Medincharm Limited

Bourne House

Inspection report

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Date of inspection visit:
08 March 2016
09 March 2016
10 March 2016

Date of publication:
16 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Bourne House on 8, 9 and 10 March 2016 and our visit was unannounced on day one.

The service was previously inspected on 2 April 2014 when no breaches of legal requirements were found.

Bourne House is situated in the Ashton-under-Lyne area of Tameside. The home provides care, support and accommodation for up to 33 people who require personal care without nursing.

All rooms provide single accommodation and 19 of the rooms are en-suite. Bedrooms are located over two floors and the first floor is accessed using a passenger lift or staircase. There are three communal bathrooms, communal toilets, one front lounge, one front dining room and one rear combined lounge/dining room. The rear lounge/dining room overlooks the patio and large well kept, secure gardens with areas for people to sit outside. The building is a two storey detached house with a large, single storey extension to the rear.

At the time of our inspection 33 people were living at Bourne House Care Home and the registered manager told us that they were currently operating a waiting list.

There was a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection was carried out in response to a regulation 28 report from the Coroner's office. This is a report that is written after an inquest into someone's death and the Coroner believes there is a risk of other deaths occurring in similar circumstances. The home is required to produce an action plan to ensure the prevention of a reoccurrence. We found that actions identified in the report had been completed by the home.

We identified 13 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 report.

During this inspection we found that there were not always enough staff available to meet people's needs. The registered manager told us they used an online tool to calculate how many staff should be on duty but this did not accurately reflect the level of the needs and dependency of the people we observed who lived at Bourne House.

The provider did not have effective systems in place to identify the risks to people's health, welfare and safety. Care plans did not include comprehensive risk assessments to identify specific risks to people.

Accidents and incidents were not comprehensively reported, analysed or acted upon.

A full building/ environmental audit would have highlighted potential environmental risks, as identified during this inspection.

People, relatives, and staff spoke of the service; one person's relative told us "Staff are caring and I am informed of any changes".

Visiting professionals were complimentary of the service and were confident that staff follow their guidance when providing care. One visiting professional told us "It's one of the better homes".

Staff we spoke with were aware how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm. However, staff did not demonstrate an understanding of the legal safeguards around mental capacity.

Safe and appropriate recruitment and selection practices had been used to ensure that suitable staff had been employed to care for vulnerable people and staff received regular supervision and support from management.

Documentation at the home showed us that people received appropriate input from health care professionals, such as district nursing and their general practitioner, to ensure they received the care and support they needed. However, we found that people were not always appropriately supported to ensure they had their nutritional needs met in a specifically prescribed way.

People were supported by staff who were mostly kind and caring, however, often interactions between people and the staff who cared for them, were task-based and observations made showed us consent was not always sought before care was provided.

People had been able to personalise their own rooms and each bedroom contained information on the walls about the person and their likes and dislikes.

Communication systems between staff and management were effective.

People and staff were complimentary about the qualities of the registered manager and told us they felt supported and able to approach the management team.

Personal care plan records were in place for people and included comprehensive information around the care and support needs, however, information in the files was not always current and up-to-date and in some files we looked at, care plans had not been reviewed for a number of months and did not reflect the current care needs of people. This could lead to people not receiving the correct care and support; however, staff we spoke with were knowledgeable around people's care needs.

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.

Safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people.

Insufficient numbers of staff meant that people did not always receive care and support in a safe and timely way.

People told us they felt safe. Staff had received safeguarding training and demonstrated a good understanding of the types of abuse that people may be at risk from.

Accidents and incidents were not comprehensively reported, analysed or acted upon.

Infection control safeguards were not always in place.

Care plans did not include risk assessments to ensure that people receive safe and effective care and support.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain their health and to access appropriate healthcare services, for example, a GP and district nursing.

Staff files and a training matrix showed us that staff had received a good level of required training.

People did not always receive the required nutritional support in the way that had been prescribed for them by health care professionals.

People were not always involved in decisions made about their care and support.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw that people were sometimes treated in a caring and respectful way; however, we also saw that people were not always treated with privacy and dignity.

The home was caring during times of bereavement and we received positive comments from visiting professionals around end of life care.

People told us they felt cared for at Bourne House.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People choices, preferences and care needs were not always met and care plans were not up to date.

There was an activities programme and part-time co-ordinator in post.

There was a complaints policy in place, however, not all complaints and outcomes had been recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and staff were complimentary about the registered manager and described them as supportive and approachable.

The service was currently led by a manager who was registered with the Care Quality Commission (CQC) since October 2010. However, the manager was not up-to-date with current regulations.

Care records and personal information was not kept secure and confidential.

Systems in place to monitor the quality and safety of the service were not robust enough and had not identified the issues we found during the inspection.

Bourne House

Detailed findings

Background to this inspection

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

This inspection took place on 8, 9 and 10 March and was unannounced on the first day. The inspection was carried out by three inspectors .

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events. No concerns had been reported to us from the local authority since the last inspection on 2 April 2014.

On this occasion, we had not requested the provider information return (PIR) before the visit. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked in all communal areas, bathrooms, five bedrooms, the kitchen, store rooms, medication room, the cellar and the laundry.

During the inspection we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff; including records which related to people's individual care and the administration of medication and four staff files to check training, supervision and safe recruitment practice.

As part of the inspection we observed how staff interacted and supported people at lunchtime and throughout the three days in various areas of the home. We observed one staff handover session and reviewed staff communication records.

During the inspection we spoke to three people who live at Bourne House, the registered manager, deputy

manager, five members of staff, three relatives and two health care professionals visiting the home at the time of our inspection.

Inadequate

Is the service safe?

