Barchester Healthcare Homes Limited

Beaufort Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Beaufort Grange on 11 August 2015. During this inspection, we found six breaches of the Health and Social Care Act 2008. Following the inspection in August 2015, the registered manager wrote to us to say what they would do to meet the legal requirements of the Health and Social Care Act 2008. They told us they would meet all of the regulations by 31December 2015.

During January 2016 and February 2016, we received a significant number of concerns about staffing levels and care provision. This information of concern was received from people living at the service, their relatives, staff and from healthcare professionals who had visited the service. As a result of this information we undertook a comprehensive inspection of Beaufort Grange on 23 February 2016. As part of this inspection, we checked to see if the service was meeting the legal requirements for the six regulations they had breached at our inspection in August 2015. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for 'Beaufort Grange, on our website at www.cqc.org.uk.

Beaufort Grange provides accommodation for people who require nursing or personal care to a maximum of 74 people. At the time of our inspection, 67 people were living at the service.

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

The provider had not ensured there was enough staff on duty to meet people's needs. There was inconsistency in undertaking an accurate assessment of the risks to people's health and safety. This placed some people living at the service at risk of receiving unsafe or inappropriate care or treatment. We also found there were issues of concern around the management and safe administration of medicines. The service was not consistently clean and appropriate systems were not in operation to reduce cross infection risks.

The provider had not implemented sufficient measures to ensure that people's nutrition and hydration needs were consistently met. We made observations that the dining experience for some people was not enjoyable due to insufficient numbers of staff being available to support people. The service had not fully complied with the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. This placed people at risk of being unlawfully deprived of their liberty. In addition to this, the provider was not providing care in line with people's consent and with mental capacity legislation.

Not all staff put into practice their knowledge of promoting people's privacy and dignity. We observed good interactions between people and staff. However, we made observations where people's dignity was not

properly maintained and communication between staff and people was not caring and reassuring when people were distressed or anxious. The provider had not been consistently responsive to people's needs and we saw examples of poor care being provided and other care not being given in line with people's assessed needs. We saw that some care provision had not been designed in line with people's preferences. There were insufficient governance systems to monitor the health, welfare and safety of people. Inaccurate records also placed people at risk of receiving inappropriate or unsafe care or treatment.

Staff we spoke with were knowledgeable about procedures around safeguarding and whistleblowing. The permanent staff we spoke with understood the needs of the people they cared for and the provider had safe recruitment procedures for new staff. Care records showed that people accessed health professionals as required. The provider had a clear complaints policy and the complaints currently being investigated by the provider and registered manager had been responded to in accordance with policy. The equipment and environment in which people were cared for was monitored to ensure it was safe.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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

There was insufficient staff to meet people's needs

People's risk assessments contained unclear and conflicting information

The management of medicines was unsafe

The service was not consistently clean

Staff recruitment procedures were safe

The equipment and environment in which people were cared for was safe

Is the service effective?

Inadequate

The service was not effective

People were not always effectively supported with their nutritional and hydration needs

The service was not meeting the requirements of the Deprivation of Liberty Safeguards.

The service had not consistently acted in accordance with the Mental Capacity Act 2005

People could receive support if required to ensure their healthcare needs were met.

There was a training and induction system for new and existing staff

Is the service caring?

Requires Improvement

The service was not always caring

People and their relatives gave mixed responses about the caring nature of staff

Staff told us they felt they could not always provide personalised care due to the current staffing levels

Not all interactions we observed promoted people's dignity and privacy

The permanent staff understood the care and support needs of the people they cared for

We observed positive interactions between people and staff

Is the service responsive?

Inadequate

The service was not consistently responsive

People did not always receive care in line with their assessed needs

Care records did not demonstrate that a person centred approach to care was consistent

Care plans did not always provide enough detail for staff on how best to support people

We received a mixed review of the activities within the service

The provider had a complaints procedure and current investigations were being completed in line with the procedure

Is the service well-led?

Inadequate

The service was not well-led

Governance systems to monitor the welfare of people were not effective and placed people at risk

People's care records placed them at risk of unsafe or inappropriate care or treatment

We received mixed views about the current leadership at the service

Staff said morale was currently low and said management changes and lack of communication were factors

The registered manager had not received internal support from the provider to improve the service since our last inspection

Beaufort Grange

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 was carried out by three inspectors and a specialist nurse advisor. When the service was last inspected during August 2015, six breaches of the legal requirements were identified.

Before the inspection we reviewed the information that we had about the service including the information of concern we had received from people, their relatives, staff and healthcare professionals. We also reviewed the statutory notifications the service had sent us. Notifications are information about specific important events the service is legally required to send to us.

Some people in the home were living with dementia and were not able to tell us about their experiences. We used a number of different methods to help us understand people's experiences of the home such as undertaking observations. This included observations of staff and how they interacted with people and we looked at nine people's care and support records.

We spoke with seven people who used the service, seven people's relatives and spoke with 12 members of staff. This included the registered manager and the deputy manager. We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Inadequate

Is the service safe?

Our findings

At the inspection of Beaufort Grange in August 2015, we found that the provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of people using the service. In addition to this, the provider had not consistently undertaken or maintained an accurate assessment of the risks to the health and safety of service users or consistently done all that was reasonably practicable to mitigate any such risks.

During this inspection, we found the provider had not taken the action they had planned to in order to meet this regulation and to reduce the associated risks to people. In relation to staffing levels, many of the concerns we received from people, their relatives, staff and healthcare professionals related to the poor staffing levels at the service.

In addition to a continuation of the breaches we found at our last inspection, we also found that people were additionally placed at risk of harm through the unsafe management of medicines and the service was not consistently clean.

