Handsale Limited

Handsale Limited - Shakespeare Court Care Home

Inspection report

1 Shakespeare Close
Butler Street East
Bradford
BD3 9ES

Date of inspection visit: 11 November 2014 and 3 February 2015
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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 and 21 August 2014. Eight breaches of legal requirements were found and we issued three warning notices. As a result we undertook a focused inspection on 11 November 2014 to follow up on whether action had been taken to address the breaches of regulations in relation to the warning notices. We found the provider continued to breach legal requirements.

After our inspection on 11 November 2014 we met with the provider and attended a multi-agency meeting. During these meetings we received information that the

Summary of findings

provider had taken immediate action to ensure improvements were made. As a result we undertook another focused inspection on 3 February 2015 to assess these improvements.

You can read a summary of our findings from all three inspections below.

Comprehensive Inspection 13 and 21 August 2014

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We inspected Shakespeare Court on 13 August 2014 and 21 August 2014 and the visits were unannounced. Our last inspection took place in February 2014 and at that time we found the home was meeting the regulations we looked at.

Handsale Limited – Shakespeare Court is registered to provide accommodation and nursing care for up to 80 people accommodated over four units. This includes two residential units and two nursing units. Two units of the home cater for people living with dementia.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Cleanliness and hygiene standards in the home were not being met and we saw some poor infection control practices. This put people at risk of transferring and acquiring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels were not adequate to keep people safe. People told us there were not enough staff. People were not adequately supervised and had to wait for support and assistance. Staff did not have the time to provide meaningful interaction with people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from abuse. There was a lack of evidence of action taken following incidents to keep people safe. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care needs were not always assessed and people did not receive care in line with the requirements set out in their care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected.

Most people said staff treated them with dignity and respect. However, we saw staff did not always treat people with dignity and respect or respect their privacy. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people spoke positively about the quality of food at the home. However, we found the mealtime experience required improvement with unnecessary delays in serving food. People were not always appropriately supported at mealtimes and appropriate action not always taken following the identification of the risk of malnutrition. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Quality assurance processes were inadequate; the issues we found had not been identified by the provider's own monitoring and audit processes. Risks to people's health, safety and welfare were not appropriately assessed and managed. This was a breach of Regulation 10, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Accurate records were not always maintained in respect of each person who used the service. For example a lack of information on people's life histories and preferences. This was a breach of Regulation 20, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider is required by law to notify the Commission of any allegation or instance of abuse. We found seven

Summary of findings

notifiable incidents which should have been reported and were not. This was a breach of Regulation 18, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Systems were in place to ensure medicines were managed safely. We found that medicines were ordered in a timely way and recorded, stored, administered and disposed of safely.

Focused inspection 11 November 2014

After our inspection of 13 and 21 August the provider wrote to tell us what they would do to meet legal requirements in relation to the breaches identified. We undertook this unannounced focused inspection to check the provider had followed their plan and to confirm that they now met legal requirements in relation to; care and welfare of people who use services, cleanliness and infection control and assessing and monitoring the quality of service provision. We focused on these three areas because these were the three areas where we had served warning notices.

The provider had not taken appropriate action to ensure they met the requirements of the warning notices in relation to monitoring the quality of the service and cleanliness and infection control. They had met some requirements of the warning notice in relation care and welfare. However, further improvements were required to ensure the legal requirements in this area were fully met. You can see what action we told the provider to take at the back of the full version of the report.

Focused inspection 3 February 2015

Following our inspection on 11 November 2014 we met with the provider and attended a multi-agency meeting chaired by the local authority. During these meetings information was shared which indicated that the provider had taken immediate action to ensure improvements were made in relation to infection control and how they assessed and monitored the quality of the service. We also received regular updates from the new manager about what action had been taken to ensure improvements were made. We decided to return to the service to undertake another unannounced focused inspection to review these improvements. We focused on these two areas because these were the areas where we had found that the provider had previously not met the warning notices.

During this inspection we found improvements had been made in relation to cleanliness and infection control and assessing and monitoring the quality of the service. However, we were unable to test the long term effectiveness of the arrangements the provider had in place to ensure these improvements were sustained. We also found that further improvements were still required to ensure the regulatory requirements in these areas were fully met.

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

13 and 21 August 2014

The service was not safe. People who used the service were put at risk because cleanliness and hygiene standards were not maintained. We observed poor infection control practices which put people at risk.

Staffing levels were inadequate and people were left waiting for assistance. Staff did not have time to engage in activities or provide companionship for people. We found people were not protected from the risk of abuse as appropriate action had not been taken following incidents.

CQC monitors the Deprivation of Liberty Safeguards (DoLS). The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected. However, we found some overly restrictive practices which could have been avoided, such as locking dining room doors. This amounted to unnecessary restrictions of people's movement around the home. Staff said they had received training in Mental Capacity Act (MCA) but were unable to confidently describe the requirements of the Act. This risked that the correct steps were not followed to assist people with limited capacity to make decisions.

11 November 2014

The service was not safe. People who used the service were put at risk because appropriate standards of cleanliness and hygiene were not maintained. We found a lack of leadership to positively promote, champion and challenge staff at all levels about best practice in infection control.

3 February 2015

Some aspects of the service remained unsafe. Although there had been some improvements in relation to the standards of cleanliness, staff culture and the management of infection control, the processes and systems introduced were not fully embedded and refined. There were inconsistencies across the units in how staff completed documentation in relation to infection control which had been identified as an issue but not yet addressed by management. The refurbishment of the building was still to be completed.

Is the service effective?

Inadequate

13 and 21 August 2014

The service was not effective. People's healthcare needs were not always met, for example around pressure area care. We received mixed feedback from health professionals, with both of those we spoke with raising concerns over some aspects of care.

Summary of findings

The mealtime experience required improvement. People were left waiting for unnecessary periods of time and were not given appropriate support. There was not always evidence that appropriate monitoring and action had been taken to protect those who were identified as being at risk of malnutrition. People's feedback about the food was mixed. People said they had a choice of food but some people said they were bored of the lunchtime options.

A range of training was provided to staff. Staff said it gave them the skills and knowledge required to undertake their role effectively.

11 November 2014

Some aspects of the service were not effective. Improvements had been made to care records to assist staff in meeting people's healthcare needs. However, there was still insufficient information to ensure staff provided effective and appropriate care.

We did not look at this key question as part of our focused inspection on 3 February.

Is the service caring?

13 and 21 August 2014

Requires Improvement

The service was not always caring. Most people said staff were kind and caring and treated them with respect. However, two people alluded to less positive relationships with staff.

Although we saw some good interactions between staff and people, we saw instances of people not being treated with dignity and respect. For example, staff broke off from supporting people at mealtimes to attend to other tasks. Staff did not have time to interact in a meaningful way with people.

An appropriate level of privacy was not offered during doctors consultations and staff openly discussed people's medical issues with the doctor in the lounge which resulted in confidential information being discussed within earshot of others.

We did not look at this key question as part of our focused inspections on 11 November 2014 and 3 February.

Is the service responsive?

13 and 21 August 2014

Inadequate

The service was not responsive. We found people's care needs were not always assessed to enable staff to deliver appropriate care. The service failed to respond to people's changing needs by ensuring amended plans of care were put in place.

We found appropriate care was not delivered. This included lack of assistance with personal care and staff not following care plans.

Summary of findings

People reported there was not enough to do in the home and said they were bored. We saw staff did not have time to engage in activities or conversation with people.

11 November 2014

Some aspects of the service were not responsive. It was not always clear how recommendations made by healthcare professionals were translated into personalised care. Care records did not always contain clear solutions or strategies to help staff control identified risks and provide responsive and appropriate care.

During our observations and conversations with people staff demonstrated a good knowledge of people and were responsive to their needs. People told us the quality of care and support provided was inconsistent and dependent on the staff on duty.

We did not look at this key question as part of our focused inspection on 3 February.

Is the service well-led?

Inadequate 

13 and 21 August 2014

The service was not well led. We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of a robust quality assurance systems. Where issues had been identified by external agencies, robust action had not been taken to resolve issues.

Accidents and incidents were not properly analysed and there was a lack of action taken to prevent re-occurances. We found seven notifiable incidents which had not been reported to CQC as required by the regulations.

Staff spoke positively about the management at the home and said they were supportive of them.

11 November 2014

The service was not well led. Areas where improvements were required had not been addressed despite the Commission repeatedly raising them with the provider.