Our findings

We observed many instances during the inspection where several people were left unattended in lounges and dining areas, for example, on day two of our inspection we walked through Sycamore unit at mid-morning and found people sat in the lounge/dining area with no staff present; one service user was distressed and calling for help whilst another was sitting leant over the dining table in front of uneaten toast and a cup of tea. We sought out a member of staff who responded to our concerns. We later saw that the toast had been removed and the person was being assisted to eat cereal, however, this was 10.50 am and would impact on the person's appetite to eat lunch at 12.30pm.

We spoke with two relatives and asked them if they felt there was enough staff their comments included, "If I have to be really honest, no" and the "main concern is staffing". They both felt some days were better than others. One relative told us that it was worse on a Saturday. Although added that when asked, "Staff never admitted to being short staffed".

As part of our inspection, we observed the lunchtime experience in the Sycamore lounge/dining room. We found that people were not given adequate or appropriate support throughout this period. We saw that there were seven people sat at dining tables and three people sat in lounge chairs, five of these ten people required assistance to eat. There were three people in their bedrooms attached to Sycamore lounge, who required their meals taken to them, two of which required full assistance and their food served to specifications prescribed by a nutritionist.

Prior to lunch being served, we saw that one person required personal care and we alerted two members of staff who left the Sycamore lounge to assist the person in their bedroom. This left one staff member to serve 10 people their lunch in the lounge/dining area, five of whom required assistance to eat. The one staff member started to serve lunch to the people sat at the dining tables at 12.45pm. The food was placed in front of people without comment and one person, who was bent forward asleep over the dining table, was served a bowl of soup and this was left there untouched in front of the person until a staff member was available to attend at 1.45pm. Another person was walking around distressed and shouting; they had spilt their juice over the table and spilt food down the front of their clothes. This person was not offered a replacement drink during our lunchtime observations. We noticed that a call buzzer had been activated and was not answered for some time; we spoke to the one person serving lunch, who told us that there was nothing they could do about it because they were busy serving lunch. The three people, who were still in their bedrooms, received their lunches at 1.50pm, 2.15pm and 2.35pm. This meant that they had been waiting a long time to get their food due to the unavailability of staff.

We spoke with two relatives and they both told us, independently, they visited at mealtimes to ensure their relatives ate sufficient amounts. One relative said there was not enough staff to cut up their relative's food and the other relative felt there was not enough staff particularly on Sycamore unit, where the needs of the service users were greater with high levels of dependency. They told us they had raised this as a concern with the manager. One of the relatives felt the routine of having three courses at lunchtime impacted on the time taken to ensure everyone was fed because of the high numbers of people who required support with

eating and drinking. Often they told us, this meant food could be cold by the time it was served and staff had told them they were not allowed to have hot trolleys. We saw that meals had to be sent back to the kitchen at 1.35pm to be reheated, as they had not yet been served to people on Sycamore unit.

We spoke with staff around staffing levels within the home. One staff member told us, "we could do with more staff… especially for high dependency". This staff member told us that they will put on extra staff if someone is poorly and gave an example where an extra staff member had been on at night when a person was suffering from anxiety.

The registered manager told us that they use an online dependency tool to assess and calculate how many care staff are needed to ensure that people receive the required levels of care and support. Usual care staff levels were four carers and one senior carer during the day and three night care staff on duty in the evenings and these levels were verified by staff rotas. Bourne house was split into two distinct areas; the original house at the front and the rear extension which housed the Sycamore unit and was accessed down a single, internal corridor. During our inspection, we found that people who lived and spent their day in the Sycamore unit at the rear of building had more complex needs and had higher dependency levels. The usual cover was two care staff at the front of the home covering the front lounge and dining area and two care staff at the rear of the building, all supported by one senior carer. Staff told us there were eight people on the Sycamore unit who had high level dependency needs and required full assistance with their meals, mobility and personal care, often with two care staff. This meant that whenever someone required assistance from two staff, this left only two carers and one senior as care cover throughout the home.

People did not always receive the care and support they needed in a timely way. Relatives and people using the service who we spoke with felt that there were not enough staff on duty. One person told us, "there is not enough staff to respond to changes in need" and that when they had visited the day before it "had been chaotic".

Staffing levels at Bourne House did not provide adequate care and support to reflect the dependency levels and care needs of the people who lived at the home and ensure that people received the care and support they required in a timely way.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We spoke with two relatives who both told us they felt their relatives were safe at Bourne House. People we spoke with also told us they felt that they were safe and that staff were trained to look after them safely.

During the inspection we looked at four staff personnel files to check that safe recruitment practices had been undertaken. We found that the files contained information including, work history, references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. This meant that the home manager had received satisfactory assurances and that robust and safe recruitment practices were followed to ensure that suitable staff had been employed to care for vulnerable people. We saw that there was a long and intensive induction programme for new starters and staff turnover was low; the registered manager told us that Bourne House did not use agency staff.

We looked at the way in which medicines were managed at Bourne House. We found that there was a relevant policy in place and system used for stock control and most medication was delivered by a local

pharmacy in prepared blister packs along with pre-printed medicine administration record (MAR) sheets. Bourne House had their own 28 day system in place for the administration of medicines and this meant there was no stock carried forward, but instead all surplus medication was returned to the pharmacy. Medicines were administered by senior care staff using a lockable medicines trolley and the medication administration record (MAR) sheets in individual file records documenting known allergies and a photograph of the person to identify that the right person was receiving the correct medication. We checked a sample of these records and found them to be mostly in order; except for two instances where hand written medication details had been added to the MAR sheet and did not have the required two signatures to ensure accuracy and double checks. We also identified one instance of a balance discrepancy of one tablet, the senior carer told us they had given the tablet that morning, but had omitted to sign the sheet and they remedied their mistake.

We noted that the home manager conducted monthly medication record audits, but had not found any significant issues or concerns with the medicine administration records.

