Eastgate Care Ltd

Park House

Inspection report

Cinderhill Road
Bulwell
Nottingham
Nottinghamshire
NG6 8SB
Tel: 0115 977 1363
Website:

Date of inspection visit: 7 August 2014
Date of publication: 03/02/2015

Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This was an unannounced inspection.

In October 2013, our inspection found that the care home provider had breached regulations relating to records.

Following the inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made. We saw that issues remained regarding records.

Park House is a care home providing accommodation and nursing care for up to 68 adults. There were 61 people living there when we visited, however three of the people were in hospital. The care home provides a service for people with physical nursing needs and for

Summary of findings

people living with dementia. The registered manager was no longer in post, however, a new manager had been appointed and they told us they would be applying to be the registered manager of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

The Mental Capacity Act 2005 was not being adhered to. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice. We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. A staff member told us that a DoLS application had been made for one person who used the service. However, we saw some people on the dementia unit trying to access the garden but the door was locked and DoLS advice had not been obtained for these people. The service was not meeting the requirements of the DoLS.

Safe staffing levels were not in place and safe medicines management and infection control procedures were not being followed. This meant that people who used the service were not always protected from the risk of harm. However, staff were recruited through safe recruitment practices and people told us they felt safe.

Staff told us they received supervision, appraisal and appropriate training as required. However, we saw that there were some training courses that had not been attended by all staff. This meant that there was a greater risk that staff would not have the knowledge and skills to meet people's needs.

Records and observations showed that people who used the service were not always protected from the risks of inadequate nutrition and dehydration and we saw that limited adaptations had been made to the design of the home to support people with dementia. However, the home did involve outside professionals in people's care as appropriate and some people told us that staff knew what they were doing.

People were not always involved in their care where appropriate and end of life care arrangements required improvements.

The service did not respond promptly and appropriately to people's needs and we made a safeguarding referral regarding the care that had been provided to one person. Activities were limited and care plans were not in place for all identified needs. People who used the service told us they were not comfortable making a complaint, however, complaints were responded to appropriately.

There were systems in place to monitor and improve the quality of the service provided, however, these were limited and were not always effective. The provider had not identified the concerns that we found during this inspection. However, staff told us they would be confident raising any concerns with the management and that the manager would take action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The service was not following the legal requirements regarding the Mental Capacity Act 2005. There were insufficient staff to meet people's needs, staff were not following safe medicines management and infection control practices and the premises were not safely maintained.

Staff knew how to recognise and respond to abuse correctly and staff were recruited using safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective as people were not always protected from the risks of inadequate nutrition and dehydration and limited adaptations had been made to the design of the home to support people with dementia.

Staff told us they received induction, supervision, appraisal and training. However, we saw that training was not always well attended. Health and social care professionals were involved in people's care as necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring as people were not always involved in their care. End of life care arrangements also required improvement.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. People's requests for assistance were not responded to promptly. People only had access to limited activities.

People did not feel comfortable making a complaint, however, complaints were appropriately responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led as audits carried out by the provider and manager were limited and had not identified all the shortcomings found during this inspection.

The registered manager was no longer working at the service, however, the newly appointed manager was considered to be approachable by staff. Staff were confident they could challenge and report poor practice and felt this would be taken seriously.

Park House

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

We visited Park House on 7 August 2014. The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed all the information we held about the home. This information included notifications and the Provider Information Return (PIR). This is a document we asked the provider to complete so they could tell us how they made sure the service was safe, effective, caring, responsive and well-led. We contacted the commissioners of the service to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with 14 people who used the service and two relatives and friends. We spoke with seven staff, two health and social care professionals, looked at the care records of seven people, observed care and reviewed management records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We saw no assessments of capacity and best interests' documentation in place for people who lacked capacity. One person had a do not attempt cardio-pulmonary resuscitation (DNACPR) decision documented but this had not been discussed with them as they lacked capacity. There was no assessment of capacity in the person's records. We saw that assessments of capacity had also not been made for other people with potential capacity issues. Staff had received Mental Capacity Act (MCA) 2005 training, however, not all staff we spoke with were able to explain how they took decisions in line with the MCA 2005. These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. We saw a recent DOLS application had been made and an advocate had been involved in the discussions regarding this application. A staff member said, "When a person is deprived of their liberty you are stopping someone going where they want to go." However, we saw that people on the dementia unit could not go freely into a secure garden area. We saw that the dementia unit patio door was open in the afternoon but there was a table blocking the exit and we saw that some people tried forcing the doors open. A person also told us that they were not allowed to go into the garden or back to their room when they wanted and they felt restricted. We did not see evidence that the DoLS had been considered for these people.

