Wellbeing Care Limited

St Georges Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Georges Care Home is a residential care home providing accommodation and personal care to 30 people aged 65 and over at the time of the inspection. The service can support up to 35 people and has a large communal lounge and dining area. People's bedrooms were all on the ground floor.

People's experience of using this service and what we found
Where people had come to harm, incidents had not always been reported to the local authority or CQC, as the provider was required to do. This meant there was no independent oversight to ensure people were fully protected.

Risks in relation to people's care were not always assessed or sufficiently detailed to ensure people were cared for in a safe way. There was not always accurate guidance in place for staff about how to manage or reduce risk.

Incidents and accidents were not always followed up to avoid the risk of recurrence. Records of incidents which had occurred were confusing and lacked detail on actions taken by staff. There was a lack of oversight and learning in relation to incidents and accidents.

There were not enough staff deployed at the service which put people at risk. Staff had not received appropriate training and supervision that ensured good practice within the service.

We could not be assured that people received their topical medicines, such as creams, as recording systems showed gaps in application. Medicines for use 'as required' did not always have a corresponding protocol so staff had guidance as to when these should be offered. This included medicines to reduce psychological agitation. Some topical medicines were not stored safely, which placed people at risk of harm.

There were systems in place to control the risks of infection such as cleaning schedules, but staff had not always followed these.

People did not always have choices around their care delivery and at times were not treated with dignity. There were not sufficient meaningful activities to keep people occupied and meet their need for mental stimulation and well-being. People told us there was not enough to do and they often felt bored. They said that in the main staff were kind to them, but they did not always have time to spend with them.

The provider's systems for monitoring and improving the quality of the service had not been effective. Audits had failed to identify the issues we found and were not being used to their full potential to identify trends which can reduce recurrence of incidents. Issues identified at our last inspection remained and we identified further concerns. The registered manager had not notified the CQC of reportable incidents and events as required with their registration. Regulatory responsibilities had not been met.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 17 November 2020) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found enough improvement had not been made and the provider was still in breach of previous regulations, and new breaches of regulation.

Why we inspected
We received concerns in relation to unsafe staffing levels and concerns about the quality of care people were receiving. As a result, we undertook a focused inspection to review the key questions of safe, caring, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Georges Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to assessing and managing risk, staffing, dignity, governance and reporting procedures.

Following the inspection we issued a Notice of Proposal to impose conditions on the providers registration. The provider did not make representations. We subsequently issued a Notice of Decision to impose conditions on the providers registration. The provider will send monthly information to us so we can monitor how the service is making improvements.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Georges Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Georges is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was also a service manager in post who managed the service on a day to day basis. This report refers to both the registered manager, and the manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan

our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and six relatives about their experience of the care provided. We spoke with two senior carers, the registered manager, and deputy manager.

We reviewed a range of records. This included four people's care records and five medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

We looked at training data and quality assurance records.

We spoke with one health professional, one social care professional, four care staff, and the service manager.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to ensure that medicines were effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made, and the provider remains in breach of breach of regulation 12.

- External applications such as creams and emollients were not being kept safely. This meant people could access them and put themselves at risk of accidental harm. A relative told us, "One day a [person] wandered in and took [relatives] barrier cream and walked out with it. Thankfully, I was here so I took it off them, otherwise I dread to think."
- Paper and electronic records indicated that some people had not received their creams and emollients as prescribed. This issue was identified at the previous inspection.
- There was a lack of written guidance available to help staff give people their medicines prescribed on a when required basis (PRN). Two people who experienced psychological agitation had no guidance in place to help staff understand when these medicines should be offered.
- PRN protocols that were in place for constipation or pain relief held minimal guidance. One person's PRN protocol described taking, "one to three sachets daily" of the medicine with no indication why one, two or three sachets should be administered. This meant staff did not have clear guidelines to determine the appropriate dose of medicine to administer.
- We identified several discrepancies between the number of tablets recorded as in stock on the Medication Administration Records (MAR) and the number of tablets we counted. A senior member of staff was unable to provide an explanation for this.

The failure to ensure safe management of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the service had failed to adequately apply infection control measures. This was a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although further improvement is required, the provider was no longer in breach of Regulation 12 in relation to infection control.

● Cleaning was not always taking place in line with the requirements identified by the provider. This included the cleaning of frequently touched surfaces such as door handles.
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises; we observed some dirty plates used cutlery and half eaten food from breakfast left in the dining room on a trolley until lunchtime. One person started to eat some of this food before a member of staff intervened. Milk and butter were left out until lunchtime in a very warm environment.
● We observed that in the communal area where the majority of people sat, staff did not always ensure that people were socially distanced when seated.
● We were assured that the provider was accessing testing for people using the service and staff. People, and staff, were regularly tested for COVID 19 infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.

Assessing risk, safety monitoring and management
● Risks were not adequately assessed. Where people displayed behaviours which challenged others, staff were not provided with detailed guidance on how to manage this and minimise the risk of harm. Three people experienced psychological agitation; one of the people had been displaying violence towards staff and other people but no risk assessment had been implemented. One staff member told us, "I wish there was some guidance, we can't keep safe."
● Other risks such as choking, self-harming and falls, had not been adequately assessed and a risk assessment put in place to provide guidance for staff. This placed people at increased risk of harm.
● Systems in place for managing people's risk of constipation was not robust. No one was allocated to have oversight of any related concerns which did not enable potential concerns about people's health to be quickly identified.
● There was not always guidance for staff to support people's health needs. We noted one person had an infected eye. Until we brought this to the attention of the registered manager, staff on shift in the morning had not reported this. There was limited information about the eye infections which this person had suffered with for several months. The care plan did not inform staff what to look out for or what action they should take if the infection appeared.
● Some people required support to reposition, due to the risk of developing pressure ulcers. When we looked at the repositioning records, we found that people had not been repositioned in line with their assessed needs. This increases the risk of people developing pressure ulcers.
● Accidents and incidents were recorded, but the information was not always clear as to who had been harmed and what actions had been taken following incidents to mitigate risk. This placed people at risk of on-going harm.
● Records relating to water temperature checks over the last three months were not made available to us as the maintenance person was away. We could therefore not be assured that the hot water temperatures were safe and people were not at risk from scalding.

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

● There was a fire risk assessment in place, but some recorded actions were outstanding. The manager told us they were working through them and had contacted trades people to carry out works. We will follow this up at the next inspection. 12 staff were not up to date in fire safety training.

Staffing and recruitment

● There were insufficient staff deployed to ensure people received their care in a timely manner and that their safety was monitored. Staff we spoke with raised concerns that it was not always possible to meet people's needs. One staff member said, "I've come on shift and people are sitting in saturated chairs as they haven't been [assisted to the toilet]. I worry when I leave shift, it's not morally right." A relative said, "The level of care is not there for [relative] to be safe, there are not enough carers."

● Staff had not received training relevant to their role. This included dementia, safeguarding and managing behaviours which challenge. Supervision sessions for staff had not taken place in line with the providers policy.

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

● Staff were recruited safely, and the required pre-employment checks were undertaken.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse. Not all safeguarding concerns had been reported to the local authority or CQC. This meant there was not always independent oversight to ensure people were fully protected.

● There was not an effective safeguarding system in place that the manager could refer to, and this also caused confusion and made it difficult to ascertain which concerns had not been referred to the local authority.

● 11 staff had not received training in safeguarding adults.

● Following the inspection, we asked the manager to make referrals, and to check others had been received by the local authority.

Learning lessons when things go wrong

● The provider had failed to ensure lessons were learnt and was subsequently still in breach of regulations.

● Lessons were not learnt from incidents to reduce reoccurrence. There was no effective oversight of incidents which had occurred in the service, placing people at risk of harm.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
● Due to the systemic failings outlined in this report, people living at the service did not benefit from a caring culture.
● The previous inspection identified that people's privacy and dignity were not always respected. At this inspection we found this had not improved.
● We observed one person being assisted to walk; their trousers fell down around their ankles and they walked a number of steps in this position before staff noticed. We could see their continence aid needed changing, but they were sat down at the table without this being addressed.
● Relatives we spoke with also voiced concerns about their family members personal care. One relative told us, "My [relative] is incontinent, but is not given any pads. Every time we take them out, [relative] is soiled. [Relative] isn't showered enough; they smell." Another said, "One day when having a visit through the window [relative] looked dressed very strangely. I asked [relative] what they were wearing, and they lifted up their jumper and [relative] had nothing on underneath, that is not how my [relative] dresses."
● We also observed people being hoisted in the communal lounge. On one occasion the privacy screen was positioned incorrectly so that the person was still exposed to several other people sitting in the communal lounge. One person told us, "Yesterday there was a [person] in the lounge with nothing on, staff just left them."