We checked the medicine store room for security and safe temperature monitoring and found the store to be locked and contained a suitable cabinet and system for recording controlled drugs (CDs). Medicines should be stored in temperatures below 25 degrees and be monitored daily. The temperature of the medication store room was checked daily and was seen to be 27 degrees centigrade on day one and 25 degrees centigrade on day two of our inspection. This meant that medications were not being stored safely as high temperatures can compromise the quality of the medicines. The registered manager acknowledged that the medicines room was too hot and explained that they were aware that the room got warmer as the day progressed due to the nearby water pipes becoming hot as hot water was used in the home. The registered manager told us that they would purchase a cooler for the room and we saw evidence during the inspection that this had been ordered.

We looked in the specified medicines fridge, located in the kitchen storeroom, and found items that did not require storage in the fridge and should be kept at room temperature. Some medications are adversely affected by not being stored in line with the instructions. We identified items that had not been labelled with the date they were opened, although these items were dated by the pharmacist's label, they should also be marked with the opened date as an extra safety check to ensure their safe and appropriate administration. This is because some medications have a limited effectiveness once opened.

As part of our inspection, we looked at the safe handling and administration of medication to check that people get their medicines in the right way at the right time. We identified during our inspection, that specific times for administered medicines were not recorded and Bourne house used just four time frames; morning, lunchtime, teatime and night. We observed one person being given paracetamol at 11.30am and this was recorded on their MAR sheet as been given as "morning" medication. We spoke to the senior carer who acknowledged the risk that another senior carer could give a further dose on the lunchtime medication round, therefore not allowing a safe space between doses. This practice also indicated that a person's pain may not be managed effectively if pain relief was not given at the specified time intervals. On day two of our inspection, we noted that the morning medication round finished at 11.25am and the lunchtime medication round started at 1.10pm. This meant that there was a potential risk for medications to be given without sufficient gaps between doses as some medicines are specifically time dependent, such as, analgesia.

On the first day of our inspection we saw that the morning medication round had commenced three hours late and this had a cumulative effect for the rest of the day's medication rounds. We observed, during an afternoon music and singing session, that the lunchtime medication was being administered at 3pm. This led us to be concerned that people may have missed time-dependent medicines, or that medicines that

need to be taken around meal times. We relayed our concerns and the senior carer, who was administering the medications; they assured us that no-one was at risk from having their medications late or not spaced correctly and they ran through the MAR sheets to check that this was correct.

During the morning on day two of the inspection, we observed that one person was slightly breathless and we reported this to a senior carer, who went to check the person's wellbeing and reported back to us that the person was well. At 12.30pm we looked at this person's inhaler that had a built-in counter facility. We ascertained and agreed with another senior carer by looking at the MAR sheet dates and prescribed dosage, that the inhaler counter should read that they had taken 94 doses since the start of that prescription, however, the counter showed that they had only taken 71 doses. This meant that staff were not aware that the inhaler had not been taken as prescribed as they had not checked the counter and this may have explained why the person was breathless. Staff who administer medication must ensure that prescribed medicines are taken as per the prescription to prevent the person becoming unwell and to ensure accurate documentation is completed.

We saw that this person's drinks should also be thickened to a specific consistency and the carer also acknowledged that the consistency was too runny and explained that it was because the powder used to thicken it had run out. We intervened and the carer went to the kitchen to find supplies of the person's prescribed thickener and returned to give the person their drink in the correct form. The carer should not have been giving the drink to the person they were caring for without the required thickener. Thickener is prescribed for a person by a medical practitioner and each person receives their own prescription. If food is given that was not the correct consistency and the juice was not thickened as prescribed, the person was at risk of the complications associated with swallowing.

On the first day of the inspection, one visitor told us that their relative had been served a drink without the required thickener in it to ensure that they were able to safely take the drink.

The above examples demonstrate a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We examined records of accidents and incidents and found that records were incomplete and had information missing, such as, the time of the accident or incident, or the location. Accidents and incidents were recorded on specific documentation and kept in files in the registered manager's office. We asked the deputy manager how this information was investigated, analysed, monitored and acted upon and were shown a monthly recording sheet within the file. We did not see evidence that the monthly recording sheet information was being actioned to reduce the number of accidents and incidents and minimise the risks to people. We found that one person had fallen in the same circumstances and on two consecutive days in November 2015; we did not see any evidence of steps taken to investigate and prevent a reoccurrence and nothing was noted in the person's care plan where the last review was September 2015. This meant that information was not being acted upon in order to identify specific patterns, such as accidents occurring in specific areas of the building or at certain times, or if certain people needed a referral to the falls team or further medical investigations.

This was a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We reviewed a sample of people's individual care records and found that although they were comprehensive and covered many aspects of a person's care and support needs, they did not include specific risk assessments, for example, people who are in bed or a chair for most of the day will require a

pressure care risk assessment. The registered manager confirmed that risk assessments were not in place at Bourne House. Robust, individual risk assessments should be in place for each person living at Bourne House to ensure that any risks are identified and managed appropriately. We found that in one person's care file, there was information regarding a moving and handling assessment, however, this was dated 2012 and each subsequent review since had been noted as "no changes." The last review of this assessment was dated September 2015. We found a short moving and handling assessment from May 2014 within the care plan, but the reviews did not make reference to this and stated "support and care needs remain the same". This meant that this person's needs were not reviewed in good time to respond to any changes in their care and support. No risks to health and well-being had been comprehensively identified, assessed, rated for likelihood or impact, or plans put in place to manage those risks.

Additionally, we noted that no-one in Bourne House had a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP provides additional information on accessibility and means of escape for disabled people and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire.

This was a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Suitable arrangements were in place to help safeguard people from potential abuse. There was a safeguarding adult's policy and procedure in place and when asked, staff spoken with were fully aware of this procedure demonstrating a good understanding of the subject and were able to tell us about the different types of potential abuse and what steps to take to report any concerns. One staff member told us that if they ever saw or heard anything that could be potential abuse that they would go straight to the manager as she is approachable. A whistleblowing policy was in place and staff, we spoke with, were knowledgeable around reporting concerns if they felt that appropriate action was not being taken by management.