We looked at whether staffing levels were safe. There were insufficient staff on duty to meet people's needs. Some of the people we spoke with were not happy with staffing levels. One person said, "There aren't enough staff and too many people to help." Another person said, "I feel as though I'm sitting all the time and I'm losing my energy. There's no point asking anybody to help me because they just say they're too busy and they don't like anybody complaining." Another person said, "I've been telling them for ages that they need more staff." We observed another person who said, "Is there anyone coming? I'm fed up of waiting." A relative said, "Staff have been ever so good. They try so hard but they do seem to be short sometimes."

One staff member told us they hadn't had a break while on duty for the last four to five days. Another staff member said, "The staffing levels are not high enough. Sometimes we have enough staff, but could do with more help. There are times when you can't respond to the buzzer. When we are fully staffed there is no problem, but when we're short staffed, people are left too long." Another staff member said, "If people turn up for their shift then we have enough staff. If people phone in sick we are short, but normally we are ok." Another staff member said, "There are only two of us upstairs and I'm struggling to get to people."

Inadequate systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. A representative of the provider told us that a dependency assessment tool was not used to calculate staffing levels and data from the nurse call system was not used to check whether waiting times demonstrated correct staffing levels were in place. We looked at completed timesheets which confirmed that the provider's identified staffing levels were being met.

On the day of our inspection there were eight carers in the morning and seven carers in the afternoon identified on the staffing allocation sheet. However, we were told that one of the carers had to escort a person to hospital as an emergency so were not on duty for part of the day. We were told that there were plans to increase staffing levels to 10 care staff in the morning and nine in the afternoon.

The home had a nurse call system which monitored the time taken for calls to be answered. When we arrived in the morning the monitor was showing two calls which had not been answered for over 10 minutes. We asked for a print out of calls that morning and this print out listed people waiting 10, 12, 13, 20, 20, 22 and 29 minutes for assistance in response to calls. The 12 minutes wait related to a call bell in a toilet. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person who used the service said, "I have been given this ointment for my legs but I don't know what it is or how much and when I'm supposed to use it." We saw that staff had received medicines training where appropriate. We

Inadequate

Is the service safe?

checked the room where medication was stored and its temperature was too high. We were told that the pharmacist had been contacted to check whether this temperature would affect the effectiveness of the medication.

We checked the records for some controlled drugs and they were accurate. When we inspected the home in October 2013 we found that there were gaps in two people's medication administration record (MAR) charts. At this inspection, we found that there were still gaps in people's MAR charts. We checked nine people's MAR charts and there were gaps in eight of the people's charts. Where there were gaps we were unable to check whether these medications had been given. Medication audits had taken place but had not identified these issues. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked to see whether safe infection control practices were being followed. We saw a number of examples where safe practices were not being followed. We observed a staff member using their fingers to put medicines directly in a person's mouth without wearing gloves or washing their hands. This was not a safe practice and put the person at risk.

We saw a number of dirty toilet brushes and we saw dried faeces on the raised seats of two en suite toilets. In several rooms and en suite bathrooms, open packs of continence pads were left on the floor uncovered. We saw catheter bags were also stored out of protective wrapping and touching the floor. A pressure cushion had been left on top of an open commode. We saw staining on a set of bedside protectors and a pair of used pants had been left on top of the bin in a communal bathroom. This meant that staff were not taking appropriate action to protect people for the risk of infection. The manager told us that they were looking to employ a person as a housekeeper to supervise the domestic staff.

We saw that the provider completed an infection risk assessment for each person who used the service. No care plans were in place for those people that were identified as at risk of infection which included one person who currently had an infection. This meant that appropriate guidance was not in place for staff to manage people's identified risks of infection. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked to see how the premises and equipment were managed so people were safe. One person told us that they had been unable to use their en suite shower for a few weeks due to a leak. We saw a bath panel that was cracked in a communal bathroom. We saw that the first floor bathroom window was wide open as the window restrictor was broken. This put people at risk of harm. The manager told us that they had just appointed a full time maintenance person so that a quicker response to maintenance issues would take place. These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that one person had been assessed as at risk of falls but no care plan was in place to inform staff of how this risk should be managed. This person's personal cleansing and dressing care plan stated, 'can be resistant.' There was no guidance for staff on how to manage this situation. This meant that guidance was not always in place for staff regarding behaviours that challenge the service or for people at risk of falls.