There was still insufficient staff numbers on duty to meet people's needs. At times during our inspection, it was difficult to locate a member of staff. All of the care staff we spoke with said they felt there was not enough staff on duty. In one unit, there were two members of staff caring for nine people. One staff member said, "I don't get a break, I stay on the floor all the time." When we spoke with staff during the afternoon about staffing levels one staff member said, "It's fine now, because they've [people living at the service] all been fed and watered so they're sleepy".

On one occasion we walked onto one unit and there were no members of staff there at all. They had gone to assist staff on the neighbouring unit. This meant there was a risk of harm to the people left unattended. Some people did not always have access to a call bell and some people on the empty unit were unable to use the call bell. One person was unravelling a bandage on their leg which meant there was a risk that they or others could trip on it.

We saw that insufficient staffing numbers had an impact on the dining experience of people. For example, in one area, the tables were not laid, and there were no condiments in sight. There were not enough staff to assist people with their meals, which resulted in some people eating while others sat at the same table waiting to be assisted. People were not always told that staff would assist them when able. We observed one person sitting with three others. Two people were eating independently, and one was being assisted. No member of staff reassured the person without their meal that their food was being kept warm or that someone would be with them soon.

The registered manager told us they used a dependency assessment tool implemented by the provider to calculate staffing levels at the service. From reviewing this tool with the registered manager, it was evident that despite the current staffing concerns the registered manager had put more staff on duty that the dependency calculation tool suggested the service needed. This indicated the tool may be either being used

inaccurately or the electronic calculations made by the tool were not aligned to people's needs at the service.

People and their relatives gave negative feedback about the current staffing levels at the service. One relative told us, "The staffing changes so much from day to day." Another commented, "They only have one hoist on this floor so as well as being short of staff there is an extra wait for a hoist to be free." One relative who was very concerned said, "I don't have a day off because I'm worried she won't get the care." This particular person was not able to use the call bell. The care records stated the person should be checked hourly because they were unable to use the call bell. This included when the person was in bed. There were no records to confirm these checks were completed and staff told us the person was not checked every hour.

Other comments from people's relatives included, "Sometimes she has waited for up to two hours for the commode, staff refuse to support people when they are doing lunch [for people]. Even when prompted they sometimes then take their own break first." A member of staff we spoke with told us, "Staff numbers were dropped on this floor [1st floor] but they were increased again last week so it's not too bad if everyone [staff] turns up."

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

At our last inspection we found the provider had not consistently undertaken or maintained an accurate assessment of the risks to the health and safety of people or consistently done all that was reasonably practicable to mitigate any such risks. During this inspection, we found the system to monitor accidents and incidents had improved, however people's records for their assessed risks continued to be incomplete and inconsistent.

For example, the wound assessment records and management plans for one person were incomplete and inconsistent. As a result of this, the person's care plan was not followed and we saw the type of dressing used was changed without a documented reason. We also saw the dressings for the wound were not changed daily as prescribed in the care plan and the wound assessment and treatment record was used inconsistently. The progress of the wound was not accurately monitored. This meant the person was at risk of developing further infection and the wound was at risk of further deterioration.

During the inspection, we saw an example of a person receiving unsafe care where staff had not followed guidance to reduce the risks to people that had been identified. One person's mobility plan and personal hygiene plan showed it had been reviewed in February 2016. Within the plan, it stated that due to episodes of fatigue and loss of strength, the person now required two members of staff to move safely. However, we observed a member of agency staff assisting the person out of their armchair on their own. The person appeared to be weak and was struggling to stand with the assistance of only one member of staff. Another member of staff approached them and helped to assist the person into a wheelchair. We spoke with the agency healthcare assistant, they said they had not read the care plan, but said they knew that two people were needed to assist with personal care. They said "I thought I could stand [service user name] on my own." This meant there was a risk of harm to people because they were not always being moved in accordance with their assessed needs.

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

Medicines were not properly and safely managed. Staff did not always follow the provider's policies and procedures with regard to the supply, recording, administration and disposal of medicines. The service currently used an electronic medicines management system. Medicines were ordered and received monthly. When medicines were received they were checked and signed for. Medicines were stored safely in locked rooms. Appropriate temperatures were maintained and recorded including the monitoring of fridge temperatures.

Staff said they were not confident with the electronic system in place. The registered manager later told us they were changing to a different pharmacist on 12 March 2016 and were discontinuing the use of the electronic system. We saw from reviewing the medicine records that the absence of confidence and competence in using the electronic system had resulted in several errors being made.

For example, an error had occurred with a recent medicines order and there were duplicated entries into the electronic records. On the day of our visit, the nurse on duty told us they were in the process of trying to resolve the problem. The nurse told us there was just one nurse within the service on the day of our inspection who knew how the system worked, and their help was needed to resolve the error. From reviewing the medicines, we were unable to reconcile stock amounts because the supporting documentation was inaccurate. In addition to the duplication, we saw there was additional inaccurate recording. For example, for one medicine the amount received was recorded on the electronic record as 110 tablets. The actual box containing the medicine stated there were 112 tablets.

We observed staff administering medicines during the inspection and it was evident that absence of knowledge of the electronic system placed people at risk. For example, during the medicines round staff signed when they had given the medicines. However, when asked staff were not able to explain why some medicines had a 'red' status for the previous day. They told us it may have indicated a medicine had not been given, however staff were unsure. This meant people may be at risk of receiving the incorrect dosage of medicines.

