 Safe care and treatment.

Staff had received training in safeguarding and demonstrated an appropriate understanding of the signs of abuse and neglect. They were able to tell us about the actions they would take if they suspected abuse was taking place. The provider had appropriate policies and procedures in place and we were able to see that they had worked effectively with social care professionals in relation to investigating safeguarding concerns. Staff were informed about the provider's whistleblowing policy and information about this was displayed throughout the home. We did note that the whistleblowing posters only gave internal numbers for reporting concerns and did not include external agencies that staff could approach such as the CQC or Adult Services. Staff were clear that they could raise any concerns with the manager of the home, but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Records showed staff completed an application form as part of their recruitment. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) before employing any new member of staff. The registration details of nursing staff had been checked with the body responsible for the regulation of health care professionals. These measures helped to ensure that only suitable staff were employed within the home. We did note that in one of the staff records that we reviewed a full employment history had not been obtained. We spoke with the manager about this who obtained this information during the inspection.

Requires improvement

# Is the service effective?

## Our findings

People said that the staff met their needs and people's relatives told us that the staff seemed adequately trained,

Staff varied in the amount of training they had received and how up to date this was. The training programme was mainly via on-line courses or watching DVD's and included subjects such as fire safety, infection control, food hygiene and safeguarding people from harm. Training in moving and handling and dementia care was practice based. The registered manager told us the provider had recently employed a training and development manager to oversee the delivery of a comprehensive training programme to ensure the continued development of the staff team. They explained that some staff were undertaking additional training which enabled them to cascade training to their colleagues which would help to ensure training and updates could be delivered promptly. We also saw that training was planned in the use of equipment which helped to control people's pain during their end of life care and the registered manager had just completed a three day tissue viability course.

Most staff told us that the training provided was adequate, however we identified some gaps in training which could impact upon the effectiveness of care people received. For example, we viewed the training records of 30 care workers. 22 of these had not completed training in managing behaviour which challenged. 15 care workers had not completed training in caring for people with dementia. Most people at Oakland's House were living with dementia and a high number of these could display behaviour which challenged. We were concerned that this might mean that staff were not adequately prepared for their role and were not being kept up to date with best practice.

A health care professional told us that they felt some staff lacked the skills and knowledge to identify changes in people's health and provide an effective response. They told us that staff had not recognised that one person's skin damage was in fact a grade 3 pressure ulcer. They explained how some people living in the home were prescribed anticipatory medicines. These are provided to people who are being cared for on an end of life pathway. Having anticipatory medicines available in the home allows registered nurses to administer the medicines which may reduce pain and anxiety and prevent the need for an emergency admission to hospital. However they felt that staff were not suitably knowledgeable to know when these medicines might be required.

Most new staff had completed an induction which involved shadowing an experienced member of staff and completing a series of tasks which were in line with the Common Induction Standards (CIS). These are the standards people working in adult social care should aim to achieve within their first 12 weeks of employment. They help to demonstrate that the care worker understands how to provide good quality care and support. The CIS have now been replaced by the Care Certificate and we saw that the provider was introducing an induction for care workers that would help to demonstrate that they had the skills and competency to deliver people's care and achieve the Care Certificate.

Plans were in place to introduce a Perceptorship programme for registered nurses. The aim of Perceptorship is to enhance the competence and confidence of newly registered nurses by enabling them to be mentored by an experienced registered nurse. It helps the individuals to develop their skills and put these into practice in a healthcare setting. We saw that the deputy had been mentoring a new registered nurse during their induction and probation period which they told us they were finding supportive. However, one staff member who had been at the service for six months told us they had received no induction or supervision at all and records confirmed this. The inductions records for another staff member who had been employed within the home since 2 June 2015 showed they had only completed the day one induction tasks. Without a robust competency based induction, the registered manager and provider cannot be assured that new staff have the right skills and knowledge to deliver people's care.

Staff had received annual appraisals in September 2014, they were not always receiving supervision in line with the frequency determined by the provider. Whilst staff told us they felt well supported, supervision and appraisals are important tools which help to ensure they receive the guidance required to develop their skills and understand their role and responsibilities. Records suggested that seven of the 22 care workers had not received any supervision as yet in 2015. The organisation's policy stated that supervision should take place a minimum of six times

per year for care staff. The registered manager told us they would be working to ensure a more robust programme of supervision was established. Where staff had received supervisions, we saw that records of these had been maintained and that feedback on performance had been given in a supportive and constructive manner. However, further improvements were needed to ensure the supervision arrangements within the home operated in line with the provider's policy and were an effective tool in the on-going development of staff.

We could not be assured that staff had all of the training relevant to their role. New staff were not always provided with a robust induction and supervision was not taking place in line with the frequency as determined by the provider. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 Staffing.

Mental capacity assessments had not always been carried out in line with the Mental Capacity Act (MCA) 2005. The MCA says that before care or treatment can be carried out, it must be established whether or not the person has the capacity to consent to the care. If not any care or treatment decisions must be made in the person's best interests following relevant consultations with professionals, relatives and friends engaged in caring for the person. Most people living at the home would not have been able to give consent to many aspects of their care and treatment, however, most only had mental capacity assessments in relation to the use of bed rails and whether or not they could use their call bell. Where people had been assessed as lacking capacity to make these decisions, we were not able to see that there had been a best interest's consultation.

NICE guidance states that the process for 'covert' or 'disguised' administration of medicines should include an assessment of the person's capacity and a best interest meeting involving the care home staff, the healthcare professional prescribing the medicine, the pharmacist and family member or advocate. We found that whilst appropriate best interests consultations had taken place about the use of covert medicines, these had not been preceded by an assessment of the person's capacity. This is important as it helps to ensure that the person has not being denied the right to make a decision they are capable of making given appropriate support.

The staff we spoke with had mostly received training in the MCA 2005, but some were still not able to talk about how they put the principles of the Act into practice in their daily work. They were able to talk about how they tried to help people make choices by showing them food options or a choice of clothing. One care worker told us how they looked for a reaction in the eyes of people to help them judge whether they liked a particular meal or outfit. Staff were clear that where people were able to consent to their care, their wishes would be respected. However, the provider had not ensured that each person who lacked capacity to make decisions about their care and treatment had a clear mental capacity assessment and a record of the best interest's consultation which supported staff to act and make decisions on their behalf. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom or choices, these have been agreed by the relevant bodies as being required to protect the person from harm. The registered manager and deputy manager had a good understanding of the safeguards and a number of applications for a DoLS had been submitted by the home. We did note that people's DoLS care plans could be more detailed. Most just referred to the fact that the person had a DoLS authorisation in place and did not reflect upon how they would meet the conditions underpinning the authorisation.

People's nutritional needs were met. Drinks were readily available throughout the day and we observed staff encouraging people to drink fluids. We also saw people being offered lollies as the weather was very warm. This helped to provide additional hydration. The meals were home cooked and freshly prepared; however, feedback from people about the food was mixed. One person said, "I can't get any decent food". Most people were more positive, for example, one person said, "The food is excellent" and another told us they highly recommended the porridge. They said, "I have a menu to choose breakfast, lunch and dinner, its tasty and you get plenty". Where people required pureed diets due to swallowing difficulties, the elements of the meal had been pureed separately so that the person was still able to taste the individual flavours. The chef was informed about people's special diets including those that

# Is the service effective?

required a fortified diet. Staff were able to describe the difference between soft and pureed diets and staff had liaised with professionals such as speech and language therapists (SALT) to inform nutrition plans and manage identified risks such as swallowing difficulties.

We have reported elsewhere in this report that the meal-time experience did, however, appear to be disjointed and hectic. We also felt there were insufficient staff to make sure that people received the help they needed to ensure their meal was a pleasurable and dignified experience. We felt other improvements could be made. We noted that salt and pepper was provided in small paper sachets rather than in pots. We felt this was not very homely and were concerned that people living with dementia would not recognise, or be able to tear, these open. We noted that a number of people who did not eat their main meals were given toast and jam as an alternative. We did have some concerns that this would not provide adequate nutritional value.

Food and fluid charts were used to monitor people's dietary intake where this was required, however none of the charts contained information about the target fluid levels each person required. People require different amounts of fluid intake depending upon their individual needs and so these should be personalised and specific to each person.

People's records showed they were weighed on a regular basis and where they had lost weight, they were referred to relevant professionals such as the GP or dietician.

People had access to healthcare services. Each week, either a GP or nurse practitioner attended a 'ward round' at the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. We noted that the deputy manager had put in place an antibiotic log and which helped them to see at a glance which people were getting repeated infections, which perhaps antibiotics were not being successful in treating. They explained that this helped them to discuss the need for alternative treatments with the GP. The deputy manager also told us that anyone with a urine infection was given hourly fluids. This helped to ensure that people's healthcare needs were monitored. Staff had made referrals to other health care professionals including dieticians and the community mental health team. Professionals recorded their visits and the advice they gave and these records were included in people's care plans. We spoke with two health care professionals who visited the service. One did express concerns to us that healthcare referrals were not always made in a timely manner and that communication about agreed treatment pathways was not always understood. They felt improvements were needed to the clinical skills and knowledge of some of the nursing staff.

Some measures were in place to ensure that the design and layout of the building met the needs of people living with dementia. For example, signage was being used to readily identify toilets and bathrooms. Some people's rooms had memory boxes outside which helped them to recognise their room. Memory boxes contain familiar and meaningful items which help stimulate the memory of the person. The provider told us how they were working towards creating a living environment which supported the needs of people living with dementia through the use of lighting, colour, contrast and signage as recommended by nationally recognised research.

Requires improvement

# Is the service caring?

## Our findings

Most people spoke positively about the care provided by the staff as did their relatives. They felt they were treated with dignity and respect. One person said, "I do get respect and privacy, they knock". Another person said, "The staff are very nice, no complaints…I'm happy enough". A relative said, "This place is wonderful, they are well looked after, they [the staff] can't do enough". They told us their relative had been quite unsettled when they had first come to the home, but they had been helped to settle in. Another relative said, "I have not met anyone who was not caring, they [the staff] are very patient". A third relative told us, "The staff are lovely, very affectionate". We saw a range of positive feedback had also been recorded about the caring and attentive nature of the staff on care home review websites. Comments included, "The staff are lovely, kind, caring and affectionate" and "Each resident is cared for as if it were their own home, with dignity and professional attention and as if they are No.1 resident".

Whilst most people thought the staff were kind and attentive, some people felt this was not always the case. One person told us, that staff "Concentrated only on the task". Another person said, The girls are very good, but this is not a thoroughly caring place". They explained that this was usually because staff were just too busy. Another person said, "They don't take any notice of me".

There were positive interactions between people and staff. We saw examples of staff being attentive and treating people kindly and with care. We observed that staff made eye contact with the people they were speaking with or supporting. We saw one staff member gently wiping one person's face following their lunch. They chatted positively whilst completing the task, telling the person how pretty they were looking. We saw three staff engaged in supporting a person with a moving and handling intervention. The staff were kind. They did not rush the procedure and spoke with the person, constantly reassuring them. One of the care workers held the person's hand throughout the completion of the task. This all helped to ensure that the intervention was completed in a competent yet person centred manner. We saw that some staff engaged people in conversations about things they were interested in. For example, we saw one staff member asked a person about the coins they used when they were a child. The person responded enthusiastically and really seemed to enjoy the interaction. The atmosphere in the main lounge whilst activities were taking place was good natured and sociable and we heard lots of laughter.