The people we spoke with told us they felt safe in the home. A relative said, "[My relative] is definitely safe living here. I never leave here thinking [my relative] is going to be ill-treated." Staff told us that people were safe and they had no concerns regarding other staff and how they interacted with people who used the service. Staff were able to tell us how they would respond to allegations or incidents of abuse. We saw that the safeguarding policy and procedure contained contact details for the local authority. We saw that safeguarding concerns had been responded to appropriately. Staff told us they had received recent training in safeguarding vulnerable adults and records confirmed this. This meant the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening to protect people living in the home from the risk of abuse.

We observed people who used the service were safely supported by staff when transferring from a wheelchair to a chair and also from a chair to a walking frame.

We saw there were plans in place for emergency situations such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them. A staff member said, "If there are emergencies I know how to get people out. Care plans say how people should be evacuated."

Inadequate

Is the service safe?

We checked to see whether people were recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. The files contained all relevant information and the service had carried out all appropriate checks before a staff member started work. This showed that the service had effective recruitment practices in place to make sure that their staff were of good character.

Requires Improvement

Is the service effective?

Our findings

We looked at whether people's needs were met and enhanced by the design and decoration of the home. We saw that while some adaptations had been made to the design of the home to support people with dementia, they were limited. Very few parts of the home were personalised or modified to aid people to orientate themselves or move around the home independently. En suite bathrooms were not clearly identified. We saw limited use of large clocks and calendars to help people with dementia orientate themselves to time. People who used the service on the dementia unit could not go into a secure garden area. There was also insufficient space for people with dementia to walk with purpose, they walked a short distance to the doors and then had to return. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had mixed views about the quality of the food and whether choices were available. One person said, "There is no choice in the meals." However another person said, "If I don't like it, they bring me something else." One person said, "The food is not very good." However, a relative said, "He likes the food here, he loves it." One relative said, "If I wasn't here, I'm not sure he would get the drinks he needed."

We observed lunchtime in three areas. In two dining rooms we saw that people were being effectively supported. Staff were patient and were sitting at the same level as the people they were assisting to eat. All residents were frequently offered cold drinks and then hot drinks after their meal.

In the third dining area we saw some warm and kind interactions between staff and people who used the service. However there were only two staff members in the dining room, with a third coming in later. There were 13 people who used the service in the dining room. This meant that, because one staff member was supporting one person who could not eat unaided, it left the other to try and support everyone else and as a result, some people did not receive timely assistance. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person had a hot meal in front of them but was slumped sideways in their wheelchair and made no attempt to eat. The staff member asked the person whether they would like to try some food and the person said, "Carrots." The staff member gave the person a spoonful of carrots and then said, "There you go" before moving on. The resident promptly slumped over again in the chair. A few minutes later, the staff member asked the person whether they would prefer something else. They removed the dinner and brought some scrambled eggs and toast. Again, the staff member gave the person a spoonful and then left to support other people. This meant that the person did not receive sufficient staff support to eat their meal.

We saw that the service kept a central record of people's weights. We saw that people were not weighed as frequently as they should have been. One person had been identified by the home as at high risk and requiring weekly weighing but was last weighed in June 2014. Two other people had been identified as low risk and requiring monthly weighing but were last weighed in May 2014. This meant appropriate action was not been taken to monitor people's weights to protect them from nutritional risk.

We saw from the care record of one person that they had a catheter. There was a catheter management plan in place which stated that fluids should be recorded but there was no record of fluids available on the day of inspection. This meant that systems were not in place to ensure this person was protected from the risk of insufficient fluids.

We saw one person had an eating and drinking care plan in place but this had not been reviewed for three months. They also had a diet and fluids care plan which also had not been reviewed for three months. We checked this person's food and fluid charts which showed that fluids were being offered but did not state a recommended fluid target and were not totalled to monitor whether appropriate fluids were being taken. A staff member said, "We have people who we record what food and drink they have. I don't know where to look though, to know the amount people should be having."