Staff had not consistently acted in accordance with the provider's medicines policy. For example, the policy contained a list of medicines that may be used for homely remedy administration. We saw that a certain suppositories were held at the service and recorded in the homely remedy book. However, these items were not included in the provider's list. When these medicines were given they were recorded in the homely remedy book. The provider's policy stated they should also be recorded on a Medicines Administration Record [MAR] for the person when they received them. They were not recorded on the MAR sheet. In addition, the provider's policy stated the GP must sign a homely remedy agreement for each of their patients and this must be reviewed on an annual basis. There were no records available to confirm this was in place.

Medicines were not always dated when opened. For example, paracetamol suspension and simple linctus were not dated, and both had been opened. The homely remedy record book recorded the paracetamol suspension had been given to one person on 25 June 2015. This indicated this medicine had been opened approximately eight months prior to our inspection and in excess of the suggested the maximum storage guidance. Medicines were not disposed of safely and not in accordance with the provider's policy. Medicines were not routinely recorded in the medicines disposal book. The nurse told us they recorded the disposal of controlled medicines but not routine medicines. We saw two medicine disposal books. There were no records of medicine disposals in either book from 23 April 2015 until 19 January 2016.

Medicines prescribed as required [PRN] had supporting care plans. For one person, they required pain relief for pain in their hip. The care plan stated they were able to express pain and ask for pain relief when they

needed it. For another person, the pain plan had not been updated to reflect the change of prescription in response to their changed need. This person also had a Deprivation of Liberty Safeguard in place. There was no documentation to confirm how this person communicated their level of pain and there were no records to describe the observed effects of the medicine when it was given.

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

The service was not consistently clean and hygienic. Staff said the cleaning staff worked until 2pm and that this meant they could only clean one unit per floor and not both. One visitor showed us the bathroom of the person they were visiting. There were faeces on the wall and floor next to the toilet and a catheter stand in the bathroom also had faeces on it. When we showed this to a member of staff, they showed us that another bathroom was also dirty because it had not been cleaned that day. Some people's relatives we spoke with commented negatively about the cleanliness of the service. One person's relative told us, "Cleanliness is not good, her [person's relative] has even had to clean her toilet." We also received information from a visiting healthcare professional that the cleanliness in the service was poor. People's bins in their rooms had not been emptied and there was debris on the floors in bedrooms and communal areas.

We observed staff who were attempting to move someone using a hoist. They were unable to locate the person's sling and when we asked if people had their own slings for personal use, staff said, "They should have their own but they don't. We have one in this unit, but it was dirty this morning so we sent it to the laundry." This resulted in the staff saying they would "borrow" the sling from the adjacent unit. This took them approximately ten minutes which meant the person had to wait to be moved. The Department of Health guidance, Prevention and Control of Infection in Care Homes 2013 states, 'Slings should be laundered in hottest wash cycle allowable according to the manufacturers' instructions and not shared between residents.' Because slings were being used communally, there was an increased risk of the spread of infection.

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

We received mixed review from people and their relatives about if they felt safe in the service. People and the relatives of people living on the ground floor of the service where people were more independent spoke positively. One person commented, "I feel very safe here". Another person's relative said, "It's not perfect, but I do feel my relative is safe. They are independent and are not at risk of falling." We did however speak with some people on the first and second floor who did not feel so safe.

One person told us they felt unsafe and that that service had not improved since the last inspection by the CQC. They said, "The situation has not improved, the call bell, you can wait forever and frankly may not see anyone. I worry about whether someone is going to respond, if they do you only get the minimum, the regime doesn't give them enough time. They always have to rush, it's been gradually getting worse over last 3-4 weeks. It really does unnerve me, I see a trend of it getting worse, I think it is close to being unsafe. I would be really worried if I needed urgent attention, especially at night." We also received information about a serious argument between two male care staff during a night shift and the person told us, "I feel very vulnerable and scared."

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced

Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had systems that monitored the environment and the equipment within the service. There were systems that monitored the maintenance of the service in relation to hoists, slings and other mobility equipment such as wheelchairs and specialist bathing equipment. The nurse call bell system was serviced to ensure it was serviceable and regular water temperatures were completed. There was fire folder that showed emergency evacuation plans for people and we saw supporting records that showed the fire alarms, emergency doors and lighting were regularly checked and tested.

Inadequate

Is the service effective?

Our findings

At the inspection of Beaufort Grange in August 2015, we found that the provider had not ensured people needs were consistently met in relation to sufficient nutritional and hydration. The provider had not consistently met reasonable requirements of a service user for food and hydration that arose from the service user's preferences or cultural background.

During this inspection, we found the provider had not taken the action they had planned to in order to meet this regulation and to consistently meet people's needs in relation to nutrition and hydration. Some of the concerns we received from people and their relatives related to the dining experience at the service and the level of support people received with nutrition and hydration.

In addition to a continuation of this breach we found at our last inspection, we also found that the service had not fully complied with the requirements of the Deprivation of Liberty Safeguards(DoLS).Guidance in accordance with the Mental Capacity Act 2005 had also not been followed.

The service had not ensured people were always supported to have sufficient to eat or drink. There was a new chef in post who spoke very positively about their role and how they wanted to involve people to develop the meal experience. They said they had met the majority of the residents and had asked them the kind of food they would prefer to eat. They gave examples of how they had sourced foods based on people's choices. For example, they said one person had specifically requested skate wings and they had subsequently cooked these for them. One visitor said, "There were issues with the food before, but the new chef has been very good, he goes and speaks to people and asks what they would like on the menu."