We found an absence of leadership to ensure staff at every level were accountable for making and sustaining the required improvements. The revised quality assurance processes were not robust and did not effectively contribute to improving the quality of service provided.

The feedback from people and staff about the new manager was positive. There was some evidence that they were in the process of changing the culture within the service.

3 February 2015

Summary of findings

Some aspects of the service were still not well-led. Nurses and team leaders in charge of units did not provide consistent and effective management. Further improvements were required to ensure the provider could demonstrate they were effective in driving improvements in the quality of service provided.

However, we saw evidence of improvements to the leadership, staff culture and systems in place to assess and monitor the quality of care provided. There was evidence that the quality assurance systems had begun to identify and address issues. The feedback from people and staff was that the quality of the service provided was beginning to improve. However, there were areas where improvements were still required and further action was needed to ensure the implemented improvements were fully embedded and sustained.

Handsale Limited - Shakespeare Court Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of three inspections of Handsale Limited – Shakespeare Court. We carried out all inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 13 and 21 August 2014. This inspection identified eight breaches of regulations. Three warning notices were served.

The second inspection was undertaken on 11 November 2014. This focused on following up on action taken in relation to the three breaches where warning notices had been served.

The third inspection was undertaken on 3 February 2014. This focused on following up on action taken in relation to the two breaches where we found the warning notices had not been met.

You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection 13 and 21 August 2014

We visited the home on 13 August 2014 and 21 August 2014. We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 13 people who used the service, two relatives, seven members of staff and the deputy manager. We spent time observing care and support being delivered. 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 express their views to us. We looked at seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

The inspection team consisted of two inspectors, a pharmacy inspector 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. A specialist advisor in nutrition also accompanied us on the inspection.

Before our inspection, we reviewed the information we held about the service. This included notifications and the provider information return (PIR), a document sent to us by the provider with information about the performance of the service. We contacted the local authority safeguarding team to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health professionals who regularly visited the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this

Detailed findings

testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

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

Focused inspection 11 November 2014

We undertook an unannounced focused inspection of Handsale Limited - Shakespeare Court on 11 November 2014. This inspection was to check that improvements to meet the legal requirements planned by the provider after our 13 and 21 August 2014 inspection had been made. The inspection team checked improvements had been made in three of the eight areas where breaches were previously identified. This is because these were the three areas where we served warning notices. We will undertake another unannounced inspection to check on the other five areas where breaches were identified.

During this inspection the team inspected the service against four of the five questions we ask about services: Is the service safe? Is the service effective? Is the service responsive? Is the service well led?

The inspection was undertaken by three inspectors and an expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we spoke with 20 people who lived at the home, three visiting relatives, the manager, the provider's operations manager, six members of care staff and three domestic staff. We reviewed the care records of seven people and other documentation relating to the management of the service.

Focused inspection 3 February 2015

We undertook an unannounced focused inspection of Handsale Limited - Shakespeare Court on 3 February 2015. This inspection was to check the provider had taken action to address the two breaches where we found the warning notices had not been met. We will undertake another unannounced inspection to check on the other areas where breaches were identified.

The inspection was undertaken by three inspectors. The team inspected the service against two of the five questions we ask about services: Is the service safe? Is the service well led?

During our inspection we spoke with five people who used the service, three visiting relatives, the manager, three members of care staff and three domestic staff. We also reviewed the care records of three people who lived at the home and other documentation relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Comprehensive Inspection 13 and 21 August 2014.

We found significant problems with cleanliness and hygiene in the home. The home and equipment was not clean, hygienic or well maintained and we observed poor infection control practices that put people at risk. Before the inspection we received a complaint from a relative concerned that areas of the home were "filthy" and their relative's room was particularly unhygienic. On the day of the inspection, a visiting health professional also raised concerns with us about the cleanliness of some areas of the home. During the inspection our observations confirmed some people's rooms were dirty and had not been cleaned properly. For example, in one person's room we found faeces and other dirt on the walls and chairs which put the person at risk of infection. Some people's mattresses were stained and some bedding was stained and ripped. There was a strong odour in the dementia units of the home. Chairs throughout the home were stained with food such as in communal dining areas and a number were sticky to the touch and ripped. In one lounge area, we found food was splashed on walls and dried food was observed embedded in the carpet. In another person's room we found a meal left on a side table from the previous night. When we asked the carer who was spending 1-1 time with the person about this, they said they had found it on the floor in the morning, had removed it and placed in on the side table. This indicated proper cleaning and checks of people's rooms were not taking place, as the food was left on the floor all night. Some areas were poorly maintained which meant they could not be effectively cleaned such as bathroom and toilet floors. Some furniture was also in a poor state of repair and required replacing so that it could be effectively cleaned to keep it hygienic.

We observed some poor infection prevention practices. For example, we noticed faeces was on the knob of one bedroom door. We saw a staff member touched the door knob and then went to handle food for someone else without washing their hands. This posed a risk of infections were passed between people. The faeces was only cleaned from the bedroom door when a member of the inspection team prompted staff and even then it was not cleaned properly. In some toilets in the dementia nursing unit there were no bins to dispose of waste and instead black bags were tied to the toilet rail. This was not a hygienic way to manage and dispose of waste. Personal Protective Equipment (PPE) was not always available. For example, gloves were locked in the linen cupboard and staff were not able to easily access them. One agency member of staff confirmed this by telling us they did not know where the gloves were kept. We observed open packs of incontinence pads were left by the side of a toilet which had the potential to increase the risk of infection.

The deputy manager told us daily room checks were undertaken, however these were not documented. This meant there was no evidence that the checks took place and there was no accountability for maintaining the standard of each room.

These issues put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Through our observations and discussions with people and staff, we found that there were not enough staff to meet the needs of the people who used the service. People told us there were not always enough staff. For example, one person told us, "They are always so busy." Another told us, "It all seems to have fallen apart a bit over the holiday season. I think they are a bit short staffed at the moment." People said staff did not always attend when they needed them. For example, one person talked about staff availability in a lounge said, "It depends: – If there's someone here in the room it's easy, otherwise I have to shout or just wait." One relative also told us that their family member was always complaining about staff not coming back in a timely fashion to assist them. Another visitor raised concerns stating, "I've come more than once at lunchtime and found my relatives' breakfast still sitting beside them because they had been asleep. It's still there, cup of tea and everything," This indicated there were not enough staff to ensure meals were promptly cleared away.

Agency staff were used to cover absences, but staff said sometimes it was not always possible to get them at short notice. Staff confirmed they were struggling with staff over the holiday season and there were times when they did not meet their target staffing levels due to difficulty obtaining agency staff. Staff also told us that the cleaners had not been available the last two weekends as they had to do the

laundry instead. This had put a strain on cleaning and meant the standard of cleaning had suffered. This showed there were not always sufficient staffing levels to keep people safe.

We looked at the care of a person whose care plan stated they required constant supervision and found this person was left unsupervised putting them at risk. Staff confirmed there were not enough staff to ensure that all people's care needs were met, such as providing the required supervision for this person. When we looked at people's care plans and the care they had actually received there was evidence there were not enough staff to meet people's needs. For example, people had not received regular pressure area relief as stated in their plans, nor were people's personal hygiene needs being met such as the frequency of showers or baths as stated in their care plans. This showed there were not enough staff to meet people's needs and keep them safe.

We observed a number of occasions where people had waited in excess of 10 minutes for staff assistance after calling out. There were periods of 10-15 minutes when communal areas were not supervised and staff were not visible. This included areas where people displayed behaviour that challenged, putting people at risk. Reviewing incident data from June and July 2014 there were incidents which happened when staff had not supervised communal areas. These could have been avoided if sufficient staff had been available. For example instances of one person throwing cups of tea at other people.