Another person had been admitted to the home from hospital and the discharge information stated, 'prone to dehydration, poor with oral fluids and diet – needs encouragement.' The home's admission information stated, 'normal diet and fluids'. No eating and drinking care plan was in place. Another person had been identified as

Requires Improvement

Is the service effective?

high risk following the nutritional risk assessment. There was no care plan in place for this need. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at whether staff were supported to have the knowledge and skills they needed to carry out their roles and responsibilities. Staff told us that they had received an induction, supervision and appraisal. One staff member said, "I had an induction with my managers, I had a tour of the building and was introduced to the carers. I shadowed a person for a week before I started my role. I also had three days training before I started. I felt well prepared for the job I would be doing." Staff told us they had received equality and diversity training.

We looked at the service's overview of training. We saw that training was mostly well attended though there were some training courses where attendance required improvement. There were 62 staff employed at the home and 11 staff had not attended moving handling training, 14 had not attended tissue viability training, 16 had not attended Dementia Awareness training and 27 staff had not attended Challenging Behaviour training. We looked at the service's supervision records which showed that staff had received recent supervision. This meant that staff were not fully supported to have the knowledge and skills they needed to meet the needs of people who used the service.

We checked to see whether people were supported to have access to healthcare services**.** One person said, "They do call the doctor when I'm not very well." We saw that other health and social care professionals were involved in people's care as appropriate. We saw examples of people visiting the opticians and the GP. We saw examples of the involvement of social workers, dieticians, chiropodists and the tissue viability nurse. This showed that the service involved other professionals to meet people's needs.

We looked at how people with a risk of skin damage were cared for. We saw that people's pressure risk assessments were reviewed regularly and people were being supported to change position in line with their care plans. However, we saw one person whose dressings required changing. We asked a staff member to do this.

Requires Improvement

Is the service caring?

Our findings

We saw that staff treated people with kindness but were very rushed so interactions were brief and task orientated.

We asked people whether they were involved in their care planning and were able to express their views about their care. One person said, “I was a very independent person but now I feel as though I have no rights. I am very unhappy.” Another person said, “I can’t go into the garden because I can’t walk. I’ve only been out there once. There’s no freedom here.”

We saw limited evidence of people’s involvement within their care records. While there was some information regarding people’s preferences there was no evidence that people had been involved in care planning. Evidence of relative involvement when the person lacked capacity was also limited. We saw some records indicating that care plans had been discussed with relatives but very little detail was noted of these discussions.

We asked people whether staff treated them with dignity and respected their privacy. One person said, “I can manage my own personal care but there is always somebody around to help if I need it.”

We spoke with staff about how they respected people’s privacy and dignity. Staff had an understanding of the role they played in making sure this was respected. However, during our visit we observed an example of a person’s privacy not being respected. A person who used the service was told by a staff member in a loud voice that, “You must eat because you're diabetic.” This was said within earshot of other people who used the service.

We checked how people were supported at the end of their life to have a private, dignified and pain free death.

Healthcare professionals told us that they felt people were safe when receiving end of life care but improvements in end of life care at the home were needed. There were two people who were receiving end of life care at the home. One staff member said, “I don’t think there is anyone here who is on end of life care.” They were also unable to explain what end of life care was. However, another staff member said, “This is taking care of someone when they are near the end of their life. We have to make sure they pass away gracefully and not suffering.”

A person said at around 11am, “Can someone come and clear me up. I’ve been waiting for bloody hours. I’ve been waiting for three hours.” We checked their notes and there was no entry made since 5am that morning. We informed a staff member and they went to the person. We looked at the care records for this person who was receiving end of life care. Staff we spoke with did not know how frequently they needed to check the person when they were in their room. We looked at the room records which showed some gaps of four and five hours between checks. The person’s end of life care documentation was not completed. This meant that information was not in place for staff to support the person during the end of their life in their preferred way.

We looked at the care records for another person. Their end of life care plan included an assessment of needs, their preferred place of care, and a DNACPR decision. A letter had been written to the person’s family asking them to discuss the person’s end of life care arrangements. The letter was sent on June 2012 and November 2012 with no response. A note had been written to review the situation in February 2013 but this had not taken place. This meant that the home had not taken recent action to discuss the person’s end of life care arrangements with their family to ensure that appropriate arrangements were in place for that person.