The meal experience for all of the people using the service was not the same. We observed lunch in different areas of the service. Many of the staff serving food to people did not know what the food was. There was no menu available, and staff did not know if the lasagne was beef or chicken. When people with dementia were offered a choice of meals, they were not shown plates of food, but were repeatedly asked, "Do you want lasagne or fish?" This does not demonstrate people were supported to make choices with their meals.

In a different unit, the meals were delivered into the dining room by a kitchen assistant who told us people had made meal choices during the morning. We were later told by people and staff they had not made choices. Staff did not know what was going to be served. People in this dining room were also not given choices. They were not asked or shown the meals to help them make a decision and the staff did not know what the meals were. We heard one member of staff ask, "Is this chicken in with the pasta?" The response from another member of staff was, "No I think its Veggie." It was later confirmed this meal contained chicken.

Within a third unit people were being brought or were coming to the table at 12.20pm. The lunch meal did not arrive until 12.45pm. A member of staff commented to people that lunch was late. A person responded to this by saying, "It's late a lot lately, it was late last night." People were observed saying to each other about how it would be nice to know in advance what meal is. One resident said, "[We were] promised we

would have menus to our rooms but that's not happening. Would be nice to know in advance so we could choose. Could then order something else if don't like it." When the meal trolley did arrive, a staff member asked a member of the catering team what flavour the soup was. The member of catering staff replied with, "I don't know, smells like mushroom." The staff member then proceeded to put their head right into trolley to smell it. Additionally we observed one person asked what type of lasagne was being served. The member of the catering staff said, "I'm not sure." They then poked a fork into it and replied, "Chicken."

We found that where people received support with liquid nutrition through a Percutaneous Endoscopic Gastrostomy (PEG) tube guidance for this was not clearly recorded. For example, within one person's records we were unable to establish the amount of fluids the person had per day. We spoke with a nurse on duty who explained that they had recently increased the amount of fluids for the person. They told us the person now had 600ml of fluid four times per day. Within the care records there was no care plan or rationale for the fluid amounts being given to the person. This presented a risk that agency nursing staff may not have given the person the prescribed amount of fluids. This meant there was a risk the person may not receive the required level of prescribed fluids as described by a healthcare professional.

Some people were having their fluid intake monitored. The charts were not always fully completed and there was no record of target intakes for people. The escalation process was not clear if staff had concerns that people were at risk of malnutrition or obesity. The food and fluid records were supposed to be calculated daily, however these were not always completed. This concern had been raised at the previous inspection. One person's fluid charts showed that on 16 February 2016 they had received a total intake of 515 mls of fluid. The chart had been signed by a member of staff indicating that they were aware of the limited intake. No target intake was recorded to indicate if the amount consumed was in line with the person's assessed needs. When we looked in the care notes for that day to see if the reduced intake had been documented, there was nothing documented for that date. On 17 February 2016, the person's fluid chart showed they had received a total intake of 450 mls. This had also been signed by a member of staff. The care record for that day stated, "All ok, no concerns." This showed that staff were not monitoring people's intake effectively to ensure they received adequate fluids. In addition, when people received a reduced or low intake, there was no escalation process in place to highlight this.

Food charts were also not consistently filled in by staff. Staff had not always accurately written what people had eaten so it was difficult to assess if people had received a sufficient intake. For example, one person's chart stated they had been offered soup. A member of staff had ticked next to the word soup. They had documented, 'Main' to describe the main meal and again, ticked next to it. The quantities of food were not documented and there was not a description of the type of food consumed. Other food charts had been poorly filled in. One chart stated a person had eaten "Soup, chips, cottage and sponge." This did not demonstrate that people had received adequate nutrition to meet their needs.

We saw within some people's records that body weights had not been recorded in line with people's assessed needs. For example, within one person's record it showed that the person was to be weighed at least monthly. The supporting records showed the person was weighed in August 2015, September 2015 and the final entry was October 2015. We asked the nurse on duty and a member of care staff who told us that nowhere else do they record weights and that weights were recorded in care records on the nutrition form. The care staff member told us people were regularly weighed as part of the 'Resident of the Day' scheme in operation at the service. We reviewed the person's record that showed they were 'Resident of the day' on a day in February 2016. The record of this demonstrated that no weight was recorded on that day for this person.

This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The service had not fully complied with the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. DoLS authorisations had been authorised for two people in the service. We saw a record that showed that applications had been made for six additional people during 2015 and fourteen other people during 2014. There was no system in operation that monitored the status of these historical applications that showed whether they had been refused or approved. We observed one person repeatedly asking staff if they could go home. There was no record of a DoLS authorisation being applied for on behalf of this person. The log showed where applications had been discussed with relatives, but the care plans we looked at contained no evidence of discussion with people's relatives in relation to this.

We spoke with staff who told us they had received training and they had a basic understanding of the DoLS. However, the care staff, the registered nurse and the registered manager we spoke with in relation to two separate people were not aware of the DoLS status for these people. In one other person's records a completed mental capacity assessment stated the person did not have capacity to make decisions about their care. This was dated 16 December 2015 and stated a DoLS was to be applied for .There was no follow up in the person's records. The registered manager was not sure whether a DoLS was in place or not. This meant there was a risk that some people in the service may be being unlawfully deprived of their liberty. We discussed this with the registered manager who understood that authorisations were not in place for all the people who needed them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care and treatment was not always sought in line with legislation because mental capacity assessments were not decision specific and were not reviewed regularly. For example, one person had a completed mental capacity assessment undertaken for personal care and medication administration on the same document. Three of the plans we looked at did not have mental capacity assessments in place for the use of bed rails. Four people's plans we reviewed contained mental capacity assessments and for three of the people these were dated in June 2014. There was nothing in place to indicate if these had ever been reviewed.