There were examples of care provision which were solely focused on the completion of the task and lacked any meaningful engagement with the person. This was partly because staff were constantly busy. We heard people being referred to as tasks, for example, "Has [the person] been fed, can you do them" or "X needs to be toileted". We saw aprons being placed over people's heads without them being asked if they would like one or whether that was alright. We saw people being left with their meals in front of them for long periods of time without staff being available to support them. Some people were supported to eat and drink in a very person centred manner, but others were assisted in relative silence. We observed a person calling out. A care worker went over to the person who told them they needed the toilet. The care worker did not speak with the person, although they did leave and return a moment later with another member of staff and helped the person to the toilet and did interact well with the person whilst completing the task. We did not feel that staff lacked concern for people or were uncaring, but they were not always able to respond to their needs in a person centred manner. A number of staff expressed their regret about this saying the staffing levels meant they couldn't give people the attention and time they would like to.

Staff were aware of their role in promoting people's privacy and dignity and told us about some of the ways in which they achieved this. They described how they ensured they knocked before entering people's rooms and used privacy screens in the shared rooms when personal care was taking place. They told us how they sensitively and discreetly assisted people for whom aspects of their behaviour could at times compromise their dignity.

Most people told us their decisions were listened to and their choices respected. For example, they told us they could choose what to eat or drink or whether to join in activities. One person however told us that their decision to spend time in their room was not always respected. They told us they did not like going downstairs but that staff forced them to. They told us they hated this. There was a lack of evidence of people being actively involved in making decisions about their care and support and how this was delivered. Whilst we saw that people's care plans

Requires improvement

# Is the service caring?

were reviewed monthly, it was not always evident that this was with the involvement of the person and their relatives. However, the registered manager told us a 'resident of the day' system had recently been put in place. This system provided a structured approach for all staff to get to know a particular person and their families and understand what was important to them, their likes and dislikes and interests. The initiative also provided an opportunity for the persons care and support needs to be fully reviewed along with their relatives. The registered manager felt this would ensure people's care needs were reviewed on a regular basis. This process needs to be embedded in practice and sustained in order for this to become an effective tool for involving people and their relatives in reviews of their care. We had mixed feedback from relatives as to whether they felt they were kept informed about changed to people's needs. One visitor told us their relative had been 'pushed by another resident and got bruises on their legs, they told me straight away". Others however, felt this was an area which could improve. One relative told us they had not been informed that their relative had had a fall and had only heard about this when a healthcare professional came to review the person whilst they were visiting.

Requires improvement

# Is the service responsive?

## Our findings

People's views about how responsive the service was were mixed. Some people told us staff were responsive to their needs and wishes, but others felt this was an area which could improve. We met one person who told us they should be sitting with their legs raised as they were swollen. They told us they did not like to do this as it meant they could not see their television. Staff had not identified this as a problem or explored with the person alternative ways of meeting the person's healthcare needs whilst also ensuring they were able to watch the TV which they valued. One person told us, "Staff have no time to come and chat". They also told us they had at times been 'told off' for ringing their call bell. Another person told us they did not feel able to ask for help from staff as they didn't want to 'bother them' as they were so busy and they were concerned about it being 'awkward'. A third person whose call bell we noted was not in reach said, "They [the staff] don't take very much notice of it [the call bell] anyway, you can ring and ring and ring". We were concerned that this demonstrated that staff were not always able to be responsive to people's needs and choices and provide their care in a personalised manner.

Care plans did not consistently contain sufficiently detailed and personalised information about people's needs to help staff deliver responsive care. This is important as detailed information about people's needs helps staff to provide appropriate interventions and also assists them to recognise and respond to changes in people's health. One person living with dementia, frequently displayed behaviour which challenged resulting in their need for sedation. However we were unable to see that this person had a detailed care plan which provided information about the specific strategies and interventions staff could use to support the person and de-escalate agitation. We were not able to see that staff considered whether the behaviour might be related to pain or discomfort which can be a common cause of agitation in people living with dementia. A second person had a more detailed behaviour care plan, which talked about staff monitoring any factors that might trigger the behaviour such as constipation or infection. It talked about how staff should stop interventions if the person became agitated and explain again the help they were trying to provide. However, this plan had not been updated to include information and guidance about a particular behaviour the person was now demonstrating which was being explored by the GP and community mental health team.

The records relating to how people's wound care should be managed lacked detail. We saw examples where people had been assessed as having skin damage around their groin area caused by moisture, but their continence care plan had not been reviewed and updated to ensure staff understood the importance of keeping the area as free from moisture as possible. We looked at the care plans of two people who were diabetic. Their records identified that they required a diabetic diet but did not included a detailed individualised nutrition care plan which described how their dietary needs could be met in a way which helped to avoid deterioration of the condition. This meant we could not be confident that these people were receiving appropriate care.

There was no standardised pain assessment tool in use at the home which meant there was a risk people may not receive the care or treatment they needed to manage pain and discomfort. We found a number of examples where people's records suggested they experienced pain. Most of these people would not have been able to communicate this to staff. In one person's record it stated, 'I have pain and cannot express this'. A second person was noted to have 'generalised joint pain' and was living with Parkinson's disease. This meant that they were likely to experience joint pain during movement. However there was no care plan associated with this need and no pain assessment tool in use. One person was able to tell us they were experiencing pain. They said they had no pain relief, when we checked we found they were prescribed paracetamol, however they told us this made them feel unwell. We spoke with the registered manager about this who arranged for the person to be reviewed by their GP that day following which the person's pain relief was changed. We were concerned however that this matter had not already been addressed by the care home staff.

A healthcare professional told us that they had been concerned that staff were slow to recognise when people's health might be deteriorating. They also identified that at times, documentation was poor with staff not always recording every intervention. They felt this was an area which needed to improve. A second healthcare professional told us that their feedback or guidance about

Requires improvement

# Is the service responsive?

a person's care and treatment was not always communicated with the wider staff team and sometime not understood. They were concerned that this could lead to less positive health outcomes for people.

Some staff were able to demonstrate an understanding of people's needs and preferences, this was not always reflected in their care plans. Some information about people's life history was gathered when they first started living at the home, but it was not clear how this information was being used to develop person centred care plans that were informed by the person's choices and wishes and interests. For example, whilst we saw that one person's activities plan recorded their interest in music, it went on to say that they now had, 'no particular interests as [they] forgot things too soon'. People living with dementia can continue to achieve a sense of satisfaction and achievement through a range of tasks. Even in the later stages of the illness, people can benefit from sensory experiences. Activity and meaningful occupation are essential components of living well with dementia.

We could not be assured that people received person centred care that was appropriate, met their needs and reflected their personal preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Activities were provided by designated staff and were also available at weekends. The programme for the coming month included a trip to a local country park, an American independence themed day, baking, massage and exercise and activity classes. On the second day of our inspection we observed that people enjoyed a music session with an outside entertainer during which the activities staff encouraged the participation of people which a number appeared to enjoy. We did note that the majority of the activities took place in the larger main lounge which meant that the people seated in the smaller lounger missed out on the opportunity of joining in with the activities. We also noted that in both lounges whilst the television was on, many people would not have been able to see this due to the position of their chairs. Records showed that from time to time, the activities staff set time aside to provide one to one interactions for those cared for in their rooms or for those who did not enjoy the group activities, although the records did not suggest that this happened on a regular basis and was therefore an area which could be improved.

People and their relatives had mixed views about whether their feedback or comments about the service were listened to and acted upon. We saw that satisfaction surveys were completed twice a year with the last being December 2014. 68% of the responses to his survey were either good or excellent, although some had expressed concerns about staffing, moving and handling practices and changes in the management staff. We were not able to see that this feedback was being used to drive improvements and no action plan had been developed as a result of the feedback. One relative told us, "There have been surveys, I put down the truth but they don't do anything". However, most of the people we spoke with felt that the current registered manager would be effective at listening to feedback and responding to concerns. We saw that the provider also held 'Meet the MD' meetings with people and their relatives with the next one being planned for August 2015.

People we spoke with knew how to make a complaint and information about the complaints police was readily available within the home. One person told us that if they had a complaint they "Would talk to [the registered manager] it's got a bit better than it used to be". A relative said, "I would go straight to [the registered manager] if I had complaints, before complaints went in a file but they would deal with it straight away". We saw that there had been three complaints by relatives in May 2015 which was before the current registered manager returned to the service. The records did not reflect how one of the complaints had been investigated and what the outcome was. There were partial records in relation to how the other two complaints had been addressed and therefore it was not clear that in each case, an adequate record was being maintained of the complaint, its outcome and the actions taken in response.

Requires improvement

# Is the service well-led?

## Our findings

Most people were unable to tell us their views about the leadership of the home. However those that were spoke positively about the registered manager and expressed confidence in her ability to drive improvements and address their concerns. A relative told us that they felt comfortable talking with the registered manager about any queries or concerns. Another said the registered manager was "Wonderful, she cracks the whip". Another relative said when asked about whether they would recommend the home, "Yes I would now; [this registered manager] is on the ball".

The last full inspection of this service was in February 2014 when concerns were found in a number of areas. As a result we took enforcement action in relation to the care and welfare of people, meeting their nutritional needs, the cleanliness and infection control and the arrangements in place for assessing and monitoring the quality of the service. Follow up inspections were carried out in June 2014 and September 2014 during which we found that the required improvements had been made. At this inspection we found that some of these improvements had not been sustained. We identified similar concerns in relation to the information contained in people's care plans and staff not always being responsive to people's needs. Many of the concerns we had in relation to the lunch-time experience had also been highlighted in February 2014.

The registered persons had not taken adequate steps to ensure their continued compliance with the regulations that governed their registration with the Care Quality Commission (CQC). The Regulations require that CQC are informed about any allegations of abuse, but we found that we had not been notified of two safeguarding alerts which had been raised about aspects of people's care. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 Notification of other Incidents.

Systems in place for assessing and monitoring the quality and safety of the service were not being effective at driving improvements. We found that audits were not taking place in line with the frequency as determined by the provider. Where audits were taking place, the improvements identified as being required were not taking place. For example, we saw a medicines audit had been completed on the 16 April 2015. It had identified that a review of the homely remedies being used within the home was required and that both the medicines fridges had been found unlocked. We found that the homely remedies approved list had not been reviewed since January 2014 and the medicines fridge was still unlocked on both of the days we inspected the service. The medicines audit had not identified some of the concerns we noted in relation to medicines management, for example, it had not identified that there needed to be more robust plans in place for 'as required' or PRN medicines. This was not in line with the provider's medicines policy around the use of PRN medicines which stated, 'To ensure medicines are given as intended, a specific care plan for administration must be completed and reviewed monthly. Action had not been taken to ensure that only designated staff had access to people medicines and improvements were not being made to ensure that medicines were being stored at suitable temperatures.

We had identified concerns that people were not receiving the care they needed to eat and drink in a timely manner and that. A nutrition and care plan audit was undertaken by staff on the first day of our inspection, but we were not able to see any further audits that would suggest there was an on-going programme of audit in place that assessed and monitored the quality of people's care in relation to these areas.

A 'weekly' tool was in place to monitor wound management within the service. However, this was not being completed weekly and was not being used effectively to monitor wound care as it did not list and track the progress of each person who had pressure ulcers or skin damage.

Arrangements had been put in place to hold weekly clinical risk meetings. The aim of these meetings was to assist nursing staff to be aware of risks regarding people's nutrition, weight loss, diabetic care, tissue viability, falls and incidents of challenging behaviour. The meetings had been attended by external health care professionals with specialist knowledge. However we saw that the last meeting had been held in April 2015. The deputy manager and a healthcare professional told us that the meetings had stopped as key staff were not available to attend these, This meant that a key tool for sharing skills and knowledge, best practice and monitoring risks to people's health and wellbeing was no longer taking place.

Requires improvement

# Is the service well-led?

Another health care professional told us they had shared a range of tools with the homes previous registered manager in order to improve the quality of the service. They explained that some of these measures had never really been implemented within the home. It is important that providers take note of and implement local and national recognised guidance in order that the quality and safety of the service is maintained and improved.

People did not always have a detailed, accurate and personalised care record which included a record of the care and treatment provided. Whilst most people did have an up to date and regularly reviewed assessment in relation to their risk of developing pressure sores, their daily records did not always reflect that people had been repositioned regularly and in line with their care plan. We saw three examples where repositioning charts contained gaps, one person's charts showed that they had not been repositioned between 8am and 8pm for four days in a row. Their care plan said they should be repositioned every four hours. We could not be certain whether the gaps were because the care was not delivered or because staff were not recording accurately.

Some people's care records contained conflicting information about their needs or did not reflect their current abilities. For example, one person's moving and handling risk assessment stated that they required the assistance of two care workers when transferring. Their falls care plan dated 18 March 2015, 'I use a Zimmer frame to transfer with assistance of one staff member. We were concerned that this conflicting information could lead to the person receiving inappropriate or unsafe care.

The provider and registered manager did not have a service improvement plan in place. A service improvement plan is a detailed formal plan that sets out and prioritises the improvements that the provider hopes to make to service delivery. It considers the resources needed to achieve these and the timescales within the improvements should be made.

There was not an effective system of assessing and monitoring the quality of service provision. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Feedback about the culture within the home and staff morale were mixed. Some staff felt that moral was good, one said, "We all get on and enjoy some banter with each other, the staff are a lovely bunch". Others felt that morale was 'low', that the home lacked organisation. We saw minutes of recent staff meetings indicated that staff had a number of concerns and felt that these were not being listened to. For example, we saw that staff were raising concerns about staffing levels, lack of cover for staff sickness and at weekends. Concerns were expressed about there being a divide between the nursing and care staff and of staff not being kept informed about developments or changes within the service. We shared these concerns with the current registered manager who had only been back managing the service for a week following an absence of over a year. They told us that they had an "Open door policy and were approachable". They told us that they were confident this would ensure that they became aware of concerns or grumbles that the staff might have and the areas where improvements were needed. They told us they were committed to a 'no blame culture where everyone in the staff team took ownership and pride in their work. This was confirmed by some of the staff we spoke with who told us that the registered manager had when previously working in the service been "Brilliant, firm but fair". They told us "They would definitely do something about it if you went to them with concerns". They all expressed a confidence that the registered manager would bring about improvements.

During the inspection we found the registered manager and the deputy to be open to receiving our feedback about the service and they both showed a desire to improve. A number of improvements were implemented during the inspection and we were sent an action plan following the inspection which showed some of the immediate action being taken to address the areas of concern. We have been notified since, however that the registered manager has resigned. The provider has notified us a new manager had been appointed and that they will be submitting an application to register with the Care Quality Commission.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>How the regulation was not being met: Staffing levels were not organised in in such a way as to ensure that people were safe and that their needs could be met in a timely and person centred manner. Regulation 18 (1).<br>Staff did not have all of the training relevant to their role. New staff were not always provided with a robust induction and supervision was not taking place in line with the frequency as determined by the provider. Regulation 18 (2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>How the regulation was not being met: Where people lacked capacity to consent to their care and treatment, the registered persons had not always acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (3). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br>How the regulation was not being met: The registered persons had not notified the Care Quality Commission without delay of allegations of abuse Regulation 18 (1) (e). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

This section is primarily information for the provider

# Action we have told the provider to take

Diagnostic and screening procedures

Treatment of disease, disorder or injury

How the regulation was not being met: We could not be assured that people received person centred care was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1) (a) (b) (c)

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The planning and delivery of care was not always being managed in way which mitigated risks to the health, safety and welfare of people. We could not be assured that all the necessary measures were in place to identify, assess and plan for risks that might impact upon the safety of the premises. Regulation 12 (1) (2) (a) (b) (c) (d).<br>People medicines were not managed safely. Regulation 12 (g). |

**The enforcement action we took:**
A warning notice has been served on the registered provider requiring them to become compliant by 28 October 2015

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The registered persons had not ensured that There was an effective system in place for assessing and monitoring the quality of service provision. Regulation 17 (1) (2) (b) |

**The enforcement action we took:**
A warning notice has been served on the registered provider requiring them to become compliant by 28 October 2015.