We looked at fire safety and found that fire monitoring systems were in place and a fire risk assessment had been carried out for Bourne House in July 2015. We noted that checks for safe means of escape, emergency lighting and alarms had been completed at least monthly. The last fire drill had been carried out in November 2015, but we did not establish who had attended as no names had been recorded. We asked one senior staff member about their knowledge of what to do in the case of a fire and they outlined the safe steps they would take to safeguard themselves and the people living in the home.

During the inspection, we toured the building and found communal areas within the home to be mainly clean and tidy, but we also found areas that required improvement. The laundry was only secured with a simple latch, which meant that chemicals and soiled laundry items could be accessible to people who live within the home, some of whom live with dementia. The laundry area was not clean and had a problem with damp that was being treated on the exterior wall; we found people's laundered clothes and bedding stacked up against this wall, allowing clean clothes to come in direct contact with damp. We spoke to a member of staff in the laundry and they told us that they did not have a designated laundry assistant and agreed that the laundry room was not clean. They told us staff incorporated laundry duties in to their daily routine and this meant "mornings are worst because staff are busy" and making references to supporting people who use the service with washing and dressing and also sorting bedding.

We saw that the kitchen was clean and only kitchen staff were allowed access. Other staff members who wished to access the kitchen had to wear protective clothing and be accompanied by the kitchen staff. Bourne house had recently been awarded four out of five stars for hygiene by the Food Standards Agency in

2016. However, the service was still displaying their five star rating from the previous year; this was rectified during our visit.

We found a number of issues with the safety and maintenance of the environment, such as, a soiled, wheeled commode at the top of the stairs, a broken toilet lock, missing shower curtains and doors that required to be secured, such as the electricity store. The cellar was used by the maintenance man and also used as a storage area; this area was very untidy and unclean and the key to the boiler door was hung on a hook in easy reach, making this area accessible. The cellar was described by one staff member by telling us, "It's a disgrace". Bins in the toilets and bathrooms had open tops and posed a potential infection control risk to people. We informed the registered manager of these concerns and they were addressed during our three days of inspection; the manager purchased new swing-top bins.

We looked at the cleanliness within the bedrooms and we saw that some rooms were clean and tidy, but we also saw rooms that required attention. We saw one person's room was dusty and had food debris on the chair and floor and a trolley they used for eating meals in the bedroom was particularly unclean with food debris and dust around the legs. One room we looked in was particularly malodorous and this was reported back to the registered manager. One relative told us that a room their relative had been given on admission to the home had a bad odour from the carpet, but this had been acknowledged by the registered manager and was replaced within six weeks.

We saw that although cleaning schedules were in place, they were inconsistent in completion of the documentation and were blank in places and we found that these schedules were not regularly audited by the registered manager. These documents showed us that regular cleaning was not taking place and this was not overseen by the home's management team.

We could see from the training matrix that had been given to us by the deputy manager that all staff had received training in infection control and we saw that staff wore the required personal protective equipment (PPE) when required and this was available throughout the home.

The most recent infection control audit carried out by the local authority was May 2014 and Bourne House received 98% compliance. One of the recommendations from this audit was to conduct regular checks of mattresses. The registered manager told us that they did not conduct audits of mattresses or pillows and we saw that pillows within bedrooms did not have protective covers. Government guidelines state that mattresses should be checked every month for damage and cleanliness and have protective covers.

This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The registered manager told us that each person, who required the use of a sling, had their own. However, we saw that two staff members brought a sling from another person's bedroom to assist a person to stand in the lounge and then returned the sling to the bedroom. When we spoke to staff about the availability of slings, they told us that they did not have enough slings to enable each person to have their own. This practice meant that there was a risk of cross infection by using the same sling for more than one person, additionally, slings are usually prescribed for one person taking into account their size, weight and disability. This meant that staff may not be using slings in a safe way and putting people at risk of injury and cross infection.

This was a breach of Regulation 12 (1) (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We were able to evidence that some regular electrical testing of appliances, pest control, safe removal of clinical waste and emergency lighting testing had been completed at the home. We received confirmation by telephone that a recent gas check had taken place, however, we saw that the last electricity installation check had been in 2009. We informed the registered manager that these should be done every five years.

The manager acknowledged that a more robust and comprehensive system of health and safety auditing was required and told us that they planned to introduce a new system with improved check lists.

In response to the regulation 28 report from the Coroner's office, the provider was required to ensure that effective training was in place for staff in the event of a person experiencing a fall within the home. We saw that a falls procedure was in place and that staff had recently undergone first aid training. We evidenced in the first aid training documentation that this specifically included what procedures staff needed to follow during a situation where someone had fallen.

Requires Improvement

Is the service effective?

Our findings

Many of the staff members had been working at Bourne House for several years and staff turnover was low. This meant that people were being looked after by staff who knew them and knew each other. We saw that there was a strong and supportive staff team at Bourne House. Staff and relatives told us that the management team were approachable; the registered manager told us that they often put on a uniform and go out with the staff to provide care.

On our request, the deputy manager produced for us an updated training matrix, this showed us what training staff had undergone and when refresher training was due. We saw that staff had undergone the required training for care workers, for example, first aid, moving and handling, food hygiene and safeguarding. We evidenced that staff had undergone specific training in how to respond if someone had a fall, as recommended in the Coroner's regulation 28 report. However, some staff files showed that they had also benefitted from specialised training to enable them to be more effective in delivering care, such as Dysphagia (swallowing difficulties) and Sensory Deprivation Awareness. We also saw that the management team had high level qualifications in care delivery. Staff told us that they had access to many training opportunities. This meant that staff had the required knowledge and enhanced awareness of people and their potential care and support needs whilst living at Bourne House.