There was no supporting documentation in place to show how best interest decisions were made following the assessment of people's capacity. Those people who lacked the capacity to consent had decisions made on their behalf, but it was not clear if family members or other healthcare professionals were involved in these decisions as there was no documentation in place to evidence this. For example, in one plan staff had documented, 'Lacks capacity to make decisions; all treatments given under best interests.' This did not show a decision making process had been followed showing what specific decisions had been made, who was involved in making the decisions and why they were in the person's best interests.

Some people had their medicines covertly administered by staff. This means that people are administered their medicines without their knowledge or consent if they do not have the capacity to consent themselves. This process can be completed following involvement, consultation and discussion between relevant people. There is a requirement that the decision should be taken in the person's best interest, and essentially that not taking the medicine would be detrimental to the health and well-being of the person receiving it.

The details of how people received their covert medicines were recorded on the electronic medication system to ensure staff administered the medicines as required. For example, for one person their notes stated, 'Covert medication order in place. Signed copy in [service user name] notes. Takes tablets crushed and liquids in small amounts of juice.' Details about the covert administration were not contained in the person's care records. The registered manager and staff were not able to locate the whereabouts of covert medication orders or agreements. The registered manager told us they thought the orders were all contained in one file, but the file could not be located during our visit. This meant there was a risk that staff administered covert medicines unlawfully.

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

Records showed that people had access to healthcare services such as a GP, chiropody, physiotherapy and other specialist support as required. Visitors we spoke with during the inspection said staff were swift to inform them if a doctor had been called for their relative. One said, "When my relative is ill, they call the doctor. They always let me know."

There were systems in place to ensure staff received supervision and appraisal, however these had not been fully implemented by the registered manager since the last inspection. At our last inspection we discussed supervision and appraisal with the registered manager. They told us regular and structured performance supervision and appraisal system would be started. We saw some evidence that a small number of supervisions had been completed in February 2016 but also some records showed that staff had not received supervision for in excess of 12 months. An appraisal system had still not been commenced. This was discussed with the registered manager and the newly appointed deputy manager. They informed us that staff supervision and appraisal systems were a priority and that they would be implemented soon.

There was a training schedule that ensured staff received appropriate training to carry out their roles. Staff felt they were given sufficient training to effectively support people and meet their needs. Staff had received appropriate training in a variety of relevant topics to meet the needs of the people. This included moving and handling, health and safety, fire and safeguarding. It was highlighted to the registered manager that staff had not received training in relation to behaviour that may be challenging. The registered manager told us the deputy manager would be arranging this training for staff. Nursing staff within the service also had the opportunity for continual professional development. Records showed that additional training in subjects such acquired brain injuries, bowel care, tissue viability and diabetes were scheduled.

The provider had an induction process which encompassed the new Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate.

Requires Improvement

Is the service caring?

Our findings

We received mixed comments from people at the service and their relatives about the caring nature of the staff. Some of the information we received from people and their relatives prior to the inspection was that although in general they found staff caring, the staffing levels at the service had a direct impact on the quality and standard of care being provided.

Staff we spoke with during the inspection reflected this. We spoke with nursing staff and care staff who told us the current staffing levels did not consistently allow them to be caring. This was due to constantly being rushed, not being able to take their time with people or to have time to sit and talk with them. Some staff told us it was upsetting and demotivating at times as they felt they could not always provide the high standard of care they wanted.

We saw and observed positive interactions with people, however not all interactions were positive and promoted people's dignity. For example, one person was clearly distressed and anxious during the day. They became visibly more anxious by the noises and shouting of some of the other people. They repeatedly questioned staff why they needed to be in the care home. The person told us they had found it very upsetting that staff had said they would never be able to return home. We heard the person calling to staff as they passed on a number of occasions was calling, "I can't bear it if I need to stay here." The person was also calling, "What can I do?" Staff sometimes stopped and reminded the person their relatives would be visiting. We heard one member of staff respond, "It's not our decision". This did not show the person's anxiety and distress was responded to in a compassionate, kind or reassuring way.

This person also asked a member of staff a question during the meal time. They did not have their question answered and were told, "Go and sit there for a minute." They asked another question, again saying they were worried they would never go home. The care staff responded, "Of course you can't, your [name of relative] is coming in though." The response was again not reassuring to the person who continued to appear anxious and distressed. Throughout the meal service the two care staff talked amongst themselves and did not directly engage with this person despite being with them to support them.

We spoke with a member of staff about this person later in the day. The member of staff we spoke with demonstrated they understood the person well and demonstrated what may reduce their anxiety and distress. They had given the person some socks to pair up and we observed the person sat quietly in a chair and began pairing the socks. They appeared engaged by this and calmer than they had been throughout the day. This demonstrated that not all staff were aware of how to reduce people's anxiety or distress as the person had been tearful and distressed for the most part of the day.

Although most personal care was given behind closed doors, we observed an example where this was not the case and the person's dignity was compromised. Whilst walking around the service in the morning, we walked past a person's bedroom and two staff were in the bedroom supporting the person to stand from their bed. The door was wide open and the person was wearing a night gown that was exposing the very top of their legs. This did not show the person's dignity was being protected by staff. Had the staff closed the

door to the room the person's privacy and dignity would have been maintained to a higher standard.

The provider encouraged people or their relatives to use a national website to give feedback on the service. We reviewed the website the day prior to our inspection. We found that since our last inspection in August 2015, a total of 4 reviews had been posted. The reviews were positive. For example, one from the daughter of a person who lived at the service read, "Wonderful home for my father. Really caring, friendly and helpful staff. When he died the end of life care provided for the last weeks of his life was as if he was a member of their own family. We could not fault it."

The permanent staff on duty knew people well. They knew people's preferences and their personal histories. However, as stated the staff were rushed and did not appear to have much time to spend talking to people. Staff told us that the frequent use of agency staff added an additional burden to them as agency staff often needed initial support when they started at the service. One permanent member of staff said, "Because we have so many agency staff, they are shadowing permanent staff, so things take longer to do."

Other staff we spoke with were able to demonstrate they understood people well. Staff could explain people's behaviours and the level of support they needed with day to day tasks such as personal care and mobility needs. One member of staff described the support they provided for one person who expressed their anxiety through pinching people, including staff. They were knowledgeable about how to assist the person and said, "I've got to know them really well, they trust me. I'm the only one who can assist with a shower without getting pinched."

We saw positive interactions of where staff supported people to maintain their dignity. For example, one person had soiled themselves and we observed staff walking them back to their bedroom. They were respectful towards the person and discreetly said, "Let's just go and help you have a wash shall we?" We made a separate observation when another person's incontinence pad had slipped down their leg, and staff said to them, "Shall we see if we can make you more comfortable?" They then provided the person the care they required to meet their needs.

Inadequate

Is the service responsive?

Our findings

At the inspection of Beaufort Grange in August 2015, we found that the provider had not ensured people needs were consistently met and that the service had been responsive to people's care and communication needs.

During this inspection, we found the provider had not taken the action they had planned to in order to meet this regulation and to consistently meet people's care needs. Some of the concerns we received from people and their relatives related to the provision of care and the service not being responsive to people's assessed needs.

At our inspection in August 2015 we found the service had not been responsive to people who were receiving care when they had a pressure ulcer. During this inspection we found insufficient improvements had been made and people's care needs were still not consistently met. For example, one had a long standing leg ulcer and commenced on a course of antibiotics as the ulcer was reported as infected on 5 February 2016. It was recorded the wound bed appearance was necrotic [dead tissue]. There was no reference to necrosis since this date. Records described the wound on 11 February 2016 as, 'oozing ++.' An entry made on 15 February 2016 recorded the wound as, "Still oozing but not too much". These descriptions should have been expanded to provide accurate detail which should have included the colour of wound exudate [fluid omitted through wound] and the detail of the area of necrosis. Records showed the wound was photographed on 9 February 2016, however the provider's wound photographic consent form was not completed.

The care plan stated daily dressing changes were required on this person's leg. On the 17 February 2016, the wound dressing plan was changed by an agency nurse and a different primary dressing was recorded on the wound care and treatment plan. There was no information about why the primary dressing had been changed but the frequency of planned dressing changes remained daily. The wound assessment sheet within the plan stated, 'Evaluation must be completed at each dressing change.' The entry noted the wound was deteriorating. Despite the person's wound being highlighted as deteriorating, there were no further entries on the wound assessment sheet since 17 February 2016. The daily progress and evaluation records noted there were dressing changes on the 17 and 20 February 2016. On 22 February 2016 at 4.40am it was recorded by the night staff the person had taken off their dressing. On 22 February 2016 at 08.06am it was recorded the dressing was replaced. There was no reason why the dressing had not been replaced straight away and the person's ulcer was left undressed for three hours and 26 minutes. This meant the person was at increased risk of further infection and deterioration because the leg ulcer was not protected during this period.

During the inspection, we observed the person had a foot to knee bandage loosely held in place. We spoke with a friend of the person who visited regularly. They told me, "I often find her dressing hasn't been changed. Recently I visited and found her in a puddle of liquid and staff were saying she must have wet herself but it was actually from her ulcer." They expressed concerns about the way the ulcer was dressed and told us, "I wish they would make sure the bandage was secure, it's often loose and so she sometimes does pick at it." This person's needs were not always met in relation to their footwear. Their care plan stated,

'Ensure [name of person] is dressed…..and is wearing slippers or shoes.' It was also stated the person may decline to wear footwear. The person was barefoot on the day of our visit and we did not see or hear the person being offered footwear at any time, despite one leg appearing cold. The person's friend told us, "I can never find her wearing slippers when I visit, even though I keep buying them for her. The staff always claim they can't find them or say they're lost."

One person at the service required assistance from staff for all aspects of personal care and was assessed as requiring daily bowel care to meet their needs. Should the person's bowel care procedure not be completed daily, the person was at risk of a potentially life threatening condition. Published guidance from 'The Duke of Cornwall Spinal Treatment Centre' regarding bowel care was within the person's care records. Information extract from this states, 'It is vital that you decide the time of day to carry out bowel care, and that you keep to this (i.e. mornings or evening, not a mixture of both). It is not possible to establish a good routine by frequently changing the timing of bowel care. It is necessary to carry out bowel care daily or on alternate days. This needs to be decided and kept to.' Information about a 'potentially life threatening' condition resulting from poor bowel care that can be considered a medical emergency was also available for staff to highlight the risk associated with poor bowel care.

From reviewing the person's records and speaking with the person, it was evident the person's assessed needs were not met by the service. We were unable to locate the person's bowel care records for January 2016 within the care files and staff could not locate it. We looked at the bowel care records for February 2016. We reviewed the period from 1 February 2016 to the day of our inspection on 23 February 2016. This showed 12 days where bowel care was not recorded as being delivered. In this period, it was not shown as given in the records for five consecutive days. This placed the person at severe risk of medical complications.

We spoke with the person about their care. They told us that in January 2016 they did not receive bowel care for a period of nine consecutive days. The records from the service could not be produced to check this. However, we found an entry from the person's records dated 1 February 2016. This record stated, 'Yesterday [service user name] very upset about her bowel care. Stated that she did not have her bowel care for 9 days.' The person also told us that the service had not ensured this care had been provided in accordance with their wishes and preferences. They told us, "[My] bowel care needs to be regular to train my bowel but not happening. I've been living in care for two years now and only here has it been a problem." I also mentioned to [name of registered manager] that I don't want a man doing my bowel care, they have just recruited three new [nationality of staff] nurses all are male, she [registered manager] told me she was not obliged to provide a female." This did not demonstrate that care was provided with a view to achieving people's preferences when ensuring their needs are met. Following the inspection the registered manager told us that they service had recently employed two new male nurses and not three.

Within a person's record and through talking to them, we established their continence needs were not consistently met by the service. The person had a catheter in place to support them with elimination. We reviewed the 'Record of Catheter Changes' form within their records. The care records showed the catheter should be changed every six weeks or sooner if required. On this record it was noted that catheter was changed on 18 August 2015. It showed then the next planned catheter change date was recorded as 6 October 2015 or PRN [as required]. It should be noted however that six weeks from 18 August 2015 would be 29 September 2015 so the original change date was inaccurate. The date of the next catheter change following this was recorded as 7 October 2015 with the date of the next planned catheter change indicated as 18 November 2015. The catheter was next changed on 27 November 2015, which was nine days late. The next planned catheter change was 8 January 2016, which was completed two days early on 6 January 2016. The meant there was a risk of infection to the person, with the associated discomfort and the added risk to

this person of further medical complications. The person was concerned due to the care they were receiving. They told us, "All I want is to feel safe and sure that staff know how to care for me. I am quite capable of advocating for myself but my voice is not being heard. Barchester are not living up to what they say. They are not meeting my clinical needs."

The service had not consistently met people's assessed needs in relation to physiotherapy. Within a care record it stated that a person 'Requires physiotherapy at least twice a week'. We reviewed the plan for physiotherapy to be followed by care staff. We saw this was evaluated between September 2015 and December 2015 but there were no further records since then. The person who was supposed to receive the physiotherapy to meet their care needs told us, "I have given up on this, there is never enough staff. Care staff are really nice, absolutely amazing but they have left in droves, new ones don't know what to do. They are frighteningly short staffed."

Some of the care plans we looked at showed that relatives had been involved in care reviews. One visitor confirmed they had been involved in developing the care plan for their relative on admission. However, care plans were not always person centred and did not always provide enough detail for staff on how best to support people. For example, we looked at the plan for one person who was living with dementia. The communication plan described the person as 'Confused and anxious. Rarely communicates verbally.' The plan informed staff to, 'Watch for body language' and 'Ensure to ask and inform what staff would like [service user name] to do.' The plan also informed staff to 'ensure the call bell was within easy reach.' We observed the person was sat in the lounge area during the morning. For some of that time a member of staff was assisting them with a drink, but they were then left alone. There was no call bell within their reach during this time, and it was unclear how staff would know if they needed assistance as the person did not communicate verbally. This showed that staff had not followed the care plan to ensure the person's needs were met.

Care records did not demonstrate that a person centred approach to care was consistent. For example, one person's plan in relation to their personal hygiene needs was person centred and included details such as the brand of face cream they preferred to use. However, their communication plan stated they had, 'Communication difficulties' and that only a few words could be understood by staff. There was no detail on how staff should attempt to communicate with this person. In the healthcare professionals section, there was an entry that showed that staff had discussed with the GP that the person called out a lot. It showed the GP had informed staff they felt this was 'behavioural' but there was nothing in the care plan to reflect this discussion, or to inform staff how to best support the person. In the same person's plan in the cultural and social section staff had documented, 'Values still relevant, no changes, see plan below' but there was nothing else documented.

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

We received a mixed review of the activities within the service. There were no organised activities on the day of our visit. We were told there were two designated activity coordinators employed at the service but neither were on duty. On the first floor, people who were mobile wandered without purpose and were not provided with social stimulation. People who displayed agitated behaviour were not distracted or given the opportunity to participate in any form of meaningful activity. Staff we spoke with told us they did not currently have the time to support people with activities or to sit down and engage with them. This was supported by our observations during our inspection. Staff appeared very busy throughout the day and were task focused and unable to provide personalised care. Other comments about activities were positive, and people's relatives spoke of visiting entertainers attending the service and they observed their relative being

engaged and excited by this. One relative said, "The activities co-coordinator and their assistant are very good, lots of things going on every day. They have thought of ways to engage my relative and keep them busy."

People and their relatives felt able to complain or raise issues within the service. The service had a complaints procedure. We reviewed the complaints record within the service and spoke with the registered manager about the current complaints. We saw that since our last inspection, two complaints had been received and both related to staffing levels. The service had acted and responded in accordance with their policy. We also saw a record that showed three people had complained directly to the provider and had elected not to complain to the service. These complaints were currently being addressed. One relative we spoke with said they had never needed to, and one other said they had raised, "One or two hiccups" with the registered manager and that these had been dealt with swiftly and satisfactorily.

Inadequate

Is the service well-led?

Our findings

At the inspection of Beaufort Grange in August 2015, we found that the provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. In addition to this, the provider had failed to send the correct notifications to the Commission as required.

During this inspection, we found the provider had not taken the action they had planned to in order to meet this regulation and to reduce the associated risks to people through poor governance. In addition to a continuation of the breaches we found at our last inspection, we also found that people were additionally placed at risk of harm through the inaccurate record keeping.

People were at risk of unsafe and inappropriate care as accurate and complete records were not maintained for people. This includes a record of the care and treatment provided to people and of decisions taken in relation to the care and treatment provided. For example, during our inspection we found multiple examples of inaccurate or incomplete records. Within one record there were various references to the person's leg ulcer. Sometimes the ulcer was noted as being on the right leg and sometimes noted as being on the left leg. The ulcer was on the right leg. Food and fluid charts were not accurately maintained. For example, one person's plan stated 'Encourage to drink 1.5litres per day.' There was no documentation to support or confirm if this was achieved. We found daily care provision records that had not been completed daily as required and omissions were seen. In addition to this, some records such as covert medication orders and wound care plans could not be produced when requested.

Governance systems were not robust and did not ensure the provider assessed, monitored and improve the quality and safety of the services provided. The current use of systems did not mitigate the risks relating to the health, safety and welfare of people. At our previous inspection we found the provider had governance systems that were not always accurate or used correctly. During this inspection, we found that that risks identified during our inspection had not been identified through an effective, robust and regular governance system. We found a clinical governance file that showed a monthly a total number of records for people with care needs relating to skin care, weight loss or safeguarding matters.

This had not however ensured risks to people were reduced. There was no system that ensured senior management reviewed wound care records, nutritional records, bowel records or records relating to people's care needs. This had resulted in poor and inaccurate recording keeping being identified during our inspection, together with omissions by staff in care provision. We saw that the registered manager had completed an unannounced site visit during the night over the Christmas and New Year period. This had resulted in some records being checked, for example food and fluid records, repositioning charts and medicine records. The audit highlighted that some records reviewed required updates. There had been no second audit or follow up to this initial audit to ensure these records had been updated and there was not evident system in place to allow this to happen. The absence of a second audit or follow up had not ensured that initial issues identified had been addressed by staff and rectified.

At the last inspection we identified the service had failed to notify the Commission of a serious injury notification as required. During this inspection, although we found that most legally required notifications had been sent to us since the last inspection, we found that a Deprivation of Liberty Safeguard (DoLS) had been authorised by the relevant local authority in October 2015. The required legal notification had not been sent. This further demonstrated the absence of governance systems in operation to ensure all notifications were sent as required.

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

We received mixed views about the leadership and management of the service. For example, relatives were positive about the leadership. One said, "I don't know the manager personally, but I know most of the other staff really well. I'd be happy to speak to anyone." Another visitor said, "I have been so impressed with the manager. They have been very open about the fact there have been problems here, the use of agency etc." The same visitor said "I can't imagine I would want to move my relative from here, even if the CQC report is bad." However one relative did comment, "I feel [service user name] could be unsafe at times. It is a worry. I used to enjoy coming, not now, so deflated."

Unfortunately some negative comments were received during the inspection and other people expressed their dissatisfaction with the management of the home. A Comment from one person was, "Since the recent management changes, things have slipped, little things are not so good, like napkins are not put on the tables," One relative said that conversing with the new registered manager was like, "Talking to a brick wall." Another commented, "She [registered manager] doesn't speak much to me now since I complained and I'm now waiting for a response from [provider's staff member], one of the companies care director's." Another person told us, "There is no attention to detail, things have got a lot worse."

Most of the staff we spoke with throughout the service felt morale was low and told us that management changes and lack of communication were the main cause of this. Some of the staff we spoke with did not envisage working at the service long term and some told us they were actively looking for alternative employment.

We reviewed the records that showed the support the registered manager had received from the provider since our last inspection. There were departments within the providers group that had previously supported the registered manager but it was not evident that support had been given. For example, the provider had a regulation team that audit different services based on the five key questions the Commission ask of a service. This regulation team audit also uses the key lines of enquiry used by the Commission aligned to the fundamental standards. We saw the last audit was completed in late June 2015 and early July 2015. No additional support from this team was evident since our last inspection despite the service breaching multiple regulations at the previous inspections.

In addition, the registered manager used to receive a bi-monthly visit from a regional director. The last visit of this type was in August 2015, just after our last inspection. This had highlighted matters such as appraisal and supervision being needed, inconsistent keyworker records, sling register needing completing and fire alarm tests not being completed timely. There had been no additional regional management support visits since this visit in August 2015 to support the registered manager. We spoke with the registered manager about this who told us that this had resulted due to personnel changes however a new staff member was now in post.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured the service were consistently responsive to people's care and communication needs. Care and treatment had not always been designed with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (1)(b) and 9 (3)(b)

The enforcement action we took:

We imposed conditions on the providers registration for this location-

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured the service had acted in accordance with the 2005 Act. Regulation 11(1) and 11(3)

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not consistently undertaken or maintained an accurate assessment of the risks to the health and safety of service users or consistently done all that was reasonably practicable to mitigate any such risks. Regulation 12(1), 12(2)(a) and 12(2)(b). The provider had not ensured the people were protected from the unsafe management of

	medicines Regulation 12(2)(g)

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority Regulation 13(1) and 13(5)

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured people needs were consistently met in relation to sufficient nutritional and hydration. Regulation 14(1),14(4)(a),14(4)(b) and 14(4)(d).

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the people were consistently cared for in a clean and hygienic environment. Regulation 15(1)(a)

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	The provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(1) and 17(2)(b). The provider had not ensured accurate, complete and contemporaneous records in respect of each person, including a record of the care and treatment provided to the person had been maintained. Regulation 17(2)(c).

The enforcement action we took:

We imposed conditions on the providers registration for this location--

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of people using the service. Regulation 18(1)

The enforcement action we took:

We imposed conditions on the providers registration for this location--