Four Seasons Health Care (England) Limited

Euxton Park Care Home

Inspection report

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Ratings

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

Overall summary

Euxton Park is registered to provide accommodation and nursing or personal care for up to 63 people. The home provides care for older people and people who have a physical disability. There are two units within the home one for people who require personal care and a nursing unit.

Care is provided on a 24 hour basis, including waking watch care throughout the night. All bedrooms at the home are single and some include en-suite facilities. There are a variety of communal areas, including well maintained grounds for the use of people who use the service.

This inspection took place on 4 & 5 August and was unannounced. At the time of our inspection, 58 people were living at Euxton Park. There were 27 people were living on the nursing unit and 31 on residential unit.

At our last inspection of the service, which was carried out 22 January 2015, we found breaches of legal

Summary of findings

requirements in relation to the effective deployment of adequate numbers of staff to meet people's needs, promoting the privacy and dignity of people who used the service and the effective monitoring of the safety and quality of the service.

During this inspection we found evidence of continued breaches is relation to these areas. We also found breaches of regulations relating to safe care and treatment, medicines management, safeguarding people from abuse, arrangements for the safe maintenance of equipment, infection control, nutritional care and the provision of person centred care.

There was a registered manager who had been in post for just under twelve months at the time of the inspection. 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 identified concerns about how risks to people who used the service were managed. People at risk in areas such as developing pressures sores or from falling, did not always have clear risk management plans in place about how to maintain their safety.

We had concerns about some aspects of the management of people's health care needs. Processes for planning people's care and ensuring that all staff providing the care were competent, were not robust. Health care advice from community professionals such as pressure sore experts or dietitians, was not always followed. This meant that people were at risk of receiving unsafe or ineffective care.

People using the service were not protected against the risks associated with the administration, use and management of medicines. People did not always receive their medicines when they needed them or in a safe way. This meant that people's health and wellbeing was at risk.

The service had a safeguarding policy and guidance for staff on their responsibility to protect people who used the service from abuse. Staff spoken with demonstrated good understanding of the area and said they were confident to report any suspicions or allegations of abuse. However, we found evidence that two allegations made by people who used the service had not been reported in accordance with safeguarding procedures. This meant they were not properly investigated and arrangements had not been made to safeguard the people concerned.

We found that communication within the home was not always effective. This resulted in the management team not always being aware of significant incidents that occurred. We saw that processes for investigating adverse incidents such as accidents, were not always effective. This meant that opportunities to learn from them and put measures in place to stop them happening again were sometimes lost.

Feedback from people who used the service about the approach of some care workers was of concern. Whilst some people spoke highly of staff, others described situations where they felt they had been treated unkindly and without respect. Some people felt their privacy and dignity was not consistently promoted. These views were supported by some of our observations during the inspection.

Some people felt they were not able to make choices about their care or day-to-day lives. For example, some felt they were not able to make choices about what time to get up in the morning or go to bed. We found some good examples of person centred care planning but many care plans we viewed were missing important information such as people's preferred daily routines and social care needs.

The feedback we received from people who used the service contained an overwhelming theme regarding staffing levels. A number of people felt strongly that there were not adequate numbers of suitably skilled staff consistently deployed to meet their needs. We were given numerous examples from people regarding long waiting times for assistance. People also expressed concerns about the use of agency staff who they felt sometimes did not have sufficient understanding of their needs.

Arrangements for the safe maintenance of premises and equipment and the detection and prevention of the spread of infection, required improvement to ensure the health, safety and wellbeing of people who used the service was protected.

Summary of findings

There were a number of processes in place to facilitate the regular monitoring of safety and quality of the service. However, we identified a number of concerns during this inspection, which had not been previously highlighted by these processes. This meant they were not fully effective.

The environment was generally well maintained and suitable for people with limited mobility. We saw that all accommodation was provided on a single room basis and people had been supported to personalise their rooms with photographs, ornaments and other valued possessions. However, a number of people who lived with dementia, would have benefited from an environment better adapted to their needs. We made a recommendation about this.

We saw there was an activities programme in place and were advised this was being developed to ensure it met the needs of all the people who used the service. The newly appointed activities co-ordinator recognised the diverse needs of people who used the service and was hoping to arrange some training to assist him in developing the area further.

The registered manager had made efforts to involve people who used the service in its development. We saw that regular meetings were held during which residents and relatives were provided with opportunity to express their views and ideas. People who used the service and their relatives told us they felt comfortable in expressing their views. However, this was not the view of all staff members we spoke with.

We found a number of breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to person centred care, privacy and dignity, safe care and treatment, meeting nutritional and hydration needs, premises and equipment, good governance and staffing.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

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.

Risks to people's health, safety and wellbeing were not always well managed.

Arrangements for the safe management of medicines were not effective. This meant that people were not protected from the risks of unsafe medicines practice.

People who used the service very clearly felt there were not always sufficient numbers of suitably qualified staff effectively deployed to meet their needs.

Arrangements to safeguard people from abuse were in place but not always followed by staff.

Is the service effective?

Inadequate 

The service was not effective.

People's health care needs were not well managed. Arrangements for care planning and ensuring that staff providing health care were competent to do so safely, were not always effective.

People at high risk of poor nutrition or hydration were not always sufficiently protected.

There were inconsistencies in how people's mental health and ability to consent to their care was assessed. Not all staff had a good understanding of the legal requirements of the Mental Capacity Act 2005.

Is the service caring?

Inadequate 

The service was not consistently caring.

Some people spoke highly of staff and felt they were treated with kindness and respect. However, several expressed concern about the attitude and approach of some staff members.

Some people who used the service felt their privacy and dignity was not always promoted. This was in accordance with some of our observations throughout the inspection.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Arrangements for care planning and review were inconsistent. People's care plans did not always provide a clear up to date picture of their care needs.

Some people felt their care was not always provided in line with their needs and wishes.

Summary of findings

People who used the service and their relatives felt able to express their views and ideas.

Is the service well-led?

Inadequate

The service was not well led.

Arrangements for monitoring safety and quality across the service were not effective and did not always identify areas requiring improvement.

Adverse incidents such as accidents or safeguarding concerns were not always communicated to the management team. Processes for investigating such incidents were not consistently used, which meant opportunities for improvement were lost.

Euxton Park Care Home

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.

The inspection took place on 4 & 5 August 2015 and was unannounced.

The inspection team comprised three adult social care inspectors, including the lead inspector for the service, a pharmacy specialist, a specialist in the nursing care of older people 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. The expert-by-experience had expertise in services for older people.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with eleven people who used the service during our visit and nine visiting relatives or friends. We also had discussions with the registered manager, deputy manager, area manager, quality manager and eleven nurses or care workers. We had feedback from six community professionals during the inspection and also contacted the local authority contracts team.

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. We closely examined the care records of twelve people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, six staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Inadequate

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe when receiving care. Their comments included; "I feel safe here and if I had a problem I would talk to one of the staff." "Yes I feel safe. I feel looked out for, that makes me feel safe." And "There is always someone about walking past my room. I can hear the staff talking on the corridors, that makes me feel safe."

However, other comments we received included, "Mostly, I feel safe but I do get worried about things. I worry about when I need changing sometimes." And "I don't have confidence in this place, especially the staff training."

During the last inspection of the service in January 2015, we found that the service did not always ensure there were adequate numbers of suitably qualified staff deployed to meet the needs of people who used the service.

The registered manager sent us an action plan, which stated this area had been addressed. However during this inspection, people we spoke with felt strongly that this was not the case.

One visiting relative we spoke with felt staffing levels were appropriate. They told us they visited the service at different times and felt staffing levels had never been a problem.

However, an overwhelming majority of people we spoke with expressed concern. Comments from people who used the service included; "Staffing can be a problem at times - there seems to be a lot of new staff so it takes time getting to know people." "Sometimes I buzz and the staff come and turn the alarm off but tell me I will need to wait. Sometimes it can be an hour before someone comes back – it's not good." "From 7am -12 pm is a bad time to press the buzzer. I have waited up to one hour for someone to attend to me." "There are three staff on at night sometimes only two." This person went on to describe a situation they said happened approximately two months previously. They told us they had needed some personal care assistance and said, "When the staff arrived they told me they would have to go and get gloves and an apron but she never came back. I waited a very long time before another carer answered my buzzer. The second carer told me she was very sorry I had had to wait in such a state. She was nearly in tears herself because I was so upset."

Other comments included, "I need two people to assist me. I have to be hoisted. I have to wait two hours sometimes. I have a big sore on my back. I have to stay in this wheelchair because staff haven't the time to move me about. Staff pop their heads in and say you will have to wait." And "I can wait 30 minutes or more if I need changing. I get turned every few hours."

A visiting relative commented, "I am here more than the staff. I am here every day. They need more staff in the mornings. I see people having to wait, I hear call bells going off. The staff are run off their feet. All the residents on this floor need two people to assist them."

We spoke with staff members prior to, during and after this inspection. We also received contact from some whistle blowers regarding staffing levels at the home. In particular, concerns were expressed about night staffing levels on the nursing unit. On the first day of our inspection we arrived prior to the night shift ending. There were three staff on duty on the nursing unit, supporting 26 residents who all had complex health care needs. Every person required 2-1 support and we were told that two of the staff were in the process of doing their 'rounds' assisting people with personal care. The nurse had commenced her medication round. We asked her what she would do if someone else required assistance and she told us she would break off from the medicines round to assist them. This could lead to a delay in people receiving their medicines.

Comments from staff received prior to, during and after the inspection included, "Sometimes I get upset when I look at the rotas. It's not just the number it's the skill mix as well." "It's lovely here. Lovely people but the problem is the staffing." "You simply cannot give the quality of care you want to give, it is impossible." "We have had lots of people leave recently. It's because they can't cope with the work load."

One relative we spoke with expressed concerns about the 12 hour shifts worked by most staff members. We viewed records of staff hours worked and saw that on two occasions in July 2015, two staff members had worked shifts of almost 16 hours. This was due to an agency nurse not turning up. These staff members were responsible for administering medicines and providing nursing care. Working shifts of this length did not support safe practice.

We spoke with the registered manager, area manager and quality manager about our findings in relation to staffing

Is the service safe?

levels. We were advised that there was a formal tool in place to monitor people's dependency levels and adjust staffing levels accordingly. However the feedback we received from people demonstrated that staff were not effectively deployed to ensure people's needs were sufficiently met.

The above findings provided evidence of a breach of regulation18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We identified concerns about the way personal risks to people who used the service were managed.

A range of risk assessments were carried out for each person who used the service, in areas such as falling, developing pressure ulcers and nutrition, for example. However, in some people's care plans, although risk had been identified, there was no clear action in place to keep people safe. For example, we viewed the care plan of one person who was at high risk of developing pressure ulcers. We found there was no risk management plan in place.

We found other examples where actions to help maintain people's safety had not been completed. For two people assessed as being at high risk of falling, no referrals had been made to the falls prevention service. We were told by the registered manager that these people were carefully monitored due to their high falls risk but we observed this not to be the case at all times. We observed one of the people left unsupervised for a time period of over twenty minutes and on another occasion, observed the person to nearly fall over, when walking unaided in a communal area.

A community professional we spoke with raised concerns that there had been a recent failure to manage known risks to a person who used the service. We were advised that staff had failed to follow the person's safe transport protocols on one recent occasion, which had resulted in the person being at risk of significant harm during a journey to hospital. This issue had been investigated by the local safeguarding team.

The failure to assess and manage risks to people's health and wellbeing was in breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at medicines, Medication Administration Records (MARs) and other records for 13 people who lived in the nursing units of the home and found concerns and/or discrepancies in all of these cases.

Medicines were not always stored safely. The clinical room and medicines trolleys were dirty and unhygienic and the fridges were not being kept within the safe temperature range. We found supplies of medicines and medical devices, including antibiotics, eye drops and blood testing equipment that were out of date and unfit for use.

We saw that controlled drugs (strong medicines with additional storage and recording requirements prescribed by law) had not been disposed of safely, and these, in common with other waste medicines, were not stored safely.

We saw care workers and other members of staff take prescribed nutritional supplements and thickening products (to aid swallowing) out of the medicines room without checking who the product had been prescribed for. We asked the staff members who they were taking products for and on each occasion they gave us names other than the name on the dispensing label. People's health and wellbeing is placed at risk of harm when they are given products that have not been prescribed for them.

On the nursing units, we saw that the administration of medication and other nursing tasks were often delegated to trained senior care workers known as SNCAs (Senior Nurse Care Assistants). There was no system in place to enable nurses on duty to double check whether tasks delegated to the SNCAs had been carried out correctly. Senior management at the home told us they were 'not entirely happy' with SNCAs performing nursing roles, but had not taken action to review the situation. They were unable to tell us whether the SNCAs had completed any competency checks, but confirmed that none had been carried out this year.

Medication records, including those for Controlled Drugs, were inaccurate and incomplete. This made it impossible to determine whether or not medicines had been given correctly. Records for the application and use of topical medicines, for example creams, were incomplete and unclear, meaning that we were unable to tell who had applied the products and whether or not they had been used as prescribed. We saw evidence that some people had not been given their medicines correctly.

Inadequate

Is the service safe?

Many people were prescribed creams and medicines, for example, painkillers and laxatives, that could be given at different doses such as one or two tablets, or that only needed to be taken or used when required. We found that there was not enough information available to enable nurses and care workers to give these medicines safely, consistently and with due regard to people's individual needs and preferences. This was of particular concern as the service frequently relied on agency staff who were unfamiliar with the people living there.

Although the manager told us that regular audits were carried out to see how well medicines were managed within the home, we were concerned that the process had not been robust enough to identify the concerns and discrepancies that we found.

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

There was a safeguarding policy and related procedures in place, which provided guidance for staff in the action they must take in the event that an incident of abuse was suspected or alleged. Staff we spoke with were aware of the procedures and their responsibility to report any safeguarding concerns identified.

Staff also demonstrated awareness of the service's whistleblowing policy and said they were confident to report any concerns without delay. One staff member commented, "I would not have a problem speaking to the manager if I thought something was wrong."

Training records showed that 81% of staff employed at the service had completed training in the area of safeguarding. The registered manager advised us that those who had not yet completed this training, were due to do so as part of the service's mandatory training programme. This information was supported by our discussions with staff.

However, during the inspection we became aware of two incidents that should have been reported to the local authority safeguarding team but were not. Both were allegations, which had been made by people who used the service.

In both cases, staff members had failed to follow appropriate safeguarding procedures by not reporting the allegations and attempting to investigate the allegations themselves. In both cases investigations had not been properly completed and appropriate action had not been taken to safeguard the people concerned.

The registered manager was not aware of either of the incidents. One allegation had been made prior to her employment at the home but involved a staff member still employed at the time of our inspection. The other was more recent but the registered manager had no knowledge of it.

The failure to follow safeguarding procedures by recognising and reporting incidents of abuse was in breach of regulation 13(1)(2)&(3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the personnel files of six staff members. We found that the registered manager followed standard recruitment practices to help ensure people who were employed, had the suitable skills and were of suitable character.

In all but one of the files viewed, we found evidence that suitable background checks had been completed prior to a candidate being offered employment. These checks included identity verification, previous employment references and a Disclosure and Barring Service (DBS) check, which would highlight if the person had any criminal convictions or had ever been barred from working with vulnerable people.

However, on one of the files we viewed, a DBS check was not present. We spoke with the registered manager who confirmed the check had been undertaken but could not provide us with evidence, as only the administrator could access it and she was on holiday. We advised the registered manager that evidence of each stage of the recruitment process including DBS checks, should be available to her at all times, to provide a sufficient audit trail. The DBS information in question was provided following the inspection.

We found communal areas of the home were satisfactory and generally clean. However we were concerned about the safety of one person's bedroom. We found this room to be generally unclean. We also noted the presence of two prescribed inhalers, which were both open, with no visible opening date on them. Smoking materials including a cigarette lighter were also seen. This placed the person at risk of harm.

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Is the service safe?

On the ground floor we noted a sluice and a room containing cleaning materials were not locked. We found some store rooms were also unlocked and in one room, the light did not work.

There were processes in place for testing facilities and equipment within the service but these were not always effective. For example, there was a useful checklist in place which should have enabled the registered manager to monitor the safety testing of hoists and slings. However, this had not being completed regularly and as such, it was impossible to keep track of when the hoists and slings had been tested. According to the records, some had not been checked for several months and other records were missing. One hoist on the nursing unit was found to have last been serviced in February 14.

We noted the presence of electrical equipment in some people's bedrooms that did not have Portable Appliance Testing (PAT) stickers on to confirm it had been safety tested.

The failure to ensure all parts of the environment and equipment were safe for use was a breach of regulation 15 (1)(a)(b)&(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was an infection control policy and related procedures in place. We also confirmed that the registered manager was the appointed lead for infection control within the service. We saw that training was provided in this area and that all staff were expected to complete it. Records showed that at the time of the inspection, 75% of staff had completed the training.

The home was clean and free from clutter in communal areas. Toilets and bathrooms were noted to be clean and hygienic. However, two toilets were found to have run out of soap for much of the first day of our inspection.

We saw that staff wore appropriate protective clothing when carrying out their duties and we observed them following appropriate infection control practice, such as regular hand washing, throughout the day.

However, we identified some concerns regarding the cleanliness of some equipment used. The medication room on the nursing unit was found to be in a very unclean state. The trolley used to store medicines had ground in dirt on and what appeared to be food debris in one area.

Medicine dispensing cups, meant only for single use, were being rinsed and reused. We found a number, which had been left to dry out on a rusty radiator. A pill crusher was found to be visibly dirty and we noted debris from tablets previously crushed in the bottom. This was unhygienic and potentially dangerous.

We found that some slings used to transfer people with a lifting hoist were in a visibly unclean state. We also noted the use of some communal slings and no clear protocols for how people using the communal slings, were to be protected from the risk of infection.

One of the inspectors saw that the suction machine used for one person who used the service was very dirty and had to request that staff clean it before it was used.

The failure to assess prevent and control the spread of infection was a breach of regulation 12 (2)(h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

During this inspection we identified concerns about the management of some people's health care needs.

We looked at a number of care plans for people who had complex health care needs such as Percutaneous Endoscopic Gastrostomies (PEGs) and Nasogastric (NG) tubes. We found that care planning around areas such as these was sometimes inadequate. In some cases there were no care plans in place in relation to the safe management of people's PEG sites or NG tubes, despite the complexity of these particular health care areas.

We heard from one community professional who had raised a safeguarding alert about the inadequate care one person with a PEG had received. This was following a disclosure from the person who used the service, that nursing home staff were not carrying out important care of his PEG. The condition of the person's PEG, which had led to a required hospital admission, supported this information. In addition, this person had disclosed that an agency nurse at the home had been rough when providing his PEG care and hurt him.

We were also advised that on attending the service in July 2015, the community professional had identified concerns that the person's stoma site may be infected. Concerns had been raised that staff at the service had failed to take appropriate action in taking care of the person's stoma site, such as arranging for a swab to be done to test for infection, and the community professional had to be quite insistent with staff that this be followed up.

We were concerned about some aspects of care people received for pressure ulcers. We looked at the care plan of one person who had a number of ulcers due to her medical condition. We saw that this person was visited regularly by the Tissue Viability Nurse who gave advice about how the ulcers should be treated. This nurse had advised that the person's ulcers should be dressed every three days. However this had not been put in the person's care plan and records showed that they were often not re-dressed for timescales longer than this. On one recent occasion, records stated it had been seven days.

We saw this person used a special mattress, which helped to reduce the risk of pressure ulcers developing. The mattress had to be put on a certain setting, depending on the person's weight. However, we saw that this person had not been weighed for several months and as such, staff could not be certain it was correctly set.

We found several other examples where people had pressure sores but no care plans in place for their treatment, or the prevention of other sores developing. One person had two pressure ulcers at the time of the inspection, which were being treated by District Nurses. We saw that advice had been given by District Nurses to constantly monitor the person's pressure areas so any further breakdowns could be prevented, but this advice had not been included in the person's care plan. We asked the person if staff checked regularly their skin. They said, "They do sometimes but not always. It depends which staff it is."

We viewed the care plan of a person who had Diabetes and was dependent on Insulin. There was no care plan in place about the early detection and management of Hypo/Hyper Glycemia. Some areas of people's health needs were not regularly reviewed. We saw that one person's pressure care risk assessment had not been reviewed for seven weeks despite the fact they had two pressure ulcers.

One person who used the service returned from a hospital stay during our inspection. This person arrived at the home at 10.30am. Despite two requests from a family member, staff did not attend to her until 11.45am. No body mapping or pressure area care was provided during this time, despite this person having very high dependency needs.

Concerns were raised with the local safeguarding team by a community professional that one person who used the service had not been able to attend outpatient appointments on several recent occasions because the home had failed to make safe transport arrangements for him.

The failure to ensure people's care was planned and delivered in accordance with their needs and in safe manner was a further breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We raised our concerns with the local authority safeguarding team and CCG commissioners.

We viewed care plans for some people who were assessed as being at high risk of poor nutrition. We found that for

some people, these risks were not well managed. One person was assessed as being at very high risk and described as having a poor appetite. Their daily records often referred to a 'poor intake' of food and fluid throughout the day. However, we were concerned to find that this person had not been weighed for several months. In addition, there was no food or fluid chart in place for them. We noted that a referral to the community dietitian had been made for this person several months previous but there was no evidence this had been followed up.

We looked at the records of another person, which also stated they had taken a poor amount of food and fluid over recent days. However, no action had been taken and their risk assessments had not been updated in response to this.

We found evidence that one person who was prescribed a food supplement twice a day, was not receiving this on a regular basis. We also noted that another person who needed a special nutritional supplement, had ran out on one occasion, some weeks earlier.

We viewed the records of one person who had a special feeding regime. We saw that they had been visited by a dietician almost two months earlier who had made changes to the amount of food they should have been given. This had not been updated in the person's care plan and they were still receiving the original amount, which the dietician had advised should be altered.

Failure to safely meet the nutritional needs of people who used the service was a breach of regulation 14(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives about the quality and variety of food provided at the home. In general we received positive feedback about this aspect of life. Most people we spoke with were complimentary about the standard of food provided and said that fresh fruits, snacks and drinks such as fruit juice and smoothies were regularly available.

We were advised that people were offered menu options and were asked to make their choices for the next day on a daily basis. We were advised by the cook that the main meal of the day was served in the evening, as a number of the people who used the service preferred to have a later breakfast. This information was supported by our observations of people attending the dining room for breakfast at a time of their choosing.

We observed the lunch time service on both units. We noted that people were enabled to have their lunch where they preferred, either in the dining room or in their own bedrooms. The dining rooms were nicely set and we saw that people were given time to eat their meals at their own pace with assistance being provided to those who required it. People appeared to enjoy their meals, which were nicely presented.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

We were advised that training in this area was classed as mandatory, which meant all staff were expected to complete it. However, we viewed records that showed only 47% of staff members had completed training on the MCA and 69% had completed training on DoLS.

Some of the staff members we spoke with demonstrated a limited understanding of the area. One person who had some supervisory responsibilities told us, "To be honest I have done mental capacity and DoLS training but only online. I don't feel I could fill out an application. I would need to be shown."

All the plans we looked at had forms in for mental health and capacity assessments but in some cases these were not completed. We also noted that in one example, a brief assessment had been completed by a staff member who had not been provided with training in mental capacity. Some of the care plans we viewed contained generic MCA guidance but this was dated 2009.

Another person's care plan referred to the fact that they sometimes chose not to eat. The plan stated that staff may need to make 'best interests' decisions for the person in relation to this. However, the person's assessment stated

Is the service effective?

they had full capacity to make their own decisions so it was of concern to note that staff completing the care plan felt it may be appropriate to make decisions on the person's behalf.

It was confirmed by the registered manager that no applications for Deprivation of Liberty Safeguards (DoLS) had been made. We spoke with the manager and deputy manager about this. In light of the recent ruling related to a person 'lacking capacity, not free to leave and being under continual supervision,' it seemed this 'acid test' was met by several people who used the service during our inspection. We advised the manager that mental capacity assessments should be conducted without delay on all people who used the service to help determine if applications were required.

The failure to conduct mental capacity assessments and make applications to deprive people who lacked capacity to consent to their care was evidence of a breach of regulation 13 (5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives about their confidence in staff to provide safe and effective care. There was a strong theme in our discussions, which was that people had far more confidence in regular staff members as opposed to agency or bank workers.

People's comments included; "The regular staff are good. It's the agency and bank staff. There are too many of them they don't know what they are doing. It's not conducive to good care. (Name of relative) is not getting continuity of well trained staff." "Bank and agency staff do not know who I am or what my needs are. Agency staff who have no training don't know how to look after someone like me. Sometimes we see agency staff for one night and never see them again."

"Staff told me that the agency staff don't know how to put a feed up and I have known senior staff on many occasions having to work over their shift because they are so short staffed." However one person commented, "I think in the past there has been a high dependency of agency staff, especially at weekends but things seem better lately."

One staff member we spoke with expressed concerns that agency staff sometimes led the shift at nights on the nursing unit but did not know about people's needs. We were told about one occasion, when a day nurse had handed over to an agency nurse to lead a night shift, who had never worked at the home before.

On the first day of our inspection, an agency staff member was the only nurse on duty designated to the nursing unit. He told us he had worked at the home before but thought it was about 'three or four months ago'. The nurse was not wearing a name badge, which made it difficult for people who used the service and their relatives, as they didn't know who he was. We asked the nurse how he ensured he was aware of people's needs on the unit. He advised he would get this information through a verbal handover. However, as it was a busy unit, we were aware that he would have had little (if any) opportunity to read people's care plans.

We found evidence that some complex health care tasks were delegated to specific staff members who were not qualified nurses. In these circumstances, there must be robust systems in place to ensure the safety and quality of the care being provided. However, we found these systems were not effective and processes for ensuring the competence of none nursing staff to carry out health care tasks were inadequate.

Through viewing training records and staff personnel files we found that some of the staff undertaking nursing tasks did not have up to date training. One person's records showed that they had last completed training in PEG care in 2011. However they were regularly providing this care. In addition, this person's mandatory training was not up to date.

There was no evidence that observed competences had been carried out for any of the staff members providing nursing care. There were forms entitled 'Observed Competence Checklist' on some of the files. However, on further examination it was recorded that the procedure had been discussed, which did not equate to an observed competence.

The failure to ensure that staff were competent to provide safe care and treatment for people who used the service was a breach of regulation 12(2)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We received mixed feedback about training from staff we spoke with prior to, during and following the inspection. One staff member was very complimentary about their induction. They said, "I have had a really good induction. I

Is the service effective?

think the place has a really good feel." However, others we spoke with felt their inductions had not been as useful. One person commented, "I wasn't even shown around. I had to find things out by myself."

Some records of inductions were seen and included training related to Dementia Awareness, Emergency Procedures, Moving and Handling and Infection Control. We saw and were informed by staff members, that the training was mainly of an e-learning nature so they completed it independently and on line.

Staff had mixed views about e-learning. Whilst some felt it was helpful to be able to do their training at their own pace, others felt they would prefer more face-to-face training where they could discuss issues and ask questions.

There was a mandatory training programme, which all staff were expected to complete and update on a regular basis. We saw that training completion rates were monitored by the registered manager and individual staff members were prompted if they fell behind. However, we saw that this process was not always effective. For example, we viewed the file of one person who had been sent a letter by the registered manager about their failure to keep their mandatory training up to date. We saw that some months later, the same letter had been sent. The staff member had still not completed the required training but this had not been followed up through formal supervision.

Records were seen confirming that supervisions and appraisals took place. We saw that supervision offered staff the chance to meet with a manager on a regular basis to discuss issues such as training and development, or any concerns either party may have. In some examples we noted performance issues had been discussed and support plans implemented for the staff members in question. However, we came across two examples where there was no reference to concerns about the conduct of staff members, which had previously been identified.

The environment was accessible. There was a passenger lift and areas were wide and spacious so people who used wheelchairs could move around easily. Hand rails were fitted to walls. There was very well maintained and spacious grounds, which were accessible for people who used the service.

The bedrooms we visited were bright and airy with lovely views. Some were a very good size and had been personalised with people's photographs and treasured belongings. We did note the absence of chairs for visitors in some people's rooms. Throughout the inspection we came across a number of visitors who had to sit on people's beds.

A number of people who lived with dementia used the service. However, we noted that the environment was not particularly useful for them. There was a lack of signage around the home, which would have been beneficial and reflected a more person centred approach to providing care.

We recommend the provider considers NICE and Alzheimer's Society guidelines related to suitable environments for people who live with dementia.

Inadequate

Is the service caring?

Our findings

Following the last inspection in January 15 we found the service did not ensure that care was provided in a manner that promoted people's dignity. The registered manager provided us with an action plan stating this issue would be addressed. However, during this inspection we had outstanding concerns.

Some people we talked with spoke highly of staff and the care they received. Their comments included; "The staff are lovely and take good care of me and everyone else." "I have needed so much help over the last few weeks and the staff here, and the manager, have been marvellous." "Yes, I think the staff are very kind they are all friends with me."

However other people we spoke with were not as positive and a number of people expressed concerns about the attitude and approach of some staff members. One person who used the service told us, "[Name removed] on nights says I am lazy and not incontinent. She says I could go to the toilet."

Other comments we received included; "One of the seniors told a member of staff that was talking to me to leave me and get on with her work as they didn't have time for chatting. I felt very sad. Some staff hurry you, they are poor carers. Staff say to (name removed) next door that they don't have time to take her to the toilet she will have to use the commode." "Most of the staff are OK but some can be a bit strict and shout a bit at times." "Some are kinder than others." "They never ask if I am happy you either like it or lump it. When staff are rude I say don't forget I am paying your wages." These comments were of a similar nature to some of those received during our last inspection in January 2015.

Other people we talked with spoke highly of staff but said they felt they often didn't have the time just to sit and chat or ask them how they were although one person told us, "The cleaner is very nice, she has a chat with me when she is cleaning my room." A visitor commented, "They are caring but no time for interaction or developing any personal relationships. The manager could do with doing better team building." Another relative commented that more permanent staff would be beneficial so they would have more time to get to know the people they were caring for. A person who used the service told us, "They have no time to chat. They do talk when they come to feed me but it's a quick in and out."

We observed staff providing support throughout the inspection. Our observations were positive and we noted that staff responded to people's requests for assistance in an appropriate way.

Staff approached people in a kind and patient manner and interacted positively with them. At lunch time we observed a care worker provide very kind and sensitive support to a person who used the service. However, we observed another person sitting in the reception area for a two hour period during which no member of staff who passed by offered them a word. It was only when the afternoon cup of tea arrived that was she spoken to.

Residents and relatives we spoke with felt that the privacy and dignity of people using the service was not always respected. We heard some examples from people of when they felt their own dignity or privacy had been compromised. One person who used the service told us when she was having a shower, care workers got her undressed in her room then transported her to the bathroom with a sheet wrapped round her." Another person recalled, "When I was being changed another carer just walked in, asked the first carer something then left. I told the first carer I was not happy about that. The carer told me I was being awkward."

We observed that most people's bedroom doors were open all day. One visitor told us that people's doors were always open and said he had seen people lay on their beds in underclothes. We observed someone being provided with personal care in their room with their door open and also saw someone using a commode in similar circumstances.

We observed some staff knocking on people's doors before entering. However on four occasions, we were interrupted by care workers walking into people's bedrooms without knocking when we were having discussions with them. One person told us staff seldom knocked on their door and if they did, they never waited to be asked in.

Prior to our inspection we received concerns from a whistle-blower and a relative regarding the relocation of the nurses' station on the nursing unit at the home. Both contacts told us that the nurses' station had been relocated to a communal area on the unit and that verbal handovers

Inadequate

Is the service caring?

and private phone discussions were held here within earshot of people on the unit. The registered manager informed us that whilst the station had been moved into a communal area, staff were expected to do handover in her office and make any private phone calls in there also. However, the feedback we received indicated that this instruction was not always followed in practice.

Care plans were held at the nurses' station in the nursing unit. Although they were in a lockable cupboard we noted that for much of the day, the cupboard was not locked.

We visited one person in their bedroom and found a written sign on their wall stating they did not have capacity to make decisions. This was extremely undignified and compromised their privacy.

We were told by staff members there had been a dignity champion programme in place in the past but this had been discontinued. Such a programme meant there would be designated staff members who had a role in monitoring how people's dignity was promoted and in challenging any poor practice. One care worker told us, "We used to have dignity champions here and then it stopped. I think it is something we should bring back, definitely."

People felt their choices were respected in some areas but not others. Several people we spoke with told us they were not able to get up and go to bed when they chose to. One person said, "I have to get up and go to bed when they say. I am got up about 6am, I am not always awake. They wake me up." Another person told us, "I am put to bed at 5-30pm whether I like it or not. I don't see anyone then till they come round with the medication at 9pm."

An advocate is an independent person who can support people to make decisions and express their views. We saw no information relating to advocacy services in the home. A staff member told us, "We don't have advocacy services for the residents – we usually ask any family members who come in." This information was supported by people who used the service, none of who had ever accessed advocacy services. People told us their family members acted as advocates when needed. However, for any person who did not have a family member able to advocate for them there did not appear to be arrangements in place to signpost them to such a service.

The failure to ensure that people received care in a manner that promoted their dignity and respected their autonomy was a breach of regulation 10 (1)(2)(a)(b)&(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

Some people described a service they felt was responsive to their needs. One relative told us, "I come in every afternoon and talk to the staff and they are always helpful – any problems they tell me." Another relative explained that the registered manager had kept her well informed of her loved one's health issues and the measures being taken to address them. We also spoke with another family member who told us the registered manager had called the doctor for his loved one and arranged for him to be present at the appointment." A person who used the service told us, "I spend a lot of time in my room and the carers are in quite a bit and if I need anything they get it for me."

However, some people we spoke with did not feel their service was consistently responsive. We heard from a number of people who did not feel their preferences in relation to daily routines were respected. For example, some people didn't feel they were able to choose what times they got up and several commented that the lack of person centred care during morning routines. "They get me up between 5 and 5-30am. I ask for a cup of tea. Sometimes I get one other times not. If not, I get nothing until breakfast at 9am." "Sometimes I get a cup of tea between 6am-7am but that does not happen every day."

During the inspection we observed one person have their first cup of tea at 7.35am. However, we were aware the person had been up and dressed when we arrived at 6.25am. We asked the person if it was their first cup of tea and they said, "It is and I was ready for it I can tell you!"

On our arrival at the home there were eight people up at 6.25am on the downstairs residential unit. We were told this was their preference but it was difficult to ascertain if this was the case by speaking to them. Staff told us they had started getting people up about half an hour ago – which would have been just before 6am.

On the nursing unit, staff had almost finished washing and assisting 26 people to get washed and changed, although they were still in bed. We ascertained that some people had been woken to be washed and were told this process had started at 5am. These findings were supported by a whistleblower who contacted us and said, "We start waking people at five, sometimes earlier. We have to do that because if everyone isn't washed and changed when the day staff come in, we are in big trouble. I know it's wrong. I wouldn't want it for my parents. Who wants a wet flannel on their face at that time in the morning?"

Other examples of a service that did not provide person centred care included a person who used the service requesting pain relief at 7pm. They explained, "I was told I could not have one (a painkiller) till the medication round at 9pm." And "They answer the buzzer quickly but they are sometimes busy and need to come back so you can wait a while – nuisance if you need the toilet" And, "Sometimes at night if I get woken up to be turned, I tell the staff to go away. They hurt me when they are turning me because they don't know how to do it properly."

We viewed a selection of care plans during the inspection. We were told by staff that they were in the process of transferring over to a new system, which would be more person centred. We found the result was a number of people's care plans had not been fully completed and there were large pieces of information missing on several of those we viewed.

It was difficult to ascertain where people's care plans were up to. Some were of the old style, others were in the new format but not fully completed. Areas such as the one page profile, clinical alerts, social needs and preferred daily routines were not completed in some we viewed.

We found in several cases, that daily care notes and evaluations contained more relevant information than the person's actual care plan. For example, under one person's medicines care plan evaluation it stated, '(Name removed) now needs a spacer to take inhaler.' However, there was no mention of this in their care plan.

In some examples we noted that reviews and evaluations did not reflect the person's circumstances accurately. For example, we viewed one person's nutrition care plan which stated in the May and June reviews that their weight 'remained stable'. However, records showed they had not been weighed since April.

Another person's moving and handling risk assessment had not been reviewed for over ten months despite the fact she was assessed as being at high risk. This risk assessment also had conflicting information within it, some stating the person could weight bear and other information stating that they could not.

Requires improvement

Is the service responsive?

We found missing care plan information in relation to important areas such as pressure care, PEGs and nutrition. We also found examples of advice from community professionals not being transferred to people's care plans. For example, we saw that one person who used the service had recently attended an appointment with a medical professional who had given advice about increases in risk to her health, during certain times of the month. This information had not been put in their care plan and was found at the back of their notes in the form of a letter. This meant that care plans did not fully reflect people's needs and information about the way their care should be provided.

The failure to plan care in accordance with people's needs was a breach of regulation 9 (1)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We did see some good examples of person centred information. In one person's care plan we read that they liked to choose which perfume they wanted to wear every day and in another we noted information about a person's night care preferences. Care workers we spoke with demonstrated understanding of people's needs and were able to tell us how they provided support.

Not all the people who used the service we spoke with felt staff discussed with them how they wished to be cared for. One person said, "No one explains my care to me. I know that I have a care plan and I do sign it sometimes, but I always wait until I can discuss it with (name of family member) because I don't know what to say."

Some relatives felt communication could be improved. They told us they were not always kept informed about their loved ones. "We have to ask all the time how he is doing, no one tells you otherwise." Another person commented, "You have to ask all the time how she is doing as some of the carers don't know what to say when I ask them. Like has she had a good night? I always ask the regular senior staff."

In some of the plans we viewed there was very little information about people's preferences in relation to hobbies and activities. There was a section for this purpose, which included a one page profile, but in several examples this had not been completed. We were told this was due to the changeover of documentation.

We spoke with people about the activities provided at the service. One person said, "I go out myself so I'm not too bothered. They do things but they wouldn't suit me." Another person commented, "They do bits here and there. The odd quiz and such like." Another comment was, "I would love a trip out every now and then but I don't think there is anything like that."

There was a newly appointed activities co-ordinator who had been in post for six weeks. He was in the process of developing the programme and showed us a list of activities currently on offer that included bingo, dominoes, tea and chat and crafts and shared some ideas for the future development of the programme.

We spoke about the needs of people who lived with dementia and the people in receipt of nursing care. He advised this was an area to be developed and explained he was hoping to receive some training in activities for people with dementia.

The activities board had no information on. We were told that the activities coordinator spoke with people on a day to day basis about the activities of the day. However, this may not be the most useful system for people, especially those living with short term memory loss.

No activities were observed on the second day of the inspection but bingo was played on the first day. This was attended by five people. No one we spoke with recalled any celebrations, or events such as trips or outings. We were told by the activities coordinator there were no plans to arrange any trips, outings or entertainers until funds could be raised at the Christmas fair.

We were advised by the registered manager that residents and relatives meetings were held about every six months. This information was supported by discussions we held with people who used the service and their relatives.

Minutes of residents and relatives meetings showed that a number of issues were routinely discussed, such as catering arrangements and activities. However, one person we spoke with told us he was still waiting for an update on some points he had raised several months earlier.

People were invited to give their views and feedback about the service by way of a satisfaction questionnaire or electronic survey. However, it is noteworthy that some of the themes identified through discussion with people who used the service in the last inspection carried out in January 2015, namely staffing levels and the approach of

Requires improvement

Is the service responsive?

some staff, were still areas of dissatisfaction for many we spoke with during this inspection. This meant there had been a failure to act upon the views of people who used the service and their experiences.

Throughout the inspection we did not see a complaints procedure posted in the home. Most people we spoke with told us they were not aware of a formal complaints procedure but said they would be comfortable to raise any concerns with the manager. Their comments included, "No one has told me how to make a complaint but if I had a problem with anything I would just see one of the staff."

We heard several examples of complaints people had raised. In all cases, they felt their concerns had been properly addressed and were satisfied with the outcome However, we noted when viewing the records of complaints made, several of the examples we had been given were not recorded, due to them being verbal complaints.

It is important to record all complaints including those of a verbal nature that may be classed as minor concerns. Accurate recording not only provides an audit trail of action taken but provides a valuable tool for identifying areas that could be improved upon.

Inadequate

Is the service well-led?

Our findings

During the last inspection in January 15, we found the service did not have adequate systems in place to monitor and asses the quality of service provision. The registered manager sent us an action plan stating the service was now compliant with this regulation. However, during this inspection we found evidence that systems for assessing safety and quality were not effective.

Throughout the inspection we identified a number of serious concerns relating to the safety and quality of services. For example, the management of medicines, the assessing and managing of risks to people's safety and wellbeing and the provision of health care. We also found a number of issues, which had a demonstrable negative effect on the quality of life of people who used the service, including the failure to promote people's privacy and dignity and staffing levels which did not meet people's needs.

Of further concern, was the fact that the majority of issues we identified had not been identified or acted upon by the management team. This was evidence that the current processes for governance were not effective.

There appeared to be a lack of information within the service which meant that the registered manager was not always aware of serious incidents when they occurred. For example, the safeguarding concerns, which had not been reported and concerns about the conduct of a staff member currently employed at the home, which the registered manager was not aware of.

We could not evidence that adverse incidents such as accidents or safeguarding concerns were routinely analysed so they could be learned from. For example, we found a record of a serious incident during which a service user had fallen out of a hoist when being supported approximately 12 months previously. We saw this had been reported through the provider's 'datix' system. 'Datix' is an electronic system for reporting incidents and accidents. However, there was no record of analysis of the cause of the accident, or any investigation into how the incident had actually occurred, which could have provided valuable learning and led to better safety for people who used the service.

Concerns relating to staffing levels and the failure to promote the privacy and dignity of people who used the service that were identified in the last inspection of the service in January 2015, had not been addressed. This was evidence of a failure to take action to improve the quality and safety of the service.

The failure to effectively assess and monitor the safety and quality of the service was a breach of regulation 17 (2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had been in post for just under twelve months at the time of the inspection. All of the people we spoke with throughout the inspection knew who the registered manager was. Many thought that she had a very visible presence and felt comfortable and happy to approach her with any concerns they may have. People's comments included, "The manager comes into the dining room every morning and says hello to everyone – you do see her around quite a bit." "I do know her. She hasn't been here that long but from what I have heard she seems very nice." "Anyone will tell you we have had some problems here but I think things are getting better since the new manager came in." "I have had cause for complaint in the past but I feel much more confident with the new manager."

There was an established management structure in place which included an area manager, the registered manager, a newly appointed deputy manager and several senior staff members.

It was not clear from records held within the home what the mandatory training for staff with senior responsibilities entailed. We saw that some staff who were responsible for providing formal supervision and appraisal did not appear to have training in this area. In addition, some senior staff did not appear to have a firm grasp on areas such as safeguarding and mental capacity. This had resulted in failure to properly deal with two safeguarding concerns in the preceding twelve months and failure to address disciplinary issues through supervision, on one occasion.

Prior to and following the inspection, we heard from some staff who had concerns about the culture of the service. Several spoke about a culture within which it was not easy to raise concerns for fear of negative repercussions. One person told us they had felt bullied at times and also

Inadequate

Is the service well-led?

described a situation where an on call manager refused to come out to the service when cover was required at short notice. This had resulted in the person having to work such a long shift, they did not feel able to practice safely.

Another staff member commented, “There are loads of staff leaving. I think that it is because they don’t find management supportive or approachable.” We were able to establish that the service did have a very high turnover of staff, which had resulted in a lack of consistency for people who used the service. Whilst there was no evidence that the high turnover of staff was directly related to a perception that the management team were unsupportive, the comments we received may indicate potential areas for improvement.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had failed to ensure that people's care was planned in a way that met their needs and reflected their choices and preferences.** 9(1)(a)(b)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person had failed to ensure that people were treated with dignity and respect and that their autonomy was supported.** 10(1)(2)(a)(b)(c)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken.
We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so.** 12 (1)(2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that safe care was provided by ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.** 12 (1)(2)(c)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines.** 12(1)(2)(g)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that adequate arrangements were in place for the safe detection and prevention of the spread of infection.**

This section is primarily information for the provider

Enforcement actions

12(1)(2)(h)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had failed to ensure the effective operation of systems and processes to protect people from abuse.** 13 (1)(2)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had failed to ensure that lawful authority was obtained to deprive people who lacked capacity of their liberty.** 13 (5)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had failed to ensure people's nutritional needs were safely met.**

This section is primarily information for the provider

Enforcement actions

14 (1)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered person had failed to ensure the effective operation of systems to ensure the safety of the premises and equipment.** 15(1)(a)(b)(e)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had failed to implement systems to effectively monitor the safety and quality of the service.** 17 (1) (2) (a) (b) (e) (f)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

The registered manager had failed to ensure that sufficient numbers of suitably skilled, qualified and competent staff were deployed to meet people's needs safely.

18(1)

The enforcement action we took:

As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.