Staff did not have time to provide any meaningful interactions with people other than carrying out basic tasks. For example, they had no time to undertake activities. People reported there were a lack of activities and staff busy in routine care tasks was partially responsible for this. We saw people were left walking about the corridors with little interaction and staff did not have the time to comfort people who needed it. We saw a number of incidents occurred which indicated there were not enough staff. On the dementia unit, we observed faeces had been smeared on three people's door handles. From speaking to staff it was evident that this was due to one person and that the behaviour had been occurring for several weeks. However, staffing levels were such that staff were unable to supervise this person appropriately and prevent them from doing this. Bathroom and toilets in the Cedar Unit did not contain bins or toilet roll; staff said this was because one person misused them. However this meant other people had to rely on staff to provide these items on an individual basis. This practice indicated that there were not enough staff to offer support to that individual.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We found safeguarding incidents were not always reported to the Local Authority Safeguarding unit. For example we found one incident in July 2014 which stated 'person has been quite aggressive, smacking residents.' Another incident in July 2014 where someone's face had been marked by another person who used the service had not been reported. If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required

Through observations and speaking with staff we found people were not receiving care in line with their care plans, for example in relation to pressure area care, personal hygiene or meeting their emotional needs. This indicated a neglect of people who used the service. We found following incidents of aggression, appropriate preventative measures were not always taken to keep people safe from abuse. For example, behavioural care plans were not updated with strategies to reduce the risk of abuse and incident forms did not always contain clear preventative measures to keep people safe.

Care plan documentation showed some people required constant supervision to ensure they and others were kept safe. However, we saw this was not always possible and we saw an argument break out between two people, when one person who was supposed to be supervised was not. This put them and others at risk of abuse. Following the inspection we made a safeguarding referral to the Local Authority, in regards to the dementia units of the home because we found people were at risk of abuse due to neglect and failure to control risks to people.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,

which corresponds to Regulation 13 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This is because the provider was not taking appropriate steps to protect people from abuse.

People did not report any restrictions and said they could go to their rooms, bedroom and gardens when they wanted. We found the deputy manager had a good understanding of Deprivation of Liberty Safeguards (DoLS). They were aware of the recent supreme court judgement, had risk assessed the restrictions on each resident, and sent a number of recent DoLS applications based upon risk. This indicated that the service was taking action to ensure that its practices were assessed to determine whether there were any unlawful restrictions. However, we observed some overly restrictive practices which could have been avoided. For example, the dining room door in the Cedar unit was kept locked. This was an unnecessary restriction on people's movement. Staff said they had received training in mental capacity act but were unable to confidently describe the requirements of the Act. We saw capacity assessments had been completed for some people, but not others indicating an inconsistent approach to the assessment of capacity.

People said they felt safe in the home for example one person said, "I had started to feel nervous at home, especially when it got dark. I feel much better knowing that there are other people around all the time." People who lived at the home told us they felt able to raise concerns with staff for example one person said, "I can talk to them no problem".

Appropriate arrangements were in place for obtaining medicines. People's regular medicines were ordered in good time and a record of medicines received from the pharmacy was kept. This meant that people always had the medicines they needed. We saw that senior staff carried out daily checks (audits) to see if medicines were given safely. Appropriate arrangements were in place for recording medicines. We counted some tablets and found that the stock records were accurate. We saw that administration records were completed in the right way when medicines were administered. This meant that people received the medicines they needed. Medicines were given to people appropriately. Any change to the dose of a person's medicine was confirmed in writing by the doctor or health professional. Medicines were safely administered. We watched medicines being administered in all four areas of the home. Members of staff gave medicines in a safe and friendly way, and stayed with each person until they had taken their medicines. This meant that people were supported appropriately to take their medicines. However there were no written guidelines (protocols) to help staff decide when to administer medicines prescribed 'when required' which meant these medicines might not be administered in the right way to each person.

Medicines that were controlled drugs (CDs) were kept in cupboards that complied with the law. Medicines were disposed of appropriately. Medicines to be disposed of were recorded and collected by the pharmacy that supplied them or a licensed waste carrier (as required by law). This helped prevent mishandling and medicine errors.

We saw safe recruitment procedures were in place to ensure staff were suitable for the role. This included ensuring a Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work.

Findings from the focused inspection 11 November 2014

We looked around the communal areas and 24 bedrooms across all four units. During our tour we were accompanied by the new manager of the home. We found the standard of cleanliness to be poor. Out of the 24 bedrooms we checked, 12 bedrooms had a strong odour. The manager recognised these rooms had an odour, for example they said these rooms had an, "Established smell of urine." We found seven people's beds had been made with stained pillows and bedding. In seven people's en-suite bathrooms we saw toiletries such as creams, hair brushes and soaps being kept on top of the toilet. This had the potential to increase the risk and spread of infection. We saw six stained and dirty toothbrushes by people's sinks. When commenting on one toothbrush which had brown staining and hairs on the bristles the manager said, "I wouldn't want to brush my teeth with that." Such poor standards of cleanliness had the potential to increase the risk to people's health and spread of infection.

We found equipment and bathrooms were unhygienic. We looked in a communal shower room which had recently been used. The shower chair was stained and had hairs wrapped around the wheels. A dirty seat cushion was in the corner of the bathroom which was wet to the touch and

had a strong smell of urine. Another bathroom had a brown stained plastic jug and a brown stained bar of soap at the side of the bath. The bath and bath hoist were dirty. The manager said, "This bathroom has been used this morning, care staff should be cleaning bathrooms down after use so they are ready to be used by the next person." Four bedrooms had commodes in the en-suite bathroom. All four commodes were stained with faeces. Five en-suite bathrooms also had dried faeces in areas which included; door handles, grab rails, sinks and toilet seats. One bedroom also had dried faeces across the window. The manager said, "It looks as through someone with faeces on their hands has tried to open the window. Staff should have cleaned this up, it's unacceptable."

On our last inspection we found some areas were poorly maintained which meant they could not be effectively cleaned, such as bathroom and toilet floors. Some furniture was also in a poor state of repair and required replacing so that it could be effectively cleaned to keep it hygienic. During this visit we found areas such as bathroom and toilet floors were still poorly maintained. The manager explained that the provider had a refurbishment plan in place to address these issues. However, they were awaiting appropriate checks to be done on the builders before the work could commence. In the meantime the manager explained that all furniture had been deep cleaned. However, in five people's bedrooms we found easy chairs which were stained and had a strong smell of urine. This showed us that ongoing checks were not being made to ensure that appropriate standards of cleanliness were maintained.

Staff did not appropriately dispose of waste to ensure the risk of infection was minimised. For example, in four bedrooms and two communal bathrooms we saw staff had disposed of used personal protective equipment (PPE), which smelt of urine, in the general waste bin. The manager told us these items should have been disposed of in the clinical waste bins located in the sluice rooms on each floor.

Our findings indicated proper cleaning and checks of people's rooms were not taking place. The manager told us care staff should have addressed the identified issues as part of their daily room checks. They said, "Clearly this system is not working because of what we have just found. The room checks haven't picked these problems up. It's unacceptable." We looked at a sample of room checks completed on the day of our inspection. The documentation was not robust. Information was often recorded several hours after the checks had been completed so was not a current reflection of the cleanliness of the room. There was also no documentation to evidence issues had been identified and acted upon. Care staff told us if they found a problem they would raise this with the unit leader who would then raise it with domestic staff. However, records were not kept to evidence this. This showed us the room checks and associated documentation was ineffective and did not ensure accountability for maintaining standards of cleanliness.

The manager and operations manager told us they saw infection control as the responsibility of all staff. However, when we spoke with staff we found a lack of accountability for ensuring the service remained clean. Domestic staff told us they often had to clean up after care staff as care staff did not see cleaning tasks as their responsibility. Whilst care staff said they often had to pick up cleaning tasks and some domestics regularly refused to clear up bodily fluids as they said this was not their job. One care staff told us there was often, "Tension" between domestic and care staff over who should clean areas where people had been incontinent. They said, "Sometimes this means it's just left because some domestics, care staff and nurses refuse to clean it up." This issue had not been identified and addressed by the provider or manager.

We found a lack of leadership to positively promote, champion and challenge staff at all levels about best practice in infection control. We spoke with the infection control lead and found they also held the lead roles for dignity and dementia as well as being the activities coordinator. They had not received specialist training and did not receive appropriate allocated time to enable them to effectively fulfil their role as infection control lead. We spoke with the manager and operations manager about this. They said they had identified that this role was not being maximised to its full potential. They planned to move responsibilities for leading on infection control over to the new deputy manager who was due to start in post in December 2014.

Domestic staff did not have appropriate schedules of work to follow. The cleaning schedules in place did not contain detailed guidance about the specific needs of people or the service. We spoke with three members of the domestic team. One member told us, "I know what to do as I have

worked here for a long time, we follow our own routine." Another member of the domestic team said there was not a specific schedule for additional cleaning tasks such as shampooing carpets or deep cleaning furniture. They said these were usually done when asked by the manager. This risked a lack of consistency in how domestic tasks were completed.

Staff did not have their work regularly checked to ensure it had been completed to an appropriate standard. The housekeeper told us they checked the work of domestic staff, "As and when, but usually about once a month or so." This meant there was no formal process in place. We looked at the cleaning records completed by domestic staff for all units in September and October 2014. We found regular gaps across all four units. This meant the provider was unable to evidence that appropriate cleaning had taken place. For example, on Willow Unit people's bedrooms were only recorded as having been cleaned on 10 out of 31 days in October 2014. During the same period the communal areas and bathrooms were only recorded as having been cleaned by domestic staff seven times. The absence of appropriate checks on domestic staff's work meant the provider could not ensure that cleaning was taking place regularly and to an appropriate standard.

We spoke with three members of the domestic team who told us there was not always enough hours allocated to clean the building to an appropriate standard. They told us this was a particular problem during weekends, as sometimes there was only one member of domestic staff to cover all four units. The cleaning records we saw confirmed this. For example, across all four units for all four weekends in September 2014, domestic staff had not signed to show they had cleaned any bedrooms. We spoke with the manager about this. They explained that an additional eight domestic hours per week had been added since our last inspection. However, they recognised that a further increase in domestic hours was required to ensure adequate cleaning could be completed at all times. They said they had raised this with the provider and were awaiting confirmation that they could further increase the domestic cleaning hours.

These issues put people who used the service, staff and other people at significant risk of acquiring or transferring infections. This meant that the provider had not met the requirements of the warning notice and continued to breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Findings from the focused inspection 3 February 2015

We looked around the communal areas and 22 bedrooms across all four units. Overall we found the standards of cleanliness and hygiene had improved. Bedrooms and en-suite bathrooms were found to be clean and the majority were free from odours. People who used the service and visitors told us they had seen improvements in relation to the standards of cleanliness and found bedrooms were clean and tidy when they visited. However, they said there were still areas where improvements were still required. For example, there was sometimes a smell of urine on Cedar unit when they visited. The manager explained they had trouble eliminating some odours in particular rooms, particularly on Cedar Unit. They said, "It's in the fabric of the carpets so we have been unable to fully get rid of the smell despite shampooing them." They said they were monitoring and addressing this issue as part of their daily checks. We saw evidence of this in the documentation we reviewed. They also provided evidence to show carpets were being regularly cleaned. The provider had started their refurbishment programme the day before this visit and planned to replace most flooring and carpets throughout the home.

Equipment such as commodes and bath hoists were found to be clean. Toiletries were not being stored on top of toilets and personal care items, such as toothbrushes, were clean and being regularly checked and replaced as required. We found bedding, pillows and mattresses in all 22 bedrooms to be clean and free from stains. The manager told us they had ensured all pillows were replaced and showed us they had introduced monthly mattress and pressure cushion testing to check for cleanliness and ensure these items remained fit for purpose. They said if any items failed the monthly test they would be replaced and they provided evidence to show where they had done this.

We saw chairs in the communal lounges on Cedar and Rowan Units had been replaced with washable arm chairs. Most of the arm chairs in people's bedrooms had also been replaced and we found these to be clean and odour free.

Inadequate

Is the service safe?

The manager explained that new chairs were on order for Willow and Aspen units and the remaining bedrooms as part of the provider's refurbishment plans and these were expected to arrive by the end of February 2015.

We found greater accountability amongst staff for maintaining appropriate standards of cleanliness. The care staff we spoke with were clear about their role and what was expected of them. One member of care staff told us, "We clean as we go now, we don't just leave it all for the domestic staff." Domestic staff told us they felt they received better support, had clearer and more specific schedules of work and received assistance from the housekeeper who checked their work and raised any issues with the manager. There was evidence that where appropriate standards of cleanliness were not reached this was being identified and acted upon. For example, we found one communal bathroom and some bedrooms on Cedar Unit had not been appropriately cleaned by night staff on the morning of our visit. The housekeeper had already identified this and had raised it with the manager who was taking action to ensure this was addressed with the staff in question and did not happen again. The manager told us, "I recognise there is still a long way to go before things fully improve. But staff are now recognising what is expected of them and where appropriate standards are not met I am addressing this with the individual staff members."

We saw the number of domestic hours had been increased since our last visit. For example, there were now two domestic staff on each weekend and the housekeeper spent at least four hours of their day providing domestic cleaning support. The domestic staff we spoke with told us this had enabled them to complete more thorough cleaning. However, they said there was still not always sufficient domestic cover. One domestic team member said, "We don't always have the time to bottom everything as you would like as you just don't have the time. It's particularly bad on Cedar Unit. You can start cleaning and by the time you have finished one corridor it needs cleaning again." We raised this with the manager who said the domestic hours available to them was under constant review with the provider. We saw evidence that additional domestic hours were being allocated and domestic staff were being recruited to cover these hours from our review of the provider's monthly visit records.

Improvements were underway to ensure there was more effective leadership on infection control issues. The deputy manager had taken on the lead role for infection control. They had been in post for eight weeks so we were unable to fully assess the impact of their leadership. However, we saw evidence they were championing best practice and increasing staff awareness on infection control issues. For example, they had introduced the "Essential steps in preventing the spread of infection". This is an audit tool produced by the Department of Health to help monitor staff practices in relation to infection control, such as hand hygiene, use of personal protective equipment and waste disposal. At the time of our visit, the deputy manager had started to observe staff on one unit and planned to roll this out to include observations of every care staff member. The manager explained that any learning or development requirements identified as part of this programme would be addressed with staff as part of their supervisions. They also said that all housekeeping staff had completed specific training on infection control and all care staff were due to complete refresher training on infection control within the next six months.

We saw more structured systems were in place to check the standards of cleanliness and work completed by staff. For example, the manager completed regular spot checks of rooms. These were recorded and showed evidence of action being taken in response to any issues found. The housekeeper also checked the weekly deep cleans and completed random spot checks of domestic staff's work. However, we found the documentation completed was not always consistently and appropriately completed. For example, the housekeeper recorded their checks on the deep cleaning schedules. However there was not always a clear audit trail to demonstrate where they had identified and taken action in response to issues. We also found there were still gaps in the daily domestic cleaning logs. This meant the provider was unable to evidence that appropriate cleaning had taken place at all times. The manager told us they planned to introduce daily checks of the domestic cleaning logs as part of the housekeeper's routine so that any gaps could be identified and addressed in a timely manner. However, we were unable to test the effectiveness of this as part of this inspection.

From the information reviewed, we saw differences in the quality and consistency of the documentation completed across the four units. For example, not all care staff consistently recorded their daily room checks. Therefore,

Inadequate

Is the service safe?

we were unable to see evidence that room checks had been completed between 19 January 2015 and 27 January 2015 on Rowan Unit. But we were able to see evidence of daily room checks completed during the same period on Aspen Unit. The manager said they had identified this and were taking action to improve the leadership on each unit to ensure consistency and quality across all units. For example, they had based the deputy manager on Cedar Unit to drive improvements and best practice on this unit. They also showed us evidence they were driving improvements with individual staff members as part of staff supervisions. Following our inspection the manager informed us they had met with all unit leaders and spoken with them about the importance of care staff consistently and accurately completing all documentation. They said they would be checking the appropriate improvements were being made as part of their daily checks and would address any issues with the staff in question.

Overall we saw evidence improvements had been made in relation to the standards of cleanliness, staff culture and how infection control was being managed. The manager acknowledged there was still a lot of work to do to ensure they could demonstrate these improvements could be sustained and that the new processes and systems were fully embedded, refined and robust. Therefore, although the provider had taken steps to meet the requirements of the of the warning notice in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, there remained a breach of this regulation. Which corresponds to Regulation 12 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The other issues identified from previous inspections did not form part of the warning notices we served and so were not looked at during our focused inspections on 11 November 2014 and 3 February 2015. We will look at the outstanding issues from this key question at our next inspection.

Inadequate

Is the service effective?

Our findings

Findings from the comprehensive inspection 13 and 21 August 2014.

Staff were not effectively meeting people's healthcare needs, for example around pressure area care. A health professional we spoke with said they had some concerns over pressure area care in the home as they thought that some pressure ulcers had developed because people were left in an unhygienic state and their continence needs not always met in a timely fashion. One person's care records stated they required two hourly pressure relief, their legs to be elevated and to be sat on a pressure cushion. We observed they were left for at least four hours without a position change, their legs were not elevated throughout this time period and they were not sat on a pressure relieving cushion. This showed staff were not meeting their healthcare needs and the person was at increased risk of developing pressure ulcers. This person also had a pressure relieving mattress on their bed but there were no details recorded on the setting which it needed to be on. This meant staff did not have complete information to meet their pressure area needs. We found pressure area care plans were not detailed enough to enable staff to deliver appropriate care. For example, one person's care plan who was highlighted as being at risk of pressure ulcers stated, 'ensure pressure relief given' but did not describe the details of this or what staff needed to do. This person's records showed the District Nurse had visited in May 2014 following the development of a pressure ulcer but the care plan had not been updated with any new advice following their visit. This meant there was insufficient assessment of people's healthcare needs in order for staff to provide appropriate care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People said they had access to healthcare professionals and that staff would enable them to access those services. For example, one person said "The staff would sort it out. They would probably know if I needed a doctor." A GP was present for part of the visit and we saw them speaking with people. There was evidence other health professionals were involved in people's care such as GP's and district nurses. Feedback from health professionals was mixed about the effectiveness of care. For example, one health professional told us that overall the care was good, but they had some concerns over people's continence needs being met in a timely way. Another health professional told us they were concerned about the standard of care and said, "If I could move [the person] I would."

We spoke to people who used the service and relatives about the food. Feedback was mixed. One person told us, "The food is okay. I get what I'm given and it's ok." Another person commented, "I am sick to death of soup and sandwiches." People indicated they got choice at mealtimes. One person told us, "I think you do get to choose. I know that if it's something I don't like I can ask them to boil me an egg or something instead." People said they were given plenty to eat and drink. For example one person told us, "We get drinks with our meals and they bring them round in between as well."

We observed people were given some choices, such as a cooked breakfast tailored to their request. However, the menu provided did not demonstrate that people had a balanced diet that promoted healthy eating, for example we observed very little in the way of fresh vegetables on the menu. The choices each evening meal appeared very similar, for example meat or vegetable lasagne, fish or cottage pie. Halal meat was available, however, the cooks told us that all meat used was Halal as this was perceived to be of better quality. However, people who used the service were not given a choice as to whether they wanted Halal meat or not.

We found the mealtime experience required improvement. When we arrived at 8am, people who were up and sat in the lounges. However, breakfast was served late and people were restless whilst waiting for the food service to commence. On the Willow unit, the breakfast service commenced at 09:15, but some people did not receive their breakfast until 10.00am meaning they were waiting for three quarters of an hour at the table, with a number of people complaining about the delay. We saw this experience was repeated in the Aspen unit at breakfast and at lunchtime. Lunch began to be served at 12.30 which meant some people did not receive an appropriate time period between breakfast and lunch. The organisation of the meal service was not conducive in providing a pleasurable meal-time experience for people. We found people were not always given a required level of support with eating. For example, one person kept getting up and

walking about during the lunchtime meal service, their soup was left untouched but none of the staff encouraged this person to eat their soup. We also saw in the Rowan Unit one person in the lounge was seated with their legs over the arms of the chair and a carer sat on a coffee table in front of the resident to assist them. There was no attempt made to help this person sit up properly before they were assisted. People having their meal in the lounge had their trays placed on low height coffee tables, which made it difficult for them to eat without spilling the food. We saw people were offered hot drinks of tea but no saucers were used increasing the risk of spilling.

People's food preferences were recorded on admission and the support required identified. People were weighed on admission and regularly throughout their stay so staff could monitor their risk of malnutrition. People were assessed using nutritional risk assessment tools to determine whether they were at risk of malnutrition. There were a variety of nutritional risk assessments in care plan documentation, some risk scores were inaccurately calculated, which meant that the risk score was not always correct. This increased the risk that malnutrition may go unrecognised. We found where people were highlighted at risk of malnutrition, they were not always referred to the dietician or speech and language therapist:, the stated action on the risk assessment form. Some people were referred to their GP and/or community matron and a food suppliment prescribed, but there was an inconsistent approach, with no evidence that any action had been taken for a number of other people assessed as at risk.

Kitchen staff reported that they were informed verbally by care staff of any special dietary requirements including soft and pureed diets but there was no written confirmation. Given that the home cooked for up to 80 people, this risked that information on people nutritional needs may be missed as nothing was recorded for kitchen staff.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We found fluid and food charts were inconsistently completed. Two people's care plans stated their food and fluid input was to be monitored because they were at risk, however their records showed no monitoring of nutritional or fluid intake. This meant no checks could be made to see if they were eating and drinking enough. Two staff members when questioned were unsure why the fluid intake and output chart had not been completed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because a lack of proper information was recorded about people's food and fluid intake. This corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We asked people who used the service whether they felt that the staff had the correct skills and knowledge to care for them. Most said that they felt they did. However, one -person told us "There are one or two who could do with more training I think. I'm not always sure that they lift me properly." We raised this issue with the deputy manager for them to investigate. Staff had received a range of training which included moving and handling, fire safety, safeguarding and dementia awareness and challenging behaviour. Training compliance was analysed. Staff were up-to-date with most training and compliance was analysed by the manager so they could monitor this. However, only 13% of staff had received nutrition training which meant they may not have the required skills to ensure people received good nutrition. Induction training was provided which was a mixture of competency based workbook and videos. Staff reported training was timely and effective in enabling them to carry out their role effectively. They said they received regular supervision and appraisal and felt well supported.

Findings from the focused inspection 11 November 2014

We found that some improvements had been made to assist staff in meeting people's healthcare needs. We looked at seven people's care records and saw care plans and risk assessments had been reviewed and updated and now contained more detailed and up to date information. However, whilst risks to people's health and wellbeing were identified and assessed, it was not always clear what the level of risk was and how staff should manage this. For example, one person was assessed as having a pressure skin damage risk score of 13 and a falls risk score of 5. There was no information to explain to staff what this level

Inadequate

Is the service effective?

of risk meant for this person, such as whether a specific plan of care in place to control this risk was required. This meant there was still insufficient information to ensure staff provided effective care.

Therefore, although the provider had taken steps to meet the requirements of the of the warning notice in relation to Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, there remained a breach of this regulation. This corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We spoke with the community matron who visited the service during our inspection. They told us staff listened to and acted upon their advice and made referrals to other health professionals where appropriate. We saw evidence staff included relevant health professionals in people's care within the care records we reviewed. This included dentists, GP's, chiropodists, speech and language therapists, tissue viability nurses and district nurses. However, it was not always clear how recommendations made by healthcare professionals were translated into personalised care. For example, one person had an eye test in October 2014 which detailed they required glasses. There was no information within this person's care records to guide staff around when they should be prompted to wear their glasses.

The other issues identified from previous inspections did not form part of the warning notices we served and so were not looked at during our focused inspections on 11 November 2014 and 3 February 2015. We will look at the outstanding issues from this key question at our next inspection.

Requires Improvement

Is the service caring?

Our findings

Findings from the comprehensive inspection 13 and 21 August 2014.

Feedback from people about the attitude and nature of staff was mixed. Some people spoke positively about the care provided by staff. One person told us, "I think that I am very well looked after." Another person said, "They know when I'm a bit down and upset and they know just how to talk to me to help me feel better." Two people alluded to less positive relationships with staff. One person told us, "It can depend; one or two can be a bit less friendly." Another person told us about one member of staff that they felt spoke to them in an unpleasant way. They said, "They told me that I was nothing, and that's how they treat me." A visitor told us about concerns that their relative was often left in soiled bedding. They told us "I have arrived to find [the relative] lying in a soiled bed, with their carer seemingly unaware. I've been told that it had only just happened but even their socks were wet – [the relative] must have been like that for some time." This indicated that people were not always treated in a dignified manner.

We saw some good interactions, for example, we observed a person who used the service telling a member of staff that they felt uncomfortable. The member of staff appeared to understand immediately what the person was indicating and adjusted their clothing appropriately ensuring their dignity was respected. We observed several instances of staff speaking to people with patience, warmth and affection. However, staff did not always treat people with dignity and respect. Some interactions appeared entirely task-focused and staff did not engage in chat with people and occasionally undertook tasks without speaking to the person. For example, in one lounge, two members of staff were using a hoist to transfer a person from their chair to a wheelchair. They did not speak to the person as they put them into the sling. They did not offer any reassurance or commentary whilst they were hanging in the hoist waiting to be lowered into the wheelchair. The only time that the staff members spoke was to each other. Another member of staff was assisting a person to drink. They simply told the person, "Here's a drink for you" and broke off giving the person a drink midway through to attend to something else without telling the person why they were leaving. We saw this experience repeated at lunchtime on the Cedar Unit with a staff member breaking away from assisting a person to eat twice to attend to other matters. During the lunchtime meal we observed one member of staff spoke very loudly throughout the meal service to another member of staff, which was not a pleasant environment for people to be eating their lunch in. We also saw some people wearing clothing with food stains on them, and they were not offered the opportunity to change their clothing by staff. In people's bedrooms we observed examples of stained clothing that had been put away in people's drawers. This indicated a lack of dignity and respect towards people.

We observed the television and radio were turned on by staff with no consultation with people as to what they wanted to watch or listen to. When we asked a person whether they had input into the choice of programme they said, "The staff do it, they put it on and that's that." Another said, "I know that there's a remote control but we're not allowed to have it." We saw staff walk past one person who wanted attention and they were ignored. Another person appeared very distressed all day, calling out and shouting but they were not offered any comfort. Other than when engaging in a task with the person, for example being assisted to eat, staff did not speak to the person or otherwise reassure them.

During the inspection we observed a GP conducting patient consultations in the busy lounge area. This included the doctor and nurse on duty discussing people's health issues. This meant confidential issues were being discussed in full earshot of other people. No consideration had been given by staff to ensuring people had privacy during their consultation or to ensure discussions were done in a confidential manner.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not always treated in a dignified manner and their privacy was not always respected. This corresponds to Regulation 10 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Care plans did not always contain sufficient detail to ensure dignified and personalised care. For example, one person's care plan stated they could communicate in their own language but did not specify which language this was. Another person's care plan stated they were unable to have a basic conversation, however, during the inspection we were able to have a conversation with them about football. A number of care plans were missing life histories and there

Requires Improvement

Is the service caring?

was only limited information about people's preferences. This indicated staff had not taken the time to obtain and record proper information on people's likes, dislikes and preferences so individualised care could be provided.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People reported that they there were not any restrictions placed on visitors. One person told us, "I get quite a few phone calls." Relatives told us they could visit when they wanted.

We asked people whether they felt that the staff listened to them. Most told us they did, using phrases like "I'm always talking to them," and "You can just chat to them." Periodic surgeries were held where management would engage with people to hear about any issues or problems they had. Feedback had also been obtained from surveys and resident meetings indicating there were mechanisms in place to listen to people.

The issues identified from previous inspections under this key question did not form part of the warning notices we served and so were not looked at during our focused inspections on 11 November 2014 and 3 February 2015. We will look at the outstanding issues from this key question at our next inspection.

Inadequate

Is the service responsive?

Our findings

Findings from the comprehensive inspection 13 and 21 August 2014.

Care plans did not contain enough information about people's needs for staff to deliver responsive care. For example, medical histories were brief, one care plan stated "bowel cancer" but did not provide any further details, and others said "dementia" but did not record the type of dementia. Care plans often did not offer solutions or strategies for staff to follow. For example, one care plan highlighted the risk of a person parking their wheelchair in inappropriate places such as the corridor, but the monthly care plan updates just confirmed this was still a problem rather than offering any strategies for re-solving the problem. During the inspection we saw this person was sat in their wheelchair blocking the corridor unaware of any potential risks of this behaviour. This indicated staff had not effectively controlled the risk they had identified.

Assessments were not responsive to people's needs. For example one person no longer had their urinary catheter in situ but there was no interim plan in place for managing their continence needs. Another person, we observed had smeared faeces around the home. On speaking to staff this was clearly a problem that had been occurring for a number of weeks. However, there was no care plan responding to this problem guiding staff on how to manage the person and meet their needs. Behavioural care plans were not responsive following incidents. For example one person was frequently aggressive towards staff and people who used the service. However, their behavioural care plan had not been updated with new care strategies to reduce the likelihood of further incidents.

Care was not always delivered in line with care plans. We found people's personal care needs were not being met. For example, one person's care plan stated they should receive support to use the toilet every two hour, but records showed three to four hours between support. The person's records also stated they should be supported to shower daily but there were only 15 showers recorded since 14 January 2014. Another person's care plan stated they should be supported to shower two to three times a week; however, their last documented shower was 12th July 2014. This person looked visibly unclean, their care plan said nails should be kept clean, they were dirty. Another person's care plan stated they should be wearing glasses, we observed they were not wearing them until 15.00hrs when we raised this issue with a member of staff, who went to get this person's glasses. Another person's care plan stated that staff should assist them to wear appropriate footwear. The slippers looked too large and the person confirmed to us they were too big and uncomfortable. People were observed wearing clothing with food spills/stains on it and were not assisted to change. We observed some people who required assistance from staff had not had their hair brushed or combed. This indicated people were not receiving appropriate care.

We observed one person who was in discomfort; this person was putting their fingers in their mouth and rubbing their gums. They were visibly distressed. When we asked staff, they said their teeth were falling out and they had been seen by the dentist. However when we looked in their care plan, there was no evidence of any dental input or advice for staff to follow. Our observations concluded that staff did not know how to comfort this person or meet their needs as they were left in a distressed state with no contact from staff for long periods of time.

Some entries in care plan documentation were illegible. This meant staff could not review whether people were receiving appropriate care. In August 2014, we received a complaint from another healthcare organisation, part of which stated they were concerned that they were unable to review care records in an emergency situation due to illegible handwriting. We showed records to the deputy manager who confirmed the records were illegible and said they could not read them. They told us they were aware that some staff had poor record keeping and would ensure their record keeping improved. This risked inappropriate care and treatment as legible information on people's care was not always recorded.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People provided mixed responses about the standard of care. One person told us, "I picked here based on the atmosphere when I came for a look round. I thought it suited me, it was nice and quiet." Another said that they had picked the home based on experience of it. They told us "I used to come here and visit a friend of mine, and I thought it seemed alright. It took me a while but I feel

quite settled now." However, we did receive some negative comments. One person told us that they did not really like where they lived. They said, "I want to move somewhere else, and I think my family are looking into it. One or two things have happened that have put me off. Some of the staff are unfriendly sometimes and it's hard to get help sometimes. I'm not incontinent but I've had a couple of accidents because no one came to help me. It upset me."

People reported there was not enough to do in the home. Most were critical about the activities on offer, using phrases such as "boring" and "not much apart from the television." Our observations confirmed this. People were mainly left sitting in the lounges with little interaction between them. People had no access to any stimulus other than the television and they looked bored. The atmosphere in all the living rooms was very flat. One person told us, "There's never much to do. I like to sit and do a crossword sometimes." An activities programme was displayed on the wall, however the activities co-ordinator and our observations confirmed this was not followed. For example baking was advertised but we did not see this going on and one person told us they had never done baking at the service even though it was a hobby of theirs.

People said they would speak with staff if they had any concerns. There were notices in the reception area giving information as to how to raise concerns either with management or statutory bodies. Several 'thank you' cards were also displayed. We looked at recorded complaints and saw that written complaints had been appropriately responded to within the given timescales. However, given comments passed to us by relatives, it was evident that not all verbal complaints were recorded. The deputy manager told us they did not record some verbal complaints such as missing laundry. However, this was a missed opportunity to demonstrate they did listen to people and acted on information received.

Findings from the focused inspection 11 November 2014.

We found people's care records had been reviewed and updated and now provided staff with more information to help them deliver responsive care. For example, there was more specific and up to date information regarding people's medical history, personal preferences, known risks and life history. During our observations and conversations with people we saw staff demonstrated a good knowledge of people and were responsive to their needs.

During our observations we saw people's hair looked neat and tidy and they wore clean and appropriate clothing and footwear. This indicated staff had taken time to ensure people received appropriate support with their personal care. Overall people who used the service were positive about the support they received. One person said, "The staff in here are nice, they help me when I need it." A visitor told us that their relative, "Is always well turned out, hair nice and nails clipped and clean. They can't do these things for themselves so I'd know if the staff were not doing things for them." However, people told us the quality of care and support provided was dependent on the staff on duty. One relative said, "There is a big variation. Some staff are very good and know how to take care of our relative. Others seem not to know or care." Another relative told us, "Some things have improved. My relative's room has been decorated and we haven't found them in a wet bed or wet clothes. However, some staff don't notice what's happening. I had to draw their attention to someone who was wet at the front and back. They didn't see it." This showed us that further improvements were still required to ensure people were consistently provided with appropriate care.

From our review of care records and observations we saw evidence people received support in line with the needs specified within their individual care plan. For example, one person's care plan noted they would benefit from bed rest for at least two hours a day. Our review of this person's daily care records showed staff had offered this person a period of bed rest most afternoons in the month prior to our visit. However, we were not always able to evidence that consistent support had been offered or provided to all people. For example, two people were identified as requiring a bath or shower two to three times per week. However, in both people's personal hygiene records there were no entries that baths or showers had been offered or given in the 13 days prior to our visit. This meant we were unable to confirm these people had received appropriate support with their personal care.

Care records did not always have clear solutions or strategies for staff to follow to help them control identified risks. For example, one person's care records identified they could become verbally abusive. Their care plan stated; "Staff to use distraction techniques to attempt to diffuse escalating behaviour." However, there was no information

Inadequate

Is the service responsive?

about what were the best and most appropriate distraction techniques to calm this person's behaviour. This meant staff did not have the information required to ensure they provided this person with responsive and appropriate care.

Therefore, although the provider had taken steps to meet the requirements of the of the warning notice in relation to Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, there remained a breach of this regulation. This corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The other issues identified from previous inspections did not form part of the warning notices we served and so were not looked at during our focused inspections on 11 November 2014 and 3 February 2015. We will look at the outstanding issues from this key question at our next inspection.

Inadequate

Is the service well-led?

Our findings

Findings from the comprehensive inspection 13 and 21 August 2014.

A registered manager was in place on the date of the inspection. We found seven notifications of abuse which should have been submitted to the Care Quality Commission (CQC) had not been. This is a breach of Regulation 18 Health and Social Care Act 2008 (Registration Regulations) 2010. We are currently considering our regulatory response to this breach.

Inadequate systems were in place to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included dignity and respect, nutrition, care and welfare, managing risks to people and staffing levels. These issues had not been identified by the provider prior to our visit, which showed there was a lack of robust quality assurance systems in place. The registered manager confirmed there was no improvement plan in place or action plan to improve the service and they were waiting for CQC's findings to action improvement. As part of a robust quality assurance system the manager should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for CQC to identify shortfalls.

With regards to Infection Prevention, some issues had been identified by the local authority infection control team, who conducted an audit at the home in April 2014. They had identified issues such as dried faeces on commodes and toilets, unhygienic flooring, and stains on chairs. We found these issues were also present during our inspection, which demonstrated the provider and manager had not taken satisfactory action following the audit. There was no evidence of any more recent infection control audits/ environmental audits to monitor cleanliness and hygiene in the home on an on-going basis.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was no evidence of recent quality monitoring of care documents at the home. We saw care plan audits had been undertaken in 2013 but there were no more recent audits. We found some care plans lacked detail and others did not contain appropriate advice for staff to follow. Other care plans were missing information about people's preferences, life histories and mental capacity assessments. We found various instances of care not being delivered in line with people's care plans. These issues could have been identified through a formal system to assess and monitor the quality of care. Nutrition audits were undertaken in 2013 but there were no more recent audits looking at whether the quality of food or mealtime experience was suitable.

There was no formal system in place to assess and monitor staffing levels. Although each person had a dependency tool within their care plan to determine the level of support they required, there was no evidence this was used to calculate staffing levels within the home. We found staffing levels were inadequate which could have been identified and rectified through observations and/or the use of a formal staffing level tool.

Given the provider was registered to provide care for up to 80 people spread over four units the presence of a structured and effective quality assurance system was essential in order for management to receive assurance regarding the performance of different areas of the home.

Where issues or improvements had been identified, we saw appropriate action had not always been taken to address. For example, the resident and relative surveys' completed in late 2013 had identified that lack of activities for people was an issue. During this inspection, feedback from people was that there was not enough to do and we observed there was inadequate stimulation for people. This showed that the organisation had failed to make appropriate improvements based on people's feedback.

We saw that a complaint had been received from a health professional on the 7 August 2014, concerned that people who used the service were wandering around and one person had been crying continuously. Although this complaint had been responded to by the manager, during the inspection we also found this was an ongoing issue. We were particularly concerned about the welfare of this person and the lack of comfort given to them by staff. This indicated that once an issue had been raised with the home, insufficient action had been taken to respond to it.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. For example, we found numerous incidents of violence or aggression against staff or people who used the service which were recorded in people's care plans but not

reported on the provider's incident form. This meant there was no evidence these issues had been reported to management for action. Where incidents had been reported, the incident form was not fit for purpose, there was often insufficient space on the incident form to detail preventative measures taken to drive improvement. Staff were having to write details of the incident on the blank reverse of the form. We saw actions were not detailed enough to assure us that strong action had been taken to learn lessons from incidents. We found incidents such as people throwing tea, were re-occurant, indicating incidents were not managed appropriately to ensure a positive outcome for people who used the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

We observed a poor atmosphere in the home, with most of the communal areas populated by people and staff who seldom interacted with each other. We did not observe many examples of staff trying to engage with people who used the service or lift the atmosphere. There was no evidence of good leadership on the units by senior staff to improve the experiences for the people who lived there. Whilst people did demonstrate that they recognised and knew the staff none were able to tell us about the registered manager of the home which indicated they were not always visible and known to the people who used the service.

Staff spoke positively about the registered manager and said they were able to raise concerns with them and were confident action would be taken to address. Staff meetings took place periodically and there was evidence that issues were discussed with staff such as complaints, and care issues, indicating that management had identified some incidents of poor care practice and raised with staff to make improvements.

Findings from the focused inspection 11 November 2014.

Following our comprehensive inspection in August 2014 the registered manager and deputy manager both left the service. Whilst they recruited to these vacant positions the provider moved a manager from another service to cover the registered manager's post. We found that during this period there was a lack of ownership and accountability for ensuring the required improvements were made.

We checked the action plan developed since our last visit. It was not up to date and did not provide sufficient evidence that actions had been completed. Where actions were recorded as being completed, this was not always the case. This had not been identified by the provider which showed their checks were not robust. For example, we found most pillows on people's beds on the Rowan Unit were stained and required replacing. The action plan detailed new pillows had been ordered for all units and this was recorded as a completed action. When we looked in the linen cupboard on the Rowan Unit we found a pile of new pillows. We raised this with the operations manager who said they thought all pillows had been replaced. However, they had not checked to ensure the action had been done or identified this shortfall as part of their regular checks of the service. This showed the provider had not taken appropriate action to ensure that delegated responsibilities or actions had been completed in the period when the home was without a manager.

Our review of records and discussions with staff showed that care staff and nurses in charge of units did not have clear responsibilities for implementing and driving specific improvements. Action plans had not been discussed in staff meetings and nurses and care staff were not aware of the action plans and what their responsibilities were. Staff supervision records showed discussions had not been held with individual staff members regarding their role in making the required improvements. This resulted in a lack of accountability and poor dissemination of information and responsibilities amongst staff.

During our visit the new manager told us they had been in post for five weeks. We found they had many plans and ideas for improving the service, but had not had time to implement them yet. The manager was unsure what actions had been completed and were in the process of completing a revised action plan so they could keep a track of what improvements were outstanding. This could have been avoided had the provider taken action to ensure the action plans had been kept up-to-date and responsibilities delegated appropriately.

We found the provider had introduced a range of audits since our last visit. However, these were not robust and did

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not effectively contribute to improving the quality of service provided. For example, management checks and monthly audits had been introduced in areas such as catering, dignity, respect and dining experience. However, we found where these audits had identified issues there was no evidence of the actions taken to address them. For example, a re-occurring theme identified in the dignity audits from October 2014 was that people did not always look clean and cared for. However, there was no evidence that appropriate action had been taken to resolve this issue with staff, improve the experience for people and prevent it from occurring again.

We also saw that where the provider had introduced systems and processes to address issues these were not always effective. For example, during our last visit we identified that there was no formal system to assess and monitor staffing levels. During this visit we saw a new tool had been implemented to help assess staffing levels. However, the manager had not been trained in how to use the tool and was unsure how to correctly complete it. The tool did not consider key areas such as people's behaviour and activities when assessing dependency levels. This meant it could not provide meaningful and accurate information to ensure staffing levels were calculated effectively.

We found that the issues we identified with care records had not been identified and addressed through an effective system of care plan audits.

During our last inspection we raised concerns about the format of the provider's incident form. We found it was not always clear what action, if any, had been taken to keep people safe. At this inspection, we found the form had not been changed. Staff told us they found the forms were, "Not ideal" and there was insufficient space to document the incident and associated actions. We reviewed a sample of incident forms from September to November 2014. We saw a lack of clear actions recorded following incidents to evidence that appropriate action had been taken to keep people safe. We found some basic monthly analysis had been completed to help look for trends and patterns. However, without clear and consistent evidence being recorded it was difficult to evidence that appropriate action had been taken to keep people safe.

Our findings during this inspection demonstrated that appropriate improvements had not been made with regards to standards of cleanliness and hygiene at the service. The infection prevention audits and cleanliness checks completed since our last visit were ineffective as they did not identify and address areas where improvements were required. The concerns we found during our tour of the building, such as dried faeces on commodes and toilets, stains on chairs and unhygienic flooring, had been identified by the local authority infection control team during their audit of the home in April 2014 and during our last inspection in August 2014. The fact these issues had not been addressed despite being repeatedly raised with the provider demonstrated a widespread and consistent absence of leadership and effective quality assurance to drive improvements in infection prevention.

This meant that the provider had not met the legal requirements of the warning notice and continued to breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The new manager explained they wanted to introduce their own system of audits because they recognised that most of the current checks in place were not robust enough. They had already introduced more comprehensive systems for reviewing care records and other key information such as monthly weight changes and infections. However, these had been in place for less than a month so we were unable to assess their long term effectiveness in improving the quality of care. They told us that a new deputy manager was due to start at the beginning of December 2014 and they would be tasked with providing clinical leadership and support with more regular and robust audits.

The feedback from people and staff about the new manager was positive. There was evidence that they were in the process of changing the culture within the service. For example, the minutes of the first team meeting showed they had spoken with staff to promote a more open and honest culture and encourage staff to come to them if they had any ideas or concerns. People who lived at the home, visitors and staff all spoke positively about the new manager, saying they were "Supportive", "More visible" and "Honest". One person told us they had, "Noticed a difference already." The new manager was also open and

honest about where the organisation was up to and where improvements were still required. They said they were fully committed to making the changes required to ensure the appropriate improvement were made.

Findings from focused inspection 3 February 2015

We saw evidence of clearer leadership and accountability amongst the staff team. The manager had developed a service improvement plan which detailed all of the actions which were required to improve the service, who was responsible for the actions and monitored their progress against them. We saw this document was being actively used and updated so that progress could be tracked.

The manager had a confident oversight and realistic attitude about what improvements were working, where refinements were required and what areas still needed to be addressed. They recognised it would take time to ensure the long term culture change was fully embedded and that further areas of improvement were still required. For example, they had identified that a key area for improvement was to ensure the nurses and team leaders in charge of units provided consistent and effective management. However, we saw evidence they had begun to change the culture and attitude amongst staff. For example, our review of the minutes of the staff meetings held in December 2014 and January 2015 showed the manager encouraged a culture of openness, accountability and a focus on delivering person centred care. When we spoke with care and domestic staff they now had a clearer understanding of where the improvements were required and what their role was in ensuring they were made. All staff were realistic that there was still much work ahead, but said they now felt they had the support from the management team to help them achieve it. Care staff provided examples where they had raised issues with the manager and these had been promptly dealt with. They said morale amongst the staff team had improved as a result of the increased openness and support from management and that this would be improved even further when the refurbishment plans were completed in the coming months.

We saw evidence that management audits were beginning to identify and address issues. For example, on most week days the manager conducted 'walk-rounds' of the service. These were recorded and looked at areas such as, people's wellbeing and feedback, mealtimes and a strong focus on environmental conditions, this was especially important given the infection control related failings we had previously found in the home. We saw these checks were routinely identifying and addressing issues such as, "tables very sticky", and "inappropriately stored waste". We saw actions were signed off once completed by the manager. This indicated a pro-active approach to identifying and rectifying issues. Care records were being checked and we saw evidence that these audits picked up on issues and made improvements to the documentation where appropriate. However, the manager recognised that further work on care records was required to ensure they were fully person centred. The manager's monthly analysis of accidents and incidents had begun to identify and act upon trends and patterns. We also saw that the manager's spot checks and audits on dignity and respect had addressed issues directly with staff, such as where people had not been appropriately dressed or there was a shortfall in the standards of cleanliness. However, as all of these audits had only been in place for a few months we were unable to test their ability to contribute to long term improvements to the quality of care provided.

Overall the feedback from people who used the service and visitors was that they had noticed improvements were being made to the quality of service provided. People said there were still many areas which needed addressing. For example, a common theme was that clothing still sometimes went missing despite being labelled and that some staff did not always provide timely assistance with people's personal care needs. However, all of the people we spoke with told us they had confidence in the manager and when they raised issues with them they listened to them and tried to address their concerns as quickly as possible. The manager had also put systems in place to gain people's feedback about where future improvements were required. This included; quality surveys, relative and resident meetings and monthly manager's surgeries. However, we were unable to test the effectiveness of these as a means of improving the quality of service provided as they had not been fully implemented at the time of this inspection.

We saw evidence that the provider's operations manager now recorded their monthly visits to the service. However, further improvement was still required to ensure they could evidence that these visits were effective in driving improvements in the quality of service provided. For example, the provider visit record for January 2015 detailed that 12 care records had been audited and the information

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was found to be "Accurate but not person centred". There was no evidence of a provider led action plan to ensure the manager addressed this shortfall. The Commission had met with the provider in January 2015 to discuss the issues identified during our 11 November 2014 inspection. During this meeting they told us they were in the process of reviewing and revising how they audited their services.

Overall, we saw evidence that the leadership, staff culture and the systems in place to assess and monitor the quality of care provided had been improved. However, it was too early to be assured that these improvements could be sustained and to evidence that they were fully embedded, refined and robust. This meant that although the provider had taken steps to meet the requirements of the of the warning notice in relation to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, there remained a breach of this regulation, which corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The other issues identified from previous inspections did not form part of the warning notices we served and so were not looked at during our focused inspections on 11 November 2014 and 3 February 2015. We will look at the outstanding issues from this key question at our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **11 November 2014 and 3 February 2015** People were not protected against the risks of acquiring an infection as the maintenance of appropriate standards of cleanliness and hygiene were not consistently being met and sustained. This was a breach of Regulation 12(1)(a) and (b) and 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

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 **11 November 2014 and 3 February 2015** People were not protected against the risk of inappropriate care and treatment as the quality of the service was not being consistently assessed and monitored. Risks to people's health and welfare were not identified, assessed and managed through an effective and sustained system of quality assurance. This was a breach of Regulation 10 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **11 November 2014**

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	People were not protected against the risks of receiving care or treatment that was inappropriate as care was not planned and delivered in such a way as to meet individual needs and ensure the welfare and safety of people. This was a breach of Regulation 9 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

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 **13 and 21 August 2014** Regulation 17 (1) (a), The registered person must, so far as reasonably practicable make suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (2) (a) The registered person must treat service users with consideration and respect. This was a breach of Regulation 17 (1) (a) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. **11 November 2014 and 3 February 2015** We did not inspect this regulation as part of these focused inspections. We will undertake another unannounced focused inspection to check on this breach.

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 **13 and 21 August 2014** Regulation 14 (1) (a) Where food and hydration are provided to service users as a component of carrying out

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **13 and 21 August 2014** Regulation 11 (1) (a) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs. This was a breach of Regulation 11 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. **11 November 2014 and 3 February 2015** We did not inspect this regulation as part of these focused inspections. We will undertake another unannounced focused inspection to check on this breach.
	the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitably nutritious food and hydration in sufficient quantities to meet service users needs. Regulation 14 (1) (c) Support where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. This was a breach of Regulation 14 (1) (a) and (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. **11 November 2014 and 3 February 2015** We did not inspect this regulation as part of these focused inspections. We will undertake another unannounced focused inspection to check on this breach.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **13 and 21 August 2014** Regulation 22 – In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. **11 November 2014 and 3 February 2015** We did not inspect this regulation as part of these focused inspections. We will undertake another unannounced focused inspection to check on this breach.

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 **13 and 21 August 2014** Regulation 20 (1) (a) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. This was a breach of Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(d) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

11 November 2014 and 3 February 2015

We did not inspect this regulation as part of these focused inspections. We will undertake another unannounced focused inspection to check on this breach.