Inadequate

Is the service responsive?

Our findings

We checked whether people received care that was responsive to their needs. Some people who used the service did not feel their needs were being met. One person was very upset because their buzzer calls were not answered promptly. They told us that they were left waiting for long periods which they found distressing, particularly as they needed assistance to go to the toilet. They told us that they were put into continence pads at night which they did not want and they said, "I've told them I can go to the toilet if I'm helped but they tell me to wee in the pad. I've had to wee in the pad this morning because nobody came and my bed is wet as well."

The person's relative was visiting and they said, "They are forcing her to be incontinent." We spoke with this person at around 10.45am and they were just starting breakfast. They told us that they had been up since 7.30am and that food which should be hot is often cold by the time it is brought to them in their room. We made a safeguarding referral to the local authority and have been informed that this referral was investigated and substantiated by the local authority.

We spoke to another person at approximately 11am. They said, "I've been up since 8am and I'm still waiting for help to wash and dress. Yesterday, I got up at 7.30am and I wasn't washed until 4pm."

We observed another person, who was nursed in bed, calling for assistance for at least twenty minutes. We informed a staff member and they went to the person. These were breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw a person spill a cup of tea over their clothes. We brought this to the attention of a staff member who wiped the person but did not check whether their clothes were wet. This meant that the staff member did not respond to this person's need as we saw that their sleeve was wet through so had to bring this to the attention of another staff member.

We saw another person who used the service shout at a staff member who ignored them. The person had slipped down in their wheelchair and needed help. We saw another person asking to go to their room and couldn't understand why staff told them that they had to remain in the lounge. This meant that staff were not responsive to this person's needs.

We saw limited activities taking place. We asked a person who used the service about activities and they said, "nothing much happens." A staff member said, "We did have an activities coordinator, but not one at the moment. They play dominoes, ludo, cards. People don't really get to go outside much as we don't have the time to do it." Another staff member said, "We used to have an activities coordinator. We play bingo and sometimes have live music. People could get outside more back then too."

We checked whether people knew how to make a complaint and were comfortable doing so. One person said, "They don't like it if I complain, for example, about the food." Another person said, "I want to get outside. I need to get some fresh air but they get nasty if I complain and tell me they're doing their best."

We looked at recent formal complaints and saw that they had been responded to appropriately. Staff we spoke with knew how to respond to complaints if they arose. A staff member said, "If a complaint was made to me I would report it to the manager. I would make sure it was looked into."

Requires Improvement

Is the service well-led?

Our findings

We saw that limited audits had been completed. Audits were carried out in the areas of care records, medication, health and safety, kitchen and domestic areas. However, the domestic audit did not have an action plan in response to issues identified. We also saw only one care record had been audited since February 2014. It was also not clear whether the actions identified by this audit had been carried out.

We also identified a number of shortcomings during this inspection which had not been identified by the provider. These shortcomings were in the areas of mental capacity, care plans, nutrition and hydration, infection control, medicines management, the environment and staffing levels. These shortcomings constituted breaches of a number of regulations. We also saw that the provider had not fully addressed the shortcoming in records identified at the previous inspection. This meant there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked to see whether people were actively involved in developing the service. We saw the minutes from the most recent meeting of people who use the services in August 2014. Most comments were positive, however, one person was minuted as raising concerns about, '…waiting too long for someone to answer the buzzer.' We found the same concerns at this inspection.

There was no registered manager in place, however, a manager had been appointed. People who used the service could not tell us who the manager was. However, one relative said, "The new manager is absolutely fantastic."

One staff member told us that management was approachable and said, "For me yes, very good, no problem." Another staff member said, "The manager is great, very approachable, always listens to me. I know she always acts if I raise any concerns." We saw that a range of staff meetings had taken place and that a range of issues were discussed at these. We saw that a whistleblowing policy was in place which provided guidance to staff if they wanted to raise concerns with the management.

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed and actions were identified and taken. We saw that safeguarding concerns were also responded to appropriately and appropriate notifications were made to us where required by law. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have an effective system in place to regularly assess and monitor the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not take proper steps to ensure that service users were protected against the risk of acquiring a health care associated infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks associated with unsafe or unsuitable premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided to them.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People's personal records including medical records were not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff.