The Cottage Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 May 2016 and was unannounced.

This was the third comprehensive inspection carried out at The Cottage Nursing Home.

The Cottage Nursing Home Limited is registered to provide accommodation and care for up to 53 older people, ranging from frail elderly to people living with dementia. On the day of our visit, there were 36 people using this service.

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 service did not have a registered manager. At the time of our inspection there was an operations manager in post who visited the service four days a week. They had been in post for eight weeks. In addition, the clinical lead for the service was acting as manager until one was recruited. 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.

We found that people were not always supported to remain safe in the service. A small number of people

displayed behaviours that could challenge the service and this had an impact on other people living there. We found there was no clear system in place to log referrals, or to ensure follow up action was carried out. Risk assessments in place to protect and promote people's safety needed to be strengthened to ensure risks were managed effectively to keep people safe. We found that not all the risk assessments we looked at detailed the control measures or actions to be taken to address the identified risk. This meant that risks were not always managed in such a way as to keep people safe.

People had not been protected against the risks associated with unsafe or unsuitable premises. Some areas of the service had not been maintained to a safe standard and repairs had not been carried out in a timely manner. People had Personal Emergency Evacuation Plans (PEEP) in place but they did not provide staff with sufficient and appropriate guidance to follow, to safely support people to move to a place of safety if there was a fire. The fire risk assessment had an action plan to make it more robust; however we were unable to find any evidence that the actions had been addressed. This meant that areas of risk that may be hazardous to people's safety and
health had not always been identified and rectified as soon as possible.

Recruitment procedures needed to be strengthened to ensure only suitable staff were employed by the service. We observed that some employment checks for a small number of staff had not been obtained. There were sufficient numbers of staff available to meet people's fundamental care needs, but not always in a timely manner. In addition we found there were insufficient staff to meet people's emotional and social care needs consistently. This was having an impact on the quality of care received by people and meant that not all their needs could be met.

Inconsistencies found with the recording and administration of medicines showed that people's medicines were not always managed safely.

People did not always receive care, which is based on best practice, from staff that have the knowledge and skills to carry out their roles and responsibilities. We observed some unsafe moving and handling procedures and we found there was a lack of dementia awareness/knowledge amongst the staff. Training records demonstrated that not all staff were up to date with essential training.

Although we found systems in place to ensure people who lacked mental capacity were supported to make their own decisions, in accordance with the principles of the MCA, these were not always effectively managed. Records did not make it clear what decisions each person had the ability to consent to and what areas they did not. We observed that staff did not consistently gain consent from people before supporting them and people were not generally offered choices. This meant that people were not always given the option to make their own decisions about their day to day care.

People were not always offered the choice of meals available and in instances we observed rushed meal times. Staff support to help people eat their meals was not always carried out with sensitivity.

There were inconsistencies among the staff team in relation to how people were supported. Some staff showed kindness and compassion. A small group of staff showed indifference with poor interactions. We also found that staff did not always promote people's privacy and dignity, and confidential information was not always stored securely. This meant that staff did not always have due to regard to people's right to dignity, privacy and confidentiality.

People did not always receive care that was responsive to their needs or focused on them as individuals. We observed occasions where people's needs were not met and some people's care did not always match what

was recorded in their care plans. We found that decisions about people's routines were not always in line with their preferences and many people's daily routines were not person centred but task-led by the staff. This placed people at risk of unsafe and inappropriate care and treatment. Records showed that people and their relatives were not involved in the care planning and review process. This meant that changes to people's care and treatment were not consistently reviewed and updated with the involvement of people to whose care they related and their family members.

We found that people were not enabled to participate in sufficient, meaningful activities that met their needs and reflected their preferences. There was a lack of staff interventions and stimulation for people which resulted in boredom and some people became challenging in behaviour, which then impacted upon other people living in the service. This meant that people were not supported to follow their interests and take part in meaningful social activities.

We found the culture at the service was not person centred, but task focused. There was little in the way of a person centred culture evident in either the environment or the work ethic of the staff. We found that staff were aware of their responsibilities in relation to assisting people with their basic physical care needs; however we found there was little awareness of the needs of people living with dementia. Quality assurance, health and safety checks and feedback from people had not been undertaken consistently and did not therefore effectively check the care and welfare of people using the service. This meant that systems in place were not effective or robust enough to ensure that risks relating to the health, safety and welfare of people using the service were responded to.

Records demonstrated that decisions had been made in people's best interests where they lacked capacity; to ensure they received the right care and support to maintain their health and wellbeing. We found that DoLS were in place for those people who needed them.

We found that people were provided with nutritious, healthy meals and drinks were in plentiful supply throughout the day. Records demonstrated that people had timely access to relevant healthcare professionals to meet their specific health care needs. This meant people were supported to see a healthcare professional if they needed to.

Complaints/concerns had not previously been responded to in a timely manner; however we found that the operations manager had introduced a new system to improve this. The complaints/concerns file showed that complaints had been received by the service and had been responded to swiftly and in a timely manner in line with the organisation's complaints procedure.

We found that with the recruitment of the operations manager improvements were being introduced and staff were positive about the direction the service was taking. We found that shortfalls in relation to staffing numbers, complaints, staff training and support, activities provision and care planning had already been identified as areas for improvement and plans were being implemented to address these shortfalls.

During this inspection we identified a number of areas where the provider was not meeting expectations and where they had breached Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always supported to remain safe at the service and were at risk of harm from some people who displayed behaviours that could challenge the service.

Risk assessments in place to protect and promote people's safety needed to be strengthened to ensure risks were managed effectively to keep people safe.

People were being put at risk because the premises had not been adequately maintained.

Recruitment practices were not robust and there were some gaps in staff employment checks.

Staffing numbers were sufficient to meet peoples basic care needs. However, the deployment of staff did not ensure people's emotional and social care needs were met consistently and in a timely manner.

Systems for the management of medicines did not always protect people using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

There was no formal staff induction programme in place and there were gaps in staff training to support them to develop their skills and knowledge.

People were not always asked for their consent to care on a day to day basis.

People received nutritious meals that met their dietary needs. However staff did not always offer people a choice of meal and did not always support people with eating and drinking with sensitivity and respect for their dignity.

If needed, staff supported people to access a wide range of

healthcare services.

Is the service caring?

Inadequate

The service was not caring.

We found that people were not always treated with compassion, kindness, dignity and respect.

People were not supported to express their views and be actively involved in making decisions about their care, treatment and support.

Care was mainly task focused and did not take account of people's individual preferences and did not always respect their dignity.

Is the service responsive?

Inadequate

The service was not responsive.

The service was not flexible and receptive to people's individual needs and preferences.

There was a lack of stimulation and interaction between staff and people using the service. Meaningful activities were not provided which meant that people were not engaged adequately.

Improvements had been made to the complaints process to ensure people could raise concerns or issues about the service and to make sure they were listened to, taken seriously and addressed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager in place and this was having a significant impact on the leadership and direction for people living in the service and staff.

There was a culture amongst the staff that was task focused and often failed to treat people as individuals.

People were put at risk because systems to assess and monitor the quality of care provided to people and to manage risks of unsafe or inappropriate treatment had not been consistently undertaken.

We found that under the new management some improvements had recently been made at the service and other areas of concern had been identified as areas for requiring improvement.

The Cottage Nursing Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 18 May 2016 and was unannounced. The inspection was carried out by three inspectors from the Care Quality Commission and one specialist adviser. A specialist adviser is a person who has professional experience of people who use this type of care service. The specialist adviser had professional experience in relation to people living with dementia care needs and tissue viability. Tissue viability is about the prevention of pressure ulcers and its treatment.

We used a number of different methods to help us understand the experiences of people using the service. We reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents which may have occurred. We also liaised with the local authority that commissioned the service to obtain their views about the service.

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

We spoke with six people who used the service and five relatives, in order to gain their views about the quality of the service provided. We also spoke with 16 staff that included the operations manager, the clinical lead, three nurses, five healthcare assistants, the chef, and two members of the housekeeping staff, the receptionist, the activity co-ordinator and the maintenance person. In addition we spoke with one visiting healthcare professional.

We looked at the care records; including risk management plans, for nine people using service to see if their

records were accurate and reflected their care and treatment needs. We reviewed five staff recruitment files, four weeks of the staff duty rotas, staff training records and the medication administration records for all the people using the service. We also looked at further records relating to the management of the service, including quality audits and health and safety checks.

Inadequate

Is the service safe?

Our findings

People were not kept safe from incidents. We spoke with relatives and one said, "There are some who live here who can be very aggressive. I worry sometimes about those people who can't move out of their way. I have seen people being hit." A second relative commented, "There are not always enough staff to observe everyone and they [people using the service] need constant observation."

We observed that some people displayed behaviours that challenged the service which had an impact on other people using the service. For example, we observed one person who was agitated and frustrated throughout the day, as they walked with purpose their behavioural presentation impacted upon many people and we observed some altercations between this person and others on the days of our inspection.

Since January 2016 the Care Quality Commission (CQC) has received nine notifications where people have been physically or verbally abusive to other people using the service. Some of these have resulted in injuries for people. We discussed with the operations manager how decisions were made when the service admitted a person with behaviours that could challenge the service. The operations manager told us that the assessment process had been reviewed and consideration was now being given to the impact on people already living at the service. They said the last two people they had assessed had not been admitted because the service were not able to fully meet their needs and ensure people already using the service were protected and kept safe. However this did not resolve the current situation where people were at risk of harm from a small number of other people using the service.

We found a file of notifications sent to the Care Quality Commission (CQC) in relation to incidents and accidents. We were told the service was maintaining electronic records of when incidents were raised. However, staff were unable to demonstrate these to us at the time of our inspection. We found evidence of 25 specific incidents which had the potential to be safeguarding concerns. These dated back to the beginning of January 2016. We were unable to determine on the day of our inspection if these had been referred to the local authority or not. We requested that the service look at these and inform the CQC if they had been reported. We spoke with the clinical lead who was unsure of the status of current safeguarding referrals and acknowledged that there wasn't a clear system in place to log referrals, or to ensure follow up action was carried out.

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

Staff told us they had received safeguarding training and they were able to explain the different types of abuse and the procedure for reporting it. One staff member said, "I would go to the clinical lead or the manager. I feel it would be dealt with. I would be happy to whistle blow or go above people's heads. They [people using the service] are not here to be abused." Another member of staff commented, "I am aware of safeguarding and whistleblowing. I would be happy to raise concerns." A third staff member thought it would be beneficial if there was a poster with contact details provided so staff knew who to contact in the absence of senior staff about safeguarding concerns.

Risk assessments in place to protect and promote people's safety were not effective. We saw that risk assessments were in place for pressure area care, nutrition, sleep, mobility and falls. However, we found that not all the risk assessments we looked at detailed the control measures or actions to be taken to address the identified risk. For example, one person had been assessed to be at risk of a pressure sore and the action recorded in the risk assessment was to 'Monitor'. There was no supporting guidance for staff as to the frequency of required monitoring or any additional equipment that might be needed. We also found that for a second person assessed to be at risk of pressure sores their risk assessment had not been completed properly and the scoring to determine the risk was incorrect. This placed the person at greater risk of developing a pressure sore.

We found that risk assessments did not always include information of what the specific risk was and there was a lack of information about the control measures in place to minimise the potential for occurrence. For example, triggers for behaviour that had a negative impact on others or put others at risk and the steps that staff should take to defuse the situation and keep people safe. This meant that risks were not always managed in such a way as to keep people safe.

People had Personal Emergency Evacuation Plans (PEEP) in place, which were based on risk. We found that although people had these in place, they did not offer staff sufficient and appropriate guidance to follow, to safely support people to move to a place of safety. For example, although the assessments directed staff to move people from a communal area by moving their chair, it did not state what type of chair, or what they would first have to do if people were sitting in a standard chair. We found the PEEP's required additional information to ensure they were an accurate working document reflective of people's needs and to ensure people could be evacuated or moved safely.

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

Staff were aware of people's risk assessments and understood why they were in place. One staff member said, "Risks are well managed." Another member of staff told us, "We have risk assessments for lots of things. It can be difficult to remember them all." However, we found that this was not the case and guidance in the risk assessments was not always followed consistently by staff. This meant that people were at risk of unsafe and inappropriate care.

We found that risk assessments were reviewed regularly on a monthly basis a number of the risk assessments we looked at identified additional professional support required such as dietician involvement and Community Psychiatric Nurse and we saw details of regular medication reviews.

People were not always protected against the risks associated with unsafe or unsuitable premises. We spoke with the maintenance staff member who told us they completed a regular walk-around of the service to identify areas in need of attention; however no formal checks for this were in place. He informed us there was also a book for staff to complete if they identified any concerns relating to the environment. They said, "It's very slow and problems are not always brought to my attention quickly." At the end of our inspection a checklist had been drawn up to record any concerns relating to the environment and an action plan to show how they had been addressed.

We looked at the fire risk assessment and saw that there was an action plan in place for improvements needed to make the fire risk assessment more robust. Areas that needed to be addressed included all staff should be trained to use fire extinguishers. The maintenance staff told us that none of the staff, themselves included, had received training in the use of fire extinguishers. There were no records available to show that

staff had been trained in this area.

We observed that fire extinguishers (with the exception of two) had stickers on them stating they were due for a service in March 2016. We were unable to find any evidence of these checks. The maintenance staff told us, "They were probably missed to be honest". We also observed one fire extinguisher that had its tamper-proof seal damaged and could therefore be discharged by people using the service. We were informed that quotes were being sought for safety cases to put extinguishers in to keep them safe.

We saw one bedroom that had the smoke detector missing. We were informed this had been missing since February 2016. On the first day of our inspection we observed a fire door that had been jammed open with paper tissues, despite having a door guard on it. We were later informed that the batteries in the door guard had run out and this was why the fire door had been wedged open. We saw on the second day of our visit that the batteries had been changed and the door was working properly. We also observed a sluice room on the lower floor with a keypad entry on the door; however we noted that door was not locked and people using the service were able to access this area. This placed people at risk who may access equipment and substances that may be harmful to their health.

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

Systems in place to ensure that medicines were administered safely were not always consistently followed. One person told us, "They do it [medication]. They make sure people get the right medicines." However a relative raised concerns that their family member's prescribed shampoo for dandruff was not being used. We were unable to find any records to confirm the shampoo had been applied.

We reviewed the systems in place for the safe administration of medicines and we looked at the Medication Administration Records (MAR) charts for all the people using the service. One chart we looked at showed gaps and omissions in the recording of the persons medicines. Medication stocks demonstrated that the medicines had been given but staff had failed to sign the MAR chart.

In another person's medication file we found a homely remedies [over the counter] list of medicines approved by the person's GP, that had not been updated since 2012. This meant that the person's prescribed medicines may not be compatible to take with the homely remedies medicines and placed them at risk. In a third file we saw that one person was prescribed a food supplement to be taken twice a day. Records indicated they had only had this on seven occasions over a 15 day period and we were unable to verify if they had received the food supplement as prescribed. This meant that people may not receive their medicines as prescribed.

On the first day of our inspection we found that two people had not received their morning medicines by midday. We raised this with the nurse who had been completing the medication round on that day. We were informed this was because the two people in question often refused their medicines and staff would go back periodically to see if they would accept them. One person's medicines were for a specific health condition. We were unable to find any protocols in place for when this happens. This placed the person at risk of a deterioration of their health condition.

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

Staff told us they had received training in the safe handling and administration of medicines; and their knowledge and skills were regularly updated. One staff member told us, "We have had training and we do checks weekly of the medicines."

We observed two medication rounds taking place at different times of the day and saw these were only completed by qualified nurses trained to give medicines. The operations manager told us they were part of a pilot scheme where they ordered people's medicines on-line. This involved six weekly meetings with people's GP's and the system also flags up when reviews of people's medicines are needed. We saw this system had already identified medication reviews for people and there was good evidence in people's care plans that medication reviews had recently taken place. This meant that reviews of people medicines would be undertaken as required.

We found that medicines were securely stored and the temperatures of the storage areas had been regularly recorded to ensure they were stored in the right conditions. In addition we found that controlled medicines were stored in line with best practice guidance.

Where people were prescribed medicines on a 'when required' [PRN] basis, for example for pain relief, we found there was sufficient guidance for staff on the circumstances these medicines were to be used. We were therefore assured that people would be given PRN medicines to meet their needs. In addition we found there were risk assessments in people's care plans that recorded the level of support they required to take their medicines safely.

Recruitment procedures were not always consistently followed to ensure suitable staff were employed by the service. We looked at recruitment records for five members of staff. We found that in one file there was only one reference and no photographic identification. In a second file we observed the application form had not been fully completed and there was no Disclosure and Barring Scheme (DBS) check in the staff members file. This was not made available to us on the day of our inspection. However they did have in place an overseas police check. Following the inspection we were informed that a DBS had been undertaken in respect of this staff member prior to employment.

Following the inspection the operations manager advised us that they had applied for a DBS check for this staff member, in order to complete their file. The remaining files we examined all contained the necessary pre-employment checks and we observed Disclosure and Barring Scheme (DBS) checks, health clearance, proof of identity documents including the right to work in the UK and two references.

We spoke with a member of staff who was new to the service. They told us they had been through the recruitment process and had not been allowed to work at the service until their employment checks had been received.

There were sufficient numbers of staff available to meet people's basic care needs, but not always in a timely manner; however we found that staffing numbers and the deployment of staff did not ensure people's emotional and social care needs consistently. In addition there were insufficient staff available to support people at meal times to make sure their needs were met. A relative commented, "There seems to be a lot of staff but they are always so busy and we often have to go and find them."

Staff had mixed views about the staffing numbers at the service. One staff member told us, "There is not enough staff." A second member of staff said, "There are not really enough staff. Staffing makes it difficult to meet people's needs." A third staff member commented, "Staffing numbers can be difficult. It can be difficult if we don't' have cover, especially with how aggressive they [people using the service] are. Sometimes the

job is bam bam bam. Why should everything have to be so rushed?"

The operations manager told us they had recently increased the staffing numbers from five healthcare assistants and two nurses per shift to seven healthcare assistants and two nurses. This was a result of observations they had made that had identified staffing numbers were insufficient to deal with incidents of aggression which sometimes needed two to three staff to manage and not being able to meet people's needs in a timely manner. Some staff we spoke with felt the increased staffing was a big improvement. One staff member said, "Staffing levels generally have increased which has been a good thing." Another member of staff told us, "Staffing numbers have been increased to seven. Sometimes we have eight. That makes such a difference because it means we can spend time talking with people and it's not so rushed." Staff spoken with told us any shortfalls, due to sickness or leave, were covered by existing staff, which ensured people were looked after by staff who knew them.

We requested to look at the tool used to assess the dependency of people and calculate the staffing numbers required to meet people's needs. The operations manager told us there was a dependency tool but felt it did not provide an accurate picture of people's dependency levels. They showed us a new tool which they said was more accurate. We were told it had already been used to assess the dependency levels for two people and would be used to assess the dependency levels of all people using the service. We looked at the staff duty rota for the current month. The recorded staffing levels were consistent with those as described by the operations manager and the staff we spoke with.

Our observations found that there was a demand on the staff, especially at each meal time to ensure everyone's needs were met in a timely manner considering the diversity of people using the service; from full dependency to people who displayed wandering behaviours and behaviours that could challenge the service. For example, we observed one person who liked to walk pick their bowl of porridge up, and drink their porridge from the bowl. They spilled most of the porridge down their clothes and we observed them walking off again. There were insufficient staff available to assist the person on a one to one basis and provide support to eat their meal.

Requires Improvement

Is the service effective?

Our findings

People did not always receive care, which was based on best practice, from staff that had the knowledge and skills to carry out their roles and responsibilities.

We received mixed views about whether people and their relatives felt staff had received appropriate training to carry out their roles effectively. One person told us, "I don't think they know what they are doing." A relative commented, "Some staff seem well trained but others don't seem to have a clue." A second relative said, "Not all the staff know how to deal with them [people using the service] when they get cross and hit out. I think some staff are scared of them." A third relative informed us, "I have never had any problems. They all seem confident and know what to do to keep people here happy."

We spoke with a member of staff who was new to the service and asked them about their induction. They told us they had been shown around the premises and introduced to people using the service. They said they had not received a formal induction programme but had completed basic first aid training and moving and handling training. This meant that people were at risk of receiving unsafe care because staff new to the service had not received the necessary training to carry out their roles and responsibilities.

Staff told us that although training was available it had not always been carried out consistently. Many staff told us they needed training to manage people's behaviours more confidently. One staff member told us, "Training could be better." A second member of staff said, "There's always training to do but I don't like the paper booklets we have to complete. I haven't had any training in how to deal with aggression; no de-escalation or breakaway training." A third staff member commented, "It would be really nice to get training in how to deal with an aggressive resident. We do training, most of it is refreshers." We found that staff were not trained to manage people's behaviours that challenged and therefore were unable to support people appropriately.

We observed some poor moving and handling practices carried out by staff over the course of our inspection. For example, we observed two members of staff supporting one person to transfer by holding onto the top of the person's trousers. They were also supporting the person under the arms with no manual handling belt in place, in line with best practice. We also observed another manual handling transfer, where two staff were supporting someone to transfer from a wheelchair into a standard chair. They held the person under the arms and tried to turn them but not sufficiently and the person ended up sitting on the arm of the chair, where they then had to slide down into the cushion. Without sufficient training in place to help staff provide support in a safe and consistent way, people and staff may be at risk of possible harm or injury.

We also found there was a lack of dementia awareness/knowledge amongst the staff, which was evident in how some staff approached people. For example, we observed an interaction where it was apparent the staff member did not seem to understand that their behaviour was escalating a volatile situation. We also observed that many staff did not communicate effectively with people and some tasks were carried out in silence. For example, throughout numerous moving and handling procedures and during meal times. We saw that 59% of the care staff had received dementia care training at the time of the inspection. Following

the inspection we were informed that staff with overdue or no dementia training received Face to face Dementia Awareness training in June 2016.

We looked at the training records for staff and found training had not been regularly completed. This included dementia awareness, moving and handling, fire training, food safety and Mental Capacity Act and Deprivation of Liberty Safeguards training.

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

Staff said they hadn't always felt supported in their roles. One staff member commented, "I haven't had supervision since I have been here. I haven't felt as supported as I could be." A second member of staff told us, "The nurses do our 1:1's; they are not always getting done."

We spoke with the operations manager who told us that prior to their appointment formal staff supervisions had not been carried out consistently; however these had recently been recommenced. The operations manager was overseeing this process and where areas of concern were raised in a staff supervision, actions were taken to address the areas of concern. Records we looked at confirmed that staff supervision was being completed for staff and areas of concern were being addressed by the operations manager.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that systems in place to ensure people who lacked mental capacity were supported to make their own decisions, in accordance with the principles of the MCA, were not always effectively managed. For example, we saw that people had a mental capacity care plan in place. This stated that the person had been assessed as lacking capacity, however it did not state the specific decisions they lacked the capacity to make or any additional ways by which staff could support them to make decisions related to their care. Records showed that when people were considered to have variable capacity, there was limited guidance for staff to follow. This meant that it was not always clear within the records as to what decisions each person had the ability to consent to and what areas they did not.

Although there were MCA systems in place that demonstrated staff had given consideration to people's mental capacity, these had not been progressed to the next stage. For example, care plans we examined did not offer specific guidance about the decisions people could make and the support they needed to make decisions about their care and treatment. We also found that MCA assessments had been completed in relation to day to day decisions which did not require an MCA assessment. For example, being supported to eat and communication methods.

Records demonstrated that decisions had been made in people's best interests where they lacked capacity; to ensure they received the right care and support to maintain their health and wellbeing. We found that DoLS were in place for those people who needed them. These had been applied for and were monitored to

ensure they did not expire; therefore requests for re-authorisation were dealt with in a timely manner.

We observed that staff did not consistently gain consent from people before supporting them. We found that people were not generally offered choices as to whether they wanted support. For example, all people were given a napkin to wear at meal times, staff did not ask whether they would like a napkin but just proceeded to place them around people's necks to prevent food spillages. This meant that people were not always given the option to make their own decisions about their day to day care.

People were supported to eat and drink enough and maintain a balanced diet. However people did not always receive the support they needed in a sensitive and timely manner to eat their meals.

We observed breakfast and lunch being served over both days. We saw that people were given a choice of meals by the chef and we saw that catering staff were prepared to make people an alternative meal if they didn't want one of the options. However, we observed that care staff did not always offer people the choice of meal available from the kitchen. Meals were appetising but were not always served in a relaxed and comfortable atmosphere. People told us that the food was tasty and they enjoyed the meals they were offered. One person said, "The meals are good. We have fish and chips on Fridays and a good roast dinner on Sundays." Another person commented, "The food is lovely. He's [chef] a good cook."

We spoke with the chef about people's nutritional needs and found that they had a good awareness of what people's specific dietary preferences were and any specialist diets they needed. There were up to date records to show that this was in line with guidance provided by care staff. Menus were based on a two weekly rolling programme that showed a choice of two meals for lunch and the evening meal. We saw that food was cooked using fresh fruit and vegetables to ensure a nutritionally balanced dietary intake for people. For those people who required a pureed or soft diet, or other dietary requirements such as diabetic diet, we saw that this was well catered for.

Records demonstrated that each person had a nutritional assessment in place with a nutritional care and support plan. People's weight was monitored and food and fluid charts were completed for people if there was an identified risk in relation to their dietary intake. If people were identified as being at risk of weight loss their food was fortified and they were referred to the dietitian or GP.

We found that people's individual needs were not always met by the adaptation, design and decoration of the service. Signage was very basic and not conducive for people with varying degrees of cognitive impairment. We observed little in the way of displays and orientation boards around the service. There was an orientation board in the downstairs lounge; however this had not been completed at all. Signage throughout the home was pictorial in parts although many of the signs had been torn off the doors. These had not been replaced which meant that aesthetically, in some areas, the service looked scruffy and unkempt.

There were bold colours in the corridor areas leading to the bedrooms but no colour contrasting and bold signage in the day areas and between, to aide visibility and direction. Due to the nature of people using the service some of the stimulatory displays, i.e. fluffy sensory pictures in the corridor had been half torn from the walls. The general environment was not dementia friendly, and there was a lack of items and points of interest to stimulate people.

The lounge downstairs had a good view to the garden outside and an area for people to access and we saw a patio area on the upper floor that provided a pleasant place for people to enjoy the outdoors safely. We found that beds for people being cared for in bed were of a good standard and suitable to meet people's

needs and we found appropriate pressure relieving mattresses in place on the beds.

People were supported to access healthcare services and receive on-going healthcare support. People were able to access the services of a number of different healthcare professionals if necessary. A relative said, "[Name of relative] always gets to see the doctor if they need to. I think his health care needs are very well looked after."

Staff told us it was important that they acted on changes in people's condition to ensure they remained as well as possible. One staff member told us, "I would go to the nurses if I was worried about someone's health. They organise GP visits or appointments." The clinical lead for the service informed us that peoples GP visited regularly and records we looked at confirmed this. A visiting healthcare professional commented, "They must care for their health needs really well because residents are living a long time."

Records showed that people had been assisted to access optical and dental care and, where appropriate, referrals had been made to access additional healthcare support; for example, mental health intervention, physiotherapy and dieticians. When referrals were required to be made, records confirmed that these had been actioned in a timely manner; for example to receive CPN intervention, GP reviews for medication changes or mental health input to manage people's challenging behaviour.

Inadequate

Is the service caring?

Our findings

People were not always supported by staff in a caring and compassionate way. People gave us varied responses when we asked about the caring approach of the staff. One person told us, "I don't think they are caring." A second person commented, "They are very good to me." A relative said, "There are good staff and not so good staff." Another relative informed us that the staff were very caring not just to their relative but to the whole family.

We consistently observed a small number of staff who rarely interacted with people. For example we observed poor interactions with people during four moving and handling procedures. The staff failed to provide reassurances and explain the procedure to the person, so that they had an understanding of what was happening to them, minimising distress and maintaining their understanding. We also observed these staff interactions during meal times where no conversation took place, with no attempt to tell people what the meal was or ask whether they liked it or not. We observed one staff member who did not speak at all to any of the people using the service. It was later confirmed that English was not this member of staff's first language. This meant they were not able to communicate effectively with people, as we had observed.

We saw that people were not always offered choices or were involved in decisions about their day to day routines. For example, throughout the day we saw that people were not always given choices about the food they ate. We also observed one staff member who walked into the dining room and pointed at one person and said to their colleague, "Have they finished?" When their colleague said that they had finished the staff member uncovered a pudding and gave it to the person in question. There was no verbal interaction with the person or any choice offered to them. We observed that people were not consulted about what they would like to watch on the TV. On the first day of our inspection there was a religious channel playing on the television and on the second day a shopping channel was playing. We noticed that people were not engaged in the programmes and many people's chairs were not positioned in front of the screen, which meant that, had people wanted to watch the television they were unable to do so comfortably. We observed that people were not given the choice of what they wanted to watch and staff made no effort to ensure that the programme on screen was to people's liking.

On more than one occasion we saw that people had fallen asleep or been left in chairs in uncomfortable positions, likely to have compromised their comfort and mobility. Staff did not consider whether the pressure cushions used were appropriate for each person, for example, they took the cushion off one chair to place under one person, without considering if that was appropriate to meet that their needs.

Our observations confirmed that those people, who were vocal or demanding of staff attention, received more engagement from staff, than those who were quiet. We observed three people who had little or no interventions for long periods of time and therefore they spent most of their day asleep or being passive observers in a room with little stimulation. One person, who was more vocal, received interactions from staff members on a more frequent basis. We found that positive and meaningful interactions were limited. Most care staff were patient and kind when supporting people but were largely task rather than people focused. They provided support as and when required but social interaction with people was reserved primarily for

when an activity took place such as meal times

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

Some staff we spoke with said they had worked at the service for a long time and they had built up positive relationships with people using the service. One staff member told us, "I am passionate about my role. I feel proud about what I am doing." A second member of staff commented, "I love my job. "The people are funny, they are brilliant. They have so much character."

We spoke with two staff who had worked at the service for a long time and who were very experienced. We observed that they were competent and were seen to be advising colleagues and ensuring that 'tasks' were completed. They were also very observant and responsive to situations that could potentially become volatile between people. We found that both staff were compassionate and caring in their approach to people.

We also observed some further positive staff interactions, with timely responses to issues that occurred (spilling drinks on the floor). Some staff sat with people and spent time, maintaining eye contact, going round and saying 'Hello' when they came on duty. We also saw a staff member holding up two different drinks and asking the person which one they would like. We observed the activity coordinators asking people if they would like to participate in the 1-1 activities each time. In addition we saw that music was put on after lunch on both days and this was well received by people who were singing along and one person was dancing.

People's privacy and dignity were not always respected by staff.

A relative said, "Sometimes their [people using the service] clothes are dirty and they have an odour. That's not very dignified."

Staff we spoke with said they always tried to ensure people were respected and their privacy and dignity maintained. One staff member told us, "We make sure people are well dressed and groomed. They are respected and we respect their dignity." Another member of staff commented, "I like to think that people are treated with dignity." A third staff member described to us how people's dignity was preserved by closing curtains, knocking on doors and using peoples preferred names.

We observed that not all staff treated people with respect and dignity. For example, people were not always referred to by appropriate forms of address, for example, "[Name of Person] babes." This was not detailed within their care plan as to how they wanted to be addressed. Staff were also heard speaking with people in a reprimanding manner, "Sit down, sit down here." Another staff member said, "Take your hands off me, you are going to hurt me." This was said in a chastising way, which did not take account of the reason the person had exhibited this behaviour. We over heard comments such as, "You're clean now, all nice and clean, no more sticky hands." This comment was delivered with a cooing noise and in a childish tone.

Many interactions between staff and people using the service were not respectful. We observed that some people were not supported to use the toilet throughout the day. As the day went on we noticed that some people had developed an odour of what appeared to be urine or faeces.

We saw one person who was wearing a skirt that was too big for her and in an attempt to 'pull it in' she was pulling her skirt up which seemed to go unnoticed by staff. The person also looked unkempt and had a lot of

facial hair. We observed people with long fingernails who were also unshaven. The relative of one who was visiting at the time of our inspection fetched an electric shaver from their bag to shave their family member. When we spoke with staff about this they told us the people concerned were not compliant with personal care. However this was not reflected within their care records and there were no measures in place to suggest how and when to overcome this.

We observed that although people's clothes were protected through the use of serviettes, we saw food/drink being spilt down their faces and fronts as a result of staff putting too much food on the spoon. People, who had spilt food on their clothing, were often not supported to change this in a timely manner. This demonstrated that people's privacy and dignity was not always considered or upheld.

There was also a bath list on the wall of the lounge downstairs highlighting by initials the day of the week each person was to have a bath and this was displayed for all to see. In addition we saw a statement in one person's room that read, 'All staff need to ensure that after doing all tasks i.e. - creams, toileting, turning that they are signing the necessary paperwork. Even if the resident is not involved in any of the above they need to be checked every two hours regardless and you need to sign to say you have completed the task.' This does not promote the privacy and dignity of people and we found that staff had not taken action to address this.

We also found that some staff were not always respectful of people's right to confidentiality, speaking about them in communal areas, where they could be overheard by other people. We found that care records were stored in unlocked cabinets in the main lounge and people's supplementary notes were left out on a dining table in the lower lounge. We found two clip boards outside people's room containing personal information about people's care needs.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive care and treatment that met their needs. Most people using the service were not able to tell us if the care they received was personalised and reflective of their needs. However one person said, "I don't like it here. I don't get taken out." A relative told us, "I don't think there are enough staff to make sure everyone is happy and gets the care they need." Staff told us they tried to provide good quality care but it was often difficult to fully meet people's needs.

One staff member said, "We try to be person-centred but care plans could be a bit better." A second staff member told us, "Staffing makes it difficult to meet people's needs." Some staff felt that peoples care needs were being met in difficult circumstances. One commented, "Care is maintained but there has been an impact on staff due to uncertainty." A further comment from a staff member was, "The management situation is not good. Staff are suffering and residents are suffering."

We observed that peoples' care did not always match what was recorded in their care plans. We saw that people were not always offered choices on a day to day basis about their care. We found that decisions about people's routines were not always in line with their preferences and many people's daily routines were not person centred but task-led by the staff. For example, we observed poor support to assist people to eat their meals.

We observed one person who was given their meal on an ordinary plate, and were provided with a spoon to eat it. We saw they were becoming increasingly frustrated because they kept knocking their food off the plate and they started to bang their spoon on the table. Staff repeatedly asked the person to stop and eventually they were supported to eat their meal. We did not observe any aids in use to support people to remain independent at meal times, for example, plate guards or specialist cutlery over the course of our inspection. This meant that this person was not supported to be as independent as they could be with meals.

We found there was a large number of people dependant on staff to eat their meals. This meant that some people were left waiting for lengthy periods before they received their food. On occasions some people walked by tables and took food from other people's plates and we observed some people's drinks being removed and drunk by others. When this occurred staff did not intervene. We found there were insufficient staff available to provide everyone with the support they needed to eat their meals in a timely manner without being rushed. This meant that people were often rushed and not able to enjoy mealtimes.

During our inspection we saw numerous occasions where people's needs were not met. For example, we observed that people were left throughout the day without being supported to use the toilet and on one occasion we noticed that a person had a toileting accident and they were left in soiled clothes for over two hours. This meant that people's care needs were not met in a timely manner.

We saw that the service used SSKIN bundles, which is a five step model for pressure ulcer prevention. We looked at the SSKIN bundles in place and found that people assessed to be at risk from a pressure sore were

reportedly repositioned every two hours during the night. However this was not recorded during the day time and on observation, once people who were immobile were seated in the lounge they were not moved, even for meals. We observed three people who remained in their chairs with no movement for over five hours. This placed people at risk of developing a pressure sore.

Pre-admission assessments took place prior to people being admitted. The records we looked at did not detail any consideration about the impact of a person's admission to the service on the current group of people living there. We discussed this with the clinical lead and the operations manager who both confirmed that the admissions policy had been reviewed to take into account the impact on people and staffing. We were advised that the two previous people to be assessed had not been admitted because their needs were too great for the service to meet. The clinical lead agreed that her considerations in respect of this were not documented, and the operations manager confirmed that the pre-admission assessment was under review to include this information.

Care plans we looked at lacked person-centred information, which staff needed to know to enable them to deliver personalised care. One staff member commented, "I haven't been involved in writing people's care plans." A second member of staff told us, "Care plans are alright. Carers can provide feedback to nurses. I think we should have a bit more involvement, we know them [people using the service]."

The care plans we looked at gave basic information about people's fundamental care needs, however they did not always demonstrate an understanding of people's individual needs and preferences. For example, people had diet and nutrition care plans in place. These provided staff with information about specific dietary requirements, such as allergies, but did not always record the meals that people liked to eat or where they preferred to have their meals. We were told that a review of some care plans had started. These plans were more person-centred; however they were not fully completed and still required some work to ensure they were a true reflection of people's needs and preferences.

We found that care plans required more robust information about people's care needs. For example, they did not always detail specific sizes of continence equipment required and in some records the required setting of pressure mattresses had not recorded. Care plans were evaluated on a regular basis but there was little evidence of the involvement of people or their relatives in the care planning or review process. We did see evidence that two reviews had taken place but the participants within this process had not been detailed which meant it was not easy to see who had been present.

Care plans did not show that people had been involved in planning or reviewing their care. The care plans were not presented in a person-centred way and did not demonstrate that people's views and preferences had been taken into account. For example, in nutritional care plans, there was often no information about what food people liked. In one we reviewed it stated that the person had no food preferences at all. Although people's preferences for a bath or shower had been recorded, there was no evidence to suggest whether they had received this care in line with their wishes. We found that people did not therefore always receive person-centred care, in accordance with their own views and wishes.

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

We found that people were not enabled to participate in sufficient activities that met their needs and reflected their preferences. Staff told us that activities for people did take place, however some staff they felt this could be improved upon. One staff member said, "People do get some activities. It could be a bit better." A second member of staff told us, "We have two activities staff and staff can spend a lot of time with

people. We do chat and read to people as well." A third staff member commented, ""It would be better if all staff spent a bit more time with people."

There were staff members who were responsible for planning activities. We found that although they worked to cater for people's individual needs, in accordance with their abilities, this did not capture everybody within the service. Quite often we observed that people were left with little or no stimulation for large parts of the day. One staff member told us, "Not all staff want to spend time with people or their visitors."

People had information in their care records to show they had previously taken part in art and craft sessions, listened to music or watched a film. When activities did take place, over the two days of our inspection, these were not always age appropriate. We observed a 15 minute session of a balloon game and then other more individual 'pamper' sessions whereby two people had a hand or foot massage. These were conducted in communal areas which impacted upon people's enjoyment of the sessions because of the noise levels and interruptions from other people.

We found the deployment of staff within the service meant that people were often left with no stimulation or input for long periods of time. The lack of interventions or stimulation for people meant that they became bored and challenging in behaviour, which then impacted upon other people living in the service. This meant that people were not supported to follow their interests and take part in social activities to enhance their sense of well-being and self-worth.

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

There was a complaints procedure in place that had been improved to ensure complaints were dealt with appropriately and in a timely manner. People told us they knew how to make a complaint. One person said, "I would talk to the nurses." Relatives we spoke with also told us they knew how to complain. One relative informed us, "I know how to complain but it's difficult to know who to go to with your complaint now that the manager has left."

The operations manager told us that a new system had been introduced to improve the way that complaints were managed. They also confirmed that they would use this information to undertake an analysis of the complaints once they had been in the post for longer.

Complaints/concerns file showed that complaints had been received and were responded to appropriately. We saw that the new system had improved the way these were managed and the operations manager stated that they would carry out an analysis of complaints received by the service once they had been in the post for a longer period.

We saw a complaints/concerns file that showed complaints had been received by the service and had been responded to swiftly and in a timely manner in line with the organisations complaints procedure.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. There was an operations manager who had been in post for eight weeks and attended the service four days a week. The clinical lead for the service was acting as manager in his absence. The operations manager told us it was his priority to recruit a manager for the service and he would then work with the new manager for a month to ensure they were thoroughly inducted to the service.

When we first arrived at the service there appeared to be a lack of leadership. Staff appeared unclear as to who the manager was since the departure of the previous manager. During the first morning a relative arrived and was asking who was in charge and none of the staff were able clarify who this was. They advised the relative they were trying to contact the operations manager as, "He would know more. "Staff told us they were unsettled and anxious about the change of management. One member of staff said, "It is difficult with the change in management, it can be stressful." A second staff member commented, "The manager thing has not been too good. They keep changing things; we don't know what we are supposed to be doing." A third member of staff told us, "The management situation is not good. Managers come in and do their thing but don't ask for our suggestions. They are not consulting staff."

We found that staff had not been appropriately supported to deliver care and treatment to an appropriate standard. This was because essential training had not been completed by all staff and there were gaps in staff training. In addition the induction programme did not ensure staff had the skills and training so they could provide care safely. We observed during our inspection unsafe moving and handling procedures being carried out by staff. At the time of our visit some staff told us they had felt unsupported and we found that staff supervisions had not been undertaken on a regular basis. We spoke with the operations manager about staff training and staff supervision. We found they had already recognised these as areas that needed improvement and plans were in place to address the shortfalls. We were also able to find evidence that staff meetings had been held on a regular basis and found that subjects discussed included, locking away gloves and aprons, ensuring staff only spoke English whilst working in the service and information about confidentiality.

We saw a summarised response from staff satisfaction questionnaires that had been completed in December 2015. We saw that the staff results to the questionnaire showed that 45% of staff did not feel the service was a good employer. There was no action plan or evidence that improvements had been made to address the concerns and issues raised by the staff team.

We found the culture at the service was not person centred, but task focused. Staff were aware of their responsibilities in relation to assisting people with their basic physical care needs; however we found there was little awareness of the needs of people living with dementia. We observed poor interactions by some staff and we observed they did not offer people dignity, compassion or respect.

We found that when the previous manager had left the service in January 2016 some of the quality assurance systems had not been completed on a regular basis. For example, we saw that a detailed care

plan audit had been carried out the previous year. However we were unable to find a more recent and up to date audit. We also found evidence of infection control audits, medication audits, mattress audit and provider visits that had not always been completed on a regular basis and it was not clear how these were used to improve or develop the service. The operations manager acknowledged this and told us they had plans to overhaul the quality assurance systems, including audits and checks, to ensure they were functional and used to drive improvement at the service. They had already started this process by ensuring medication audits were completed weekly by the nurses. However we found these had not been effective in identifying some areas for improvement that we observed in the medication records.

We found that people using the service were not consulted regularly about the delivery of care and treatment. We did observe that relatives had completed a service satisfaction questionnaire in December 2015. However there was no action plan in place as a result and no evidence to show how this was being used to improve the service.

Incidents and accidents were recorded but we were unable to determine if they had been referred to the local authority appropriately or not because the records for these were disorganised and did not provide a clear audit trail.

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

The operations manager told us they had identified areas that required improvement at the service and was addressing the shortfalls. For example they informed us that they had already recognised that care plans were not person centred and lacked information. They had put plans in place to review all the care plans and the staff were in the early stages of this process. The operations manager also told us they wanted to involve all care staff in the care planning process, not just the nurses, so that all staff could impart their knowledge of the people they cared for. During discussions with staff many had expressed a wish to be more involved in the care planning process.

We found that some staff had recognised that improvements had been made and were positive about the direction the service was taking. For example, one staff member explained to us, "The new ops manager is very polite and is able to come to your level. He feels like part of the team as well, he respects you." A second member of staff said, ""It's changed a lot, everything is better. There is more organisation." They also told us, "The company ethos is positive and there have been improvements." We were told by a third staff member that although it was still early days, they felt confident that the service would be improved. They said, "[Name of operations manager] has a very sensible head on his shoulders and knows what needs to be done. He is also very approachable. I admire his leadership skills."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered provider had failed to ensure that the care and treatment provided to people was appropriate and met their needs and preferences. In addition the registered provider had not made suitable arrangements to ensure that people were enabled to participate in activities that met their specific diverse needs and reflected their interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered provider had not made suitable arrangements to ensure that personal and confidential information was stored securely and that people were treated with people with dignity and respect.

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 registered provider had failed to ensure that systems or processes were in place to assess, monitor and improve the quality and safety of the services provided and to mitigate the risks relating to the health, safety and welfare of people using the service. In addition the registered provider had not consistently gained and acted upon feedback from people for the purposes of continually evaluating and improving services.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that the risks to the health and safety of service users were safely managed and had taken appropriate action to mitigate any such risks. In addition areas of the premises used by the service were not safe and emergency evacuation plans lacked essential details to ensure people could be evacuated safely. The procedures for the safe management of medicines was not consistently followed.

The enforcement action we took:

Notice of Decision

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 registered provider had failed to ensure that systems in place to keep people safe from avoidable harm were robust and people were not protected from physical, psychological and emotional harm from other people living living in the service.

The enforcement action we took:

Notice if Decision

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 registered provider had failed to ensure the premises and equipment were suitable for the purpose for which they are being used, properly maintained to ensure people were protected against the risks associated with unsafe or unsuitable premises.

The enforcement action we took:

Notice of Decision