We reviewed, in depth, four care staff personnel files looking for evidence of a robust system of induction, regular supervisions, development and a comprehensive training schedule. We found evidence of induction, supervisions and personal development in these individual staff files. Staff supervision records were kept in a separate file. On reviewing the most recent documents within the supervision file; we found that there was evidence of regular and effective supervisions held to discuss staff development or any issues that staff may like to bring to the attention of the management team. Staff told us that they received regular supervisions every three months and they saw this as a chance to air their thoughts and felt that any ideas were taken on board and implemented. Staff told us "I feel supported in my role" and "The manager listens…supports us and is very understanding". This meant that staff were regularly supported to discuss any concerns regarding staff or residents, and their own development needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Bourne House was working within the requirements of the MCA and DoLS. We found that DoLs applications had been submitted to the local authority by the registered manager for seven people living at the home and were awaiting approval. However, we found that there were people living at Bourne House who had not been assessed for whether they required a DoLS application. The registered manager told us that no reviews have taken place for people with DoLS applications; if the registered manager feels that there has been a deterioration in someone's mental health they contact their local GP or community psychiatric nurse (CPN) in order for them to carry out the assessment and application.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We found when we spoke to staff that they did not always have an understanding of the MCA or DoLS and were not able to confidently describe to us what this meant for people who lived at Bourne House. One senior member of staff showed evidence of understanding of DoLS and MCA, who when asked, refused to give us an example of how a person could be deprived of their liberty. When asked about their knowledge of DoLS, another staff member told us it was about choice and independence; however, another staff member told us that it was about people's choices to have their hair plaited. This meant that staff were not fully aware of the requirement to ensure that people's liberties were not being deprived without the necessary legal safeguards in place.

During our inspection we saw that staff sometimes sought consent from people before providing care and support. One person told us, "they (staff) consult with me all the time….I get asked what I want". We observed a number of instances where staff asked people if they would like to come and sit at the dining table or what they would like to drink whilst sat at the table. However, during our mealtime observations, we mainly saw that people were served meals and drinks without first asking what they would like. We saw on one occasion, where two people who required assistance, were not offered a soup starter like everyone else or given a description of the food, before commencing with assistance; the food was just placed in their mouths without comment.

We spoke to staff about people's choices and gaining consent to provide care and support to people at Bourne House. One staff member told us how they would give people choices and another staff member told us people had to give consent or they could not perform the task, for example, they would not make someone get out of bed if they did not want to, but they would try and encourage the person.

We observed an incident where someone was sat at the dining table and two staff members approached the person with a walking frame and told them they would take them to "sit in a comfy chair". The staff proceeded to lift up the person to standing and then position them in front of the frame and guided them to a lounge chair. Although staff were speaking kindly, they did not ask if the person would like to move or where they might like to sit or offer them any choices; this decision was made for them. This meant that consent was not sought before moving the person without offering choice and showed poor care practise.

We did not see evidence of any best interests meetings in the care plans we looked at. A best interests meeting, is usually held when a decision needs to be made about someone's care and where a person's lack of capacity has been established through assessment. We found in the care plans; we looked at, documentation relating to people's wishes around end of life care and documents directing staff not to attempt resuscitation if needed. The registered manager told us that the care plans were not up to date and the document named "This resident is not for resuscitation" was no longer valid, however, this document was still in the person's file and could lead to the incorrect decision being made. Important decisions had been made in this care plan without evidence of a best interests meeting, capacity assessments or ensuring

that people have the legal power to do so through a LPA for health and welfare. These documents were dated 2011 and had not been reviewed. This showed us that people had not been involved in decisions about their care and support plans, nor that they had been involved in any review of their care and support needs.

This was a further breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

During this inspection we reviewed people's personal care files to check if people were supported to maintain their health and well-being. We saw that staff at Bourne House supported people to have assistance from other health care professionals, such as district nurses, dentists, opticians and dieticians. These visits or appointments for people were also documented in separate files in the registered manager's office. When looking at personal care plans, we could see that people had regular visits from additional healthcare services. It was documented that people received regular visits from their GPs; staff and the registered manager told us that they had very good links with the local GP surgeries. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

We spoke to one visiting health care professional who was complimentary about the care and support delivered at Bourne House and they told us that staff accompany them to see each resident and they told us, "they do talk to us", when we asked about communication. Another visiting professional told us the if staff had any concerns about a person living at the home that they would contact them straight away and that referrals to them were always appropriate and timely and said, "It's a really good care home".

We spoke with two relatives both of whom told us the manager and staff at Bourne House kept them up to date if there were any changes to their relative's condition and involved them in any decisions about their care.

As part of our inspection, we looked at the menus and food choices available to people living within the home. We saw that menus were varied and nutritionally balanced with a diabetic pudding option each day, food served each day looked appetising and well-presented when it came out of the kitchen. One relative we spoke with told us, "the food is good". Freshly cooked meals were available seven days per week and one person told us, "I found it was too much to have a cooked tea, so they changed it to sandwiches". The cook clearly knew the residents and was able to tell us the specific food likes and dislikes of people. We saw that staff went to each person every day with a book of meal photographs to ask them what they would like to eat the next day. This showed us that people's choices were acted upon and kitchen staff were responsive to people's wishes.

We observed one person being assisted to eat their lunch at 2.35pm and this person's care plan stated that a speech and language therapist had assessed them as requiring their food to be of a particular consistency and to be "moist, not sticky". The carer who was providing assistance, was unable to tell us what consistency the food should be, however, they acknowledged that the food was not soft enough and was therefore not giving the meat portion of the meal as they felt it was too thick in their opinion. The texture and the consistency of the food was not how it had been prescribed to be served by the nutritionist.

We spoke to care staff and kitchen staff who told us that they get information around people's specific dietary and nutritional needs. The cook was aware of people's specific requirements and likes and dislikes and had lists on the walls in the kitchen of people's prescribed needs; including copies of people's current nutritional plans. The cook was knowledgeable about people who lived at the home and when asked, was

able to name people and their specific needs. However, we found that care staff and kitchen staff were only able to tell us that certain people had a "soft" diet and explained to us that this meant that food had to be blended. Staff were not able to tell us specifically about the different consistencies and textures required for diet stages and blending food did not always meet the nutritionist's criteria for a prescribed diet.

We looked in one person's care plan and found that they had input from the community nutritionist due to weight loss and reduced food intake. They had a specific nutrition care plan prescribed for them at the beginning of February, along with meal recommendations to boost calorie intake. The nutrition meal plan stated that high calorie snacks, such as creamy puddings, be offered each day mid-morning and mid-afternoon, along with milk drinks; specifically milkshakes. We looked at the diet and fluid intake charts for the following 7 days after the nutritionist's visit to see if this person's nutrition plan had been followed. We found that some higher calorie food items had been offered, however, we did not see evidence that the person had been offered the food and drink as prescribed. The charts for the 7 days showed us that only on six occasions had the person been offered a milk drink, no milkshakes had been offered and we found that on six out of the fourteen occurrences, the person had not been offered a mid-meal high calorie snack. We did not see evidence of why these items had not been offered. We asked the cook if they had ever been asked to make a milkshake for the person and they told us that they had not.

We found that people were not receiving the necessary nutritional support that had been prescribed for them by a nutritionist.

The above examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Bourne house benefits from a large, newly built and accessible garden to the rear of the building, which has been designed specifically for older people and those people living with dementia. Due to the weather during the inspection, we were unable to visit the gardens, however, staff told us that residents made much use of the garden in the summer months and enjoyed the outdoor space.

There were several people living with dementia who lived at Bourne House. When looking in staff files, we could see that staff had been trained in dementia awareness and we saw that some attention had been paid to making the home environment conducive to people living with dementia. Each person's room had a photograph of themselves decorated with a collage of pictures to depict a number of their personal likes, such as, a photograph of a dog or the singer Tom Jones. This made it easier for people to find their own room within the home. Additionally, we found a number of other alterations, such as, a coloured toilet seat and hand rails to assist people living with dementia to differentiate items when moving around the home. This meant that efforts had been made to ensure the appropriateness of the environment for people living with dementia.

The registered manager told us that the home specialises in dementia care and they showed us evidence that they had recently received re-accreditation to a Dementia Living Award.

Requires Improvement

Is the service caring?

Our findings

People who live at Bourne House told us that they were happy with the care they received at the home. One person told us they felt looked after and told us, "the carers are really lovely" and "they're really nice". Another person told us they felt cared for and said, "the care is excellent".

Staff we spoke with, felt that Bourne House was caring and told us, "It's a nice place to work…a caring bunch of people" and "the residents are happy". When speaking about the staff team they told us, "everyone supports each other". One of the carers we spoke with told us they felt very strongly about the importance of providing person centred care. They clearly knew the needs of the individual people well but added they would have liked more time to ensure the individual care element was carried out.

We saw that people were mostly treated in a kind and caring way and we could see that people and staff knew each other and we saw some instances where staff and residents were chatting. One staff member told us that they knew of people's preferences and gave the example that one resident only liked to wear cardigans with pockets. We saw that staff knocked on residents' doors before entering and greeted them appropriately. However, it was clear that staff did not have the time to spend with people and often interactions were rushed and task led. We saw that one person was often distressed and staff did not have the time to spend comforting this person, who responded well when they received the appropriate attention. We also saw that this person had spilled a large amount of food down their top and trousers and one staff member guided them to sit in the lounge to watch television whilst still wearing the soiled clothes. We also noticed that not everyone living at the home was clean and well-groomed; we saw a number of people had long, dirty finger nails; one person had dirty dentures and a number of ladies that had facial hair. Two relatives whom with spoke with, told us that they attend to their relatives fingernails themselves. This meant that people were not always treated with dignity and respect regarding grooming and cleanliness.

Another relative we spoke with told us that they had no concerns in relation to staff always maintaining their relative's privacy and dignity; they told us their relative was always clean and had clean clothes. One of the visiting health care professionals we spoke with, also told us that they had no concerns regarding residents' privacy and dignity.

During mealtimes on the three days of inspection, we saw that all the people we could see were served their meals in brightly coloured plastic bowls and their hot and cold drinks were served in brightly coloured plastic cups or mugs. The registered manager told us that the plastic bowls were brightly coloured to assist people who were partially sighted. However, not everyone living at Bourne House was partially sighted and this meant that people were not given choices to have their food and drink served in normal cups and bowls. Research has shown that people who are living with dementia can also sometimes benefit from brightly coloured cups and plates, however, the generic use of these plastic implements throughout the home showed us that people were not given choice or being treated as individuals and in an appropriate way.

We spoke with staff and asked them about the promotion of dignity and respect and how they maintained

this whilst providing care. Staff members told us that they had received training in dignity and respect and explained to us what it means to them to treat someone with dignity and privacy when delivering care. Staff gave us examples of how they would care for someone during assisting with bathing or toileting and how people should be spoken to in a respectful manner using their preferred name. One staff member told us, "speak to people how you'd like to be spoken to". This meant that staff were able to tell us what dignity and respect meant to them when providing care and support to residents.

We found that, although most staff were caring towards people using the service, the atmosphere in the home was rushed and task-led, and staff had little time to spend with people.

We observed that sometimes people were given choices around their care, for example, we saw people being asked what they would like for lunch the next day and on one occasion a resident was asked if they would like orange or blackcurrant cordial. However, we did not see many examples of people being asked their choices or opinions. We visited two people who were cared for in their bedrooms and found that they did not have access to a drink nor were able to summon assistance as they did not have a call bell within reach. We observed one person, who liked to walk around the home, being guided by staff to elsewhere within the home and another person being told to go and sit and watch the television. Although these interactions were done in a kindly manner, the residents were not having a say in their care and support nor were given a choice during our observations.

We spoke to one person, who described themselves as being quite independent and described their care as, "able to see to myself" and told us that they had choices at Bourne House and said, "I can have a bath whenever I want and I decide when to go to bed". This showed us that some people were supported to make decisions about their own care.

During the walk around of the home, we looked in people's bedrooms and saw that each person had two documents on the wall within accessible frames. The documents were; "This is me" and "Life Story". These documents were designed to enable staff to get to know the resident so that they can provide care that is personalised to them. For example, someone may prefer a bath rather than a shower and each carer, that had taken the time to read the information, would know this and be able to tailor the care and support given. Staff confirmed to us that they read these documents about the person they are supporting.

We looked at how Bourne House provided care to people at the end of their life. There was policy in place and was dated 2015, however, this policy had not been signed off as approved, meaning that the policy was only in draft form. One of the visiting professionals we spoke with, told us in relation to care given to people who use the service at the end of their lives, "I think personally it's one of the best homes…they will keep a close eye and contact us if any concerns". In relation to the registered manager, they added, "The manager will come in during the night…I've known her to do that if someone is poorly; I've no concerns".

The registered manager was sensitive and caring during times of bereavement. There were plaques up on the wall in the home of people who had lived at Bourne House and these were acknowledged by lighting a candle on each anniversary. Bourne House sent sympathy cards and cards to families on the anniversary of each resident's death. This meant that personal care and attention was shown by the home to people and their relatives during important times in their lives and this care continued after the person had left Bourne House.

Requires Improvement

Is the service responsive?

Our findings

We looked in several bedrooms and found that some rooms showed a high level of personalisation and some rooms were basic and had the same bedding and curtains. We met one person who liked to stay mainly in their bedroom and this room was very personalised and included lots of examples of their personal interests; this had been fully accommodated by Bourne House and as this person had a particular interest in trains, the home had erected a large picture of a train in the garden positioned so that it was at eye level outside their bedroom window. Another person had covered their walls in photographs, cards and letters. This showed us that people who lived at Bourne House were accommodated to express their choices and preferences around their own room.

People's care plans contained comprehensive information around the person's support needs, and included specific personalised information about each resident, for example, their family history, previous work experiences, preferences and aspirations. We found that there was a profile photograph and information around what people like to do, for example, in one person's file there had been recorded that they liked joining in singing songs, but we did not see any evidence that this preference had been accommodated. During day one of our inspection, we saw that a singing session was going on in the front part of Bourne House's building, but we did not see this person being included. Although care plans were comprehensive, they did not reflect people's current care needs and preferences. These care plan files were not well organised in that people had separate files with different pieces of information.

We found that personal information held in care plans did not reflect the current care needs of residents. In one person's care plan, we saw that it was documented, "wears varifocals all the time", however, during the three days of inspection this person was not wearing glasses. We did not find any updates or reviews that stated that this person should not now be wearing glasses. Additionally, information in the care plan around hair and makeup preferences stated, "In a bob-style with a fringe – lipstick and face powder". The photograph on the front of the care plan showed a person with short, groomed hair and glasses; the person we met at Bourne House had long, un-styled hair and any new staff would not recognise the person from the photograph. This person's care pan and their documented, personalised care choices were not current or not being followed; information was from 2011 and had not been updated.

The care plans we reviewed during the inspection, did not show us that people had signed consent forms to show that they had been involved in, or agreed their plan of care. We saw one care plan where there was a signature present to give consent to have the person's photograph taken. Another care plan showed us a signed care plan agreement, but this had been signed by a third party and we did not see any evidence that this person had the legal power to represent the resident through a lasting power of attorney (LPA) document. A LPA is a legal document that allows people to give someone they trust the legal power to make decisions on their behalf in case they later become unable to make decisions for themselves. The registered manager was unaware if anyone living at Bourne House had a LPA in place.

When we spoke to the registered manager, they acknowledged that care plans had not been reviewed and that information was not up to date. The registered manager told us that people did receive care and

support that reflected current care needs because information about residents was kept current through a series of communication sessions held between staff on a daily basis. These sessions consisted of communication books for both night and day staff and daily handover sessions between senior carers. We were able to look in the communication books and we observed one senior handover session. We found that these exchanges contained detailed information around each resident that would enable staff to attend to the current needs of the people who lived at Bourne House. For example, information was exchanged concerning nutrition, current health and mood of people, and identification of people who may have required additional monitoring. Notes of these senior handover meetings were recorded in the senior communication book. Night handover notes included additional information, such as, building security, fire register and people who required specific care.

Additionally, we found that there was also a communication book for visiting professionals, where they could update information around people they were visiting. When we interviewed staff members, they confirmed to us that communication around people's current care needs was good and they felt that this gave them the information to safely and effectively care for people. We found that communication between staff was effectively exchanged at Bourne House. However, one senior carer told us that they were aware that care plans were not up to date and they relied on the communication between staff to provide care. The home relied on staff knowing the person and communication between staff to provide the care; however, this showed us that people did not have regular input into the plan and delivery of their care. This meant that care needs were not assessed, reviewed, recorded and we did not evidence regular input from residents into how they would like their current care needs provided.

This was a breach of Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We saw that there was a notice board on the wall in the lounge showing what activities were on that week; this was a varied programme and included music and games. The registered manager told us that members of a local church attended regularly to carry out a service and we saw that there had been a programme of activities over the previous Christmas period. One visitor, whom we spoke with, told us that their relative enjoyed the activities. The home had a regular informative newsletter, which included details of people's birthdays, church services, forthcoming events, such as, Easter activities and also included a special welcome to a new resident.

The home had part-time activities co-ordinator employed to provide mental and physical stimulation through a programme of activities. The manager told us that this person was employed for 32 hours per week to provide activities; however, during the three days of our inspection we saw that the activities co-ordinator delivered one activity session and observed that this staff member was mainly providing care, such as, toileting and assisting people to eat their meals. We spoke to the activities co-ordinator and they confirmed to us that they had mostly performed care duties throughout our inspection. We did not see evidence within the care plans that people received individualised activities; the activities co-ordinator told us that if they had chance, they would go and sit with people for a chat. The registered manager told us that staff took one resident to visit the orchestra once per month.

During our inspection, we observed that there was a large amount of CQC's requirement information on display in reception and in one of the communal seating areas. As Bourne House is home to many people, this information would be best placed in an office environment for staff to view.

The registered manager told us that there was material in the in the reception area giving information on

how people could complain about the service, however, we could not find this information in the reception area or anywhere else displayed in the home. The residents' handbook made reference to a complaints procedure; however, no information was included in the handbooks we reviewed. The registered manager told us that they had an open-door policy and that if anyone had a concern they would be able to speak to them; any issues raised would be discussed at staff handover, updates noted in the communication book and care plans and that staff notices would be displayed. One relative we spoke with told they felt the management style was open and honest and that any concerns raised would be investigated.

We reviewed the complaints file and saw that the last entry was dated 2013; the registered manager initially told us that there had been no complaints made, but that there had been complaints more recently about smaller issues, such as, missing items of laundry or toiletries. We spoke to the registered manager about the requirement to record and act upon complaints, however, they told us that relatives did not want to make a complaint and nothing had been recorded. We found that Bourne House did not operate an accessible system of complaints and did not record or respond to complaints or concerns received in order to improve the service for people living there.

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

As part of our inspection, we looked at how the home actively sought and acted on feedback from people who use the service and their relatives. We reviewed documentation around a satisfaction survey completed August 2015, where all responses were very good or good; indicating that people were very satisfied with the care and support they received. We could see that any issues raised were addressed and actions to complete were recorded. For example, an action was for staff to set up an advanced care plan meeting for residents by the end of October 2015.

Requires Improvement

Is the service well-led?

Our findings

The home had a manager in post that had been registered with the Care Quality Commission (CQC) since October 2010 at this location.

Part of a registered manager's responsibility under their registration with the Care Quality Commission is to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. When asked, the registered manager had not accessed the relevant guidance on meeting the regulations.

The registered provider is not actively or regularly involved with the home, although they still own the building. The registered manager does not have an upward support network and runs the home entirely.

People, relatives, staff and visiting professionals were complimentary about the registered manager. We spoke with two relatives and asked if they felt the manager was approachable one told us, "yes…she's a busy lady" and another relative told us that they would go to the registered manager if they had any issues they wanted to discuss; adding that the registered manager and deputy was, "very approachable".

We saw that there were effective management structures and a programme of training and supervision. Staff documentation we reviewed, showed us that staff received a good level of leadership and were aware of their responsibilities. Staff told us that they felt supported and were confident that recommendations they might make would be listened to. It was clear that there was a strong and supportive staff network at Bourne House.

We saw that Bourne House had also conducted questionnaires with staff in July 2015; addressing a number of work aspects, such as, morale, performance, development and communication. The results of this survey showed that staff were satisfied with their current employment.

During the inspection, we found that systems and procedures were mostly in place. However, we found that these policies and procedures were not always being implemented or followed by staff to ensure the effective and safe delivery of care. For example, accidents and incidents were not being comprehensively recorded and meaningful analysis was not being made of these records to ensure effective monitoring and safety of the people. We also saw that procedures put in place to ensure safe and effective delivery of care were not being fully adhered to, such as, nutrition care plans. Care plans were not being comprehensively reviewed with accurate information to ensure up to date care delivery. The management team told us that they were aware of these failings in the review of care plans and did not address the issues because they felt that the communication systems in place enabled people to receive appropriate and up to date care.

The provider did not have sufficient and effective systems in place and in use, to regularly assess and monitor the quality of service that people received. We found that no formal competency checks were carried out on staff by the registered manager. Reviews of documentation and observations made showed us that audits and checks were not always fully completed. We found issues with the general environment

as documented earlier in the report that would have been highlighted with a full environmental audit. For example, the registered manager was not aware of the safety issues around the cellar and had not implemented the recommendations from the previous infection control audit in 2015. This meant that a regular and robust auditing system was not in place or being implemented and the registered manager did not operate effective systems to monitor the safety, quality and risk of services to people within the home.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Personal information around people who lived at the home was not kept confidential and systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plans, was not secured away but was kept in an unlocked cupboard. This meant that this private information was accessible and not kept secure; anyone living at or visiting Bourne House could access this information in the building. The registered manager was accompanying us during the building tour when we were able to access this confidential information.

This was a breach of Regulation 17 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not regularly involved in the plan of their care and did not have their current preferences and choices recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not receiving care in accordance with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards because appropriate assessments had not been made to ascertain if people were being deprived of their liberty without the required application/authorisation. Major decisions had been made about people's care and treatment without the consent of the person, best interests meetings or input from a lawful representative.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The home did not ensure that people received their medicines in a timely way. Accident and incident reporting was inconsistent. People's risk assessments were not in place or effectively and accurately reviewed and there

were no personal emergency evacuations in place.
People were not adequately protected against the risks associated with not effectively preventing and controlling the spread of infection.
The provider did not ensure that they had sufficient numbers of suitable slings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were being placed at risk because their prescribed nutritional support plans were not been fully adhered to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an accessible complaints system and actively record and act upon concerns/complaints raised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient and effective systems in place to ensure a robust overview of the quality and safety of the services provided. The provider did not ensure the security and confidentiality of information relevant to carrying out the regulated activity and did not adhere to the Data Protection Act 1998.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk from not receiving safe care and treatment because they were not being cared for by a sufficient number of suitably

qualified, competent, skilled and experienced staff.