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity;
● People did not always receive person centred care due to the poor staffing levels. People living at the service did not always receive safe care. For example, where people had come to harm, reduction of risk was not always explored.
● Staff were observed to be kind and caring. However, they were under increased pressure due to the failings identified in this report and therefore unable to deliver the care they wanted to.
● We observed care to be task focussed, as staff did not have the time to spend with people. One person told us, "I don't hardly see anybody; they [staff] might just stick their head round the door and then off they go." Another said, "It's a home, but it doesn't feel like my home. What you see is what you get."
● Whilst the service supported people who lived with a disability and/or an impairment, staff had not received training in areas such as equality and diversity.

Supporting people to express their views and be involved in making decisions about their care

● People said they were not involved in creating their care plans. One person said, "Never seen a care plan, have I got one?" Relatives said they were involved when care plans were first written but not since. A relative said, "I wrote out a care plan for the manager when [relative] first came in. I had been caring for [relative] for months and I wrote down the routine. I have never seen a care plan though." Another said, "I have never been asked for feedback, and they have no meetings at all."

● Resident surveys were completed on a regular basis and showed generally good feedback. However, these were not always reflective of the feedback we received from people using the service as highlighted in this report.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- There was not always sufficient and up to date guidance in care plans around the specific needs of people. Care plans did not provide staff with sufficient information and guidance so they could respond positively and provide people with the support they needed in the way they preferred. One staff member told us, "I can deal with [people's] challenging behaviours as I have a background in care, but some of the newer staff don't and they just look scared."
- The care and treatment provided by staff was task-centred rather than in response to people's individual needs. Staff did not have the time to provide meaningful interactions with people. One staff member said, "We cant spend time with people as we would like to. Its impossible"
- Training and development for staff was not adequate to ensure they understood the importance of human rights and diversity. Training records showed that staff working the service had not completed this training.
- During lunch there was one member of staff in the dining room with 18 people, many of whom needed assistance to eat. We observed two people eating with their fingers, one attempting to eat with only a knife and several who needed assistance to eat but were left staring at their food for a long period. One person said they didn't want lunch. They were left with no food and staff did not try to encourage or offer an alternative.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans included COVID-19 plans to set out how they would be supported through the pandemic. However, how people maintained social contact with those that were important to them was not always clear. Care plans were not fully reflective of people's mental, emotional and social needs.
- We observed that throughout the majority of the day, people were sat for long periods of time with no meaningful interaction. People told us there wasn't always very much to do. One person told us, "I go and sit outside, come in for dinner, then go to bed and sleep". Another said, "I read, and watch TV but it's a boring old life. They don't do any activities here at all, you would expect it in a place like this". And a third person said, "I get very fed up."
- In the morning, we observed a member of staff provided a few people with musical instruments and was attempting to engage with them. The television was still on with a radio station on very loudly. In the afternoon, the same member of staff was making cakes with two people. Other than this, interaction was minimal as staff did not have the time to give.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff knew how to communicate with people to understand their wishes if their needs were not complex. However, where people were living with dementia and/or had behaviours which challenged, staff had not always received appropriate training to understand how best to communicate with people to provide the most effective care.

● Care plans included a section on people's communication needs, however, in situations where people's moods became heightened or they felt anxious, there was limited guidance for staff.

● The service was not dementia friendly; there was minimal navigational signage, and a lack of interactive activities.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place. The manager kept a log of complaints, however the way the information was written was confusing. For example, someone had complained about, 'missing clothes and a bruise'. No other information was written down about what had happened, and it was not clear who had made the complaint.

● People told us they wouldn't always complain as they weren't sure issues would be listened to. One person said, "I have thought of complaining. An incident happened once and [manager] saw it, she didn't help me at all. She was the top woman, so who am I going to make a complaint to, she could just change what I said." A relative said, "I complained three times about [relatives] wheelchair, it was filthy, food, down the sides, spills all over it, you could have grown things in it. It has been done now. I go straight to [manager] I feel I'm listened to, but things don't get done as quick as I would like it."

End of life care and support

● The majority of staff had not received training in end of life care. One person living in the service was receiving end of life care.

● Whilst care plans were in place in relation to end of life needs, they did not always include how people would like to spend their final hours, or who they would like to be with them. Additional person-centred information was required to ensure people's wishes were known.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our previous inspection we found that the service was not effectively assessing monitoring and improving the quality of the service provided. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made, and the provider remains in breach of Regulation 17.

- Despite the issues being identified in October 2020 the provider had not resolved the breaches from the last inspection and new issues had also emerged. The failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of harm.
- Systems for identifying, capturing and managing risks and issues were ineffective. Audits had not fully identified the deficiencies we found at this inspection. This was a failure to manage risks posed to the health, welfare and safety of people. The provider visit carried out in March/April 2021 highlighted some similar issues, which had still not been rectified.
- The action plan submitted following the last inspection stated that audits would be monitored by the operations manager who would follow up on all actions to ensure trends were identified, and lessons were learnt. We found that analysis of incidents were not carried out to improve the quality of the service.
- People were not always protected from the risk of harm. Some safeguarding concerns had not been properly investigated and had not been referred to appropriate authorities such as the local safeguarding team and CQC as required. This meant there was no independent oversight to ensure people were fully protected.
- Effective systems were not in operation to support a culture of learning and improvement. The provider had not ensured that its workforce was adequately trained and skilled to work with vulnerable older people, many of whom were living with complex needs. Nationally recognised evidence-based guidance was not used when delivering and reviewing care, for example in falls.
- Systems for communication between staff were poor; incidents which staff told us had occurred, the manager was not always made aware of.
- The dependency tool showed that the calculated number of staff on shift did not always reflect what was on the rota, meaning staffing levels were lower than had been assessed. Staff and people told us there was not enough staff. One person said, "I just sit and wait, sometimes I might wait half an hour". Another said, "If

I ring my alarm, I can be waiting anything from 10 minutes to half an hour".

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager had not submitted notifications about events such as safeguarding incidents to CQC as they are required to do by law. People and staff had been physically assaulted, but these incidents had not been reported to CQC.

The failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The service operated a culture that exposed people to the risk of harm as safeguarding concerns were not always reported and investigated fully.

● Risks that affected people and others were not properly assessed to reduce the risk of recurrence. People did not always receive person centred care due to the low staffing levels.

● Staff were observed to be kind and caring. However, they were under increased pressure and therefore were unable to deliver the care they wanted to, or spend any quality time with people. One staff member said, "I've reported things before to [management] but nothing gets done. Staff don't always act appropriately, but if you tell someone about it nothing happens. I'm looking for another job as no one listens, and it just gets worse."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Two people's relatives told us communication was poor and they had not been informed about how their relative was. One relative told us, "There have been three different managers. I have asked them all to ring me, and no one has ever called me back. We have now complained to [relatives] social worker". Another said, "It would have been nice to get a phone call during lockdown to let us know how [relative] was doing. we received no updates on any policy changes around visiting. I used to like it when details of [relatives] care were written down on paper as I could see it, now I just have to take their word for it."

● Staff we spoke with mostly felt unsupported. One staff member said, "New staff don't always understand dementia. We have really complex people who hit out, and I don't think some staff know what to do. We haven't had any training. The new manager seems ok, but there are a lot of problems [at the service]. I'm hoping things will get better." Another said, "I don't feel valued, I'm thinking of leaving as I can't work there if I can't do my best. The staffing levels are so poor I can't do my best however hard I try."

● 'Resident' surveys were issued on a regular basis to hear people's views on the care they received. The results were mainly positive, but were not reflective of the feedback from people that we received.

Working in partnership with others

● The service had worked with the local authority and healthcare professionals such as district nurses and dietitians.

● Feedback from external professionals about working with the service was mixed. One told us they found the new manager 'combative' when they tried to discuss people's needs. Another felt they were working well and had made improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always respected. People were sometimes left in undignified situations 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff deployed to ensure people's safety and that people received their care in a timely manner. 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The manager had not submitted notifications about events such as safeguarding incidents to CQC as they are required to do by law. 18 (1) (e)

The enforcement action we took:

NoP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not adequately assessed, and plans put in place to mitigate risk as far as possible. Medicines were not always kept securely, and guidance was not always in place for staff when administering 'when required' medicines. 12 (1) (2) (a) (b) (c) (g)

The enforcement action we took:

NoP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place for identifying where improvements were needed were not being used effectively. Oversight of risks affecting people's safety were not analysed to ensure risk was reduced. There were not enough staff who were not suitably trained Reportable incidents were notified to CQC.

17 (1) (2) (a) (b) (c)

The enforcement action we took:

NoP