The Old Rectory Residential Home Limited

The Old Rectory

Inspection report

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Breaston
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Tel: 01332874342

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The Old Rectory is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were 17 people using the service.

People's experience of using this service:
The provider had failed to act to ensure improvements had been made within the service. This is the third consecutive time the service has been rated 'Requires Improvement' or 'Inadequate'. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive and we found systems in place to ensure improvements were made and sustained were not effective.

Systems to monitor the service had not been effective in identifying the improvements that were still needed. People were not always protected from harm as action had not been taken where risk had been identified. People's support was not provided in line with current legislation and best practice guidelines; this had resulted in people being placed at risk of harm. People did not always have a care plan which reflected how to minimise risks and record how they wanted to be supported. Staff had not received training to support people with complex behaviour.

There were not always sufficient staff to support people safely. Where people needed additional support to stay safe or prevent harm to others, staffing was not arranged to ensure people's safety. The lack of staff support through the day meant some people did not receive individual respectful care and did not enable people to be involved with activities outside of the home. People had limited opportunities to engage with activities that interested them. Improvements were needed with how medicines were recorded, and accurate audits were not completed for the medicines kept in the home.

A new electronic care planning system had been developed, although people's care plans did not always include information about how to provide their support or how to reduce identified risks. The system was not accessible in all parts of the home due to limited internet connection.

People could make everyday decisions. However, some people were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service did not support this practice. Where restrictions required an urgent referral to support any restriction, this had not been recognised. CCTV had been installed in the home and although this was not currently in use, people had not been consulted and their consent had not been obtained for its use.

People's dignity was not always respected. Where people needed supported to eat and drink, staff did not support people in a respectful and dignified way.

People were able to stay in touch with people who were important to them as visitors could come to the home at any time.

Staff understood how to support people with individual preferences and recognised and valued people's diverse needs. People knew who to speak with if they had any concerns. People had access to healthcare services and felt they received the support they needed from staff. People knew who the registered manager was and were able to share their views about the service.

Rating at last inspection: Requires improvement. (Published January 2018)

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

The Old Rectory

Detailed findings

Background to this inspection

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

Inspection team:
Two inspectors carried out this inspection.

Service and service type: The Old Rectory is a residential care home for older people who may also be living with dementia. There were 17 people living in the home at the time of our inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
Before our inspection we reviewed information that we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We reviewed the provider information return (PIR). This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

During the inspection we spoke with six people who used the service, three relatives, five staff members, the deputy manager, the administrator and the registered manager. We also received feedback from the local authority commissioning service. We looked at care plans relating to five people and reviewed records relating to the management of the service. We asked the provider to send us information relating to how they completed quality monitoring audits as there was a technical issue with their computer during the

inspection. We received this information on 21 March 2019 as requested.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
Learning lessons when things go wrong
•On our last inspection we identified improvements were needed to ensure that all risks were considered and that risk assessments were up to date and took account of any accidents or incidents that had occurred. On this inspection we found improvements had not been made.
•Risk assessments were not always detailed and did not clearly describe the controls in place to help mitigate risks to people's safety and well-being. For example, where people had complex behaviour which may place themselves or others at risk of harm, there was no information about how to support them to help reduce the risk and the occurrence of this behaviour. There was no information about how to keep them safe when they became anxious or when they were at risk of harming others.
•Staff had not received training to support people with complex behaviour. We saw this meant staff left the person alone when they were agitated because they were not sure how to provide their support, leaving them and others at risk of harm.
•Where incidents had occurred, we saw these were not always recorded to identify what happened and to review their care to reduce future risks.
•Where people needed to spend time in bed to help prevent skin damage, we saw there was a care plan in place which recorded the risk and how to keep them safe. However, we visited one person during the afternoon and saw they had partly fallen out of their bed. There was a padded mat on the floor but there was no monitoring system in place to ensure their safety. A member of staff confirmed the sensor mat which should be in place to alert staff had not been connected on this occasion.
•Another person told us they had a sensor mat by their bed to alert staff if they got out of bed in the night. They knew it had been placed there for their safety and agreed to this. However, they told us, "I have a mat on the bedroom floor, so they know when I'm up, but last night I got up twice and it wasn't working, and no-one came to me."
•Lessons were not learned when things went wrong. The registered manager had not taken suitable action following incidents and learning was not shared with staff.
•Risk assessments and care plans were not updated after accidents and incidents to ensure that the measures in place were effective.

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

Systems and processes to safeguard people from the risk of abuse
•Systems were not in place to help protect people from the risk of harm or abuse. Staff had received training to recognise and identify where harm or abuse had occurred, although we saw where potential safeguarding concerns had been recorded, these had not been reported to the local authority safeguarding

team or to us.
•□We saw recorded incidents where people who used the service had frightened other people and this was not reported. We saw incidents recorded where staff had left people alone and vulnerable and where one member of staff had shouted at a person using the service. The registered manager had not identified that these may be safeguarding incidents and had not made any safeguarding alerts.
•□The PIR recorded that safeguarding training had been completed and has been discussed during staff meetings and the registered manager was confident that staff had a good knowledge in relation to safeguarding practices. However, we found that although staff had received safeguarding training, action had not been taken to ensure people were safe.

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

Staffing and recruitment
•□People told us there was not always enough staff available to provide the support they wanted. We saw staff were not always available in communal areas and some people were not able to stand independently to summon support; call bells were not in accessible locations. One person told us, "We do have to wait sometimes if we need to go to the bathroom. The call bell is on the wall over there and we can't reach it."
•□Staff told us there was not always enough staff on duty. A number of people who used the service needed the support of two staff with personal care. Some people had complex behaviour and we saw were not closely observed and we had to alert staff to incidents where they were at risk of harm to help to keep them safe.
•□Staff were also responsible for the laundry during the day and serving and clearing away the evening meal. A member of staff told us this meant they were not available for to support people during these times.
•□At lunch time we saw one member of staff support two people to eat their meal and sat between them offering alternating support between them. At times other people needed assistance to eat, or have their food cut up, so they left these people to support others.
•□People told us there was not enough staff to provide support to carry out activities in the home and when out. People told us that they were only able to go out with family members; people without any visiting family did not have any opportunity to go to local places of interest or participate in activities or events they enjoyed. One person told us, "If we go out anywhere, it is with our family." Another person told us. "I do miss going for walks, but the area is strange to me, so I can't go from here."
•□Where people were ill and needed to go to hospital, there was a short care plan which was provided to emergency service staff with important information about them. The staff confirmed they would not support people on appointments or when they were taken to hospital. The provider's policy recorded that any trip to hospital was the responsibility of family members, although they had not considered what should be done, where family were not available, or where people did not have family to support them.

This evidence demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Effective recruitment practices were followed to help ensure staff were of good character, physically and mentally fit for the roles they performed. Staff explained that references had been sought and police checks were carried out before they were able to work in the service.

Preventing and controlling infection
•□The home was generally clean, and we saw staff used gloves and aprons. However, we saw a ground floor bathroom and toilet needed attention. One toilet had a leaking sink, wall paper was peeling off the walls

and the floor was not suitably sealed and was dirty.

• The flooring in one ground floor bathroom was also not sealed and wall paper in this room was peeling away from the walls. This meant these rooms could not be effectively cleaned and could not meet suitable infection control standards.

• An infection control audit had been completed and recorded there were no concerns and had not identified where improvements were needed.

Using medicines safely

• Where people needed medicines covertly (without their knowledge) we saw the GP had been involved with a best interest decision. However, there had been no involvement with a pharmacist to give guidance about the food and drink the medicines were safe to administer with.

• People were supported to take their medicines by staff who had been trained to administer medicines. People felt they received their medicines on time and we saw staff explaining what the medicines were for and asking people if they needed any medicines for pain.

• Medicines were stored securely, and we saw where medicines were given, staff recorded this in the administration record sheet.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

- On our last inspection we found improvements were needed to ensure all restrictions were recognised for people. On this inspection we found further improvements were needed.
- Where restrictions were identified, the registered manager had recognised these and standard DoLS applications had been made to ensure these restrictions were lawful. Where people had complex behaviour and further restrictions were needed to keep them safe or to prevent them leaving the home, the registered manager had not considered that these restrictions needed to be considered as urgent. Therefore, they confirmed an urgent application had not been completed and these restrictions had not been reviewed.
- Where staff felt people may not have capacity, an assessment had been completed but did not record how capacity had been assessed to demonstrate how the decision regarding capacity had been reached. Improvements were needed with how assessments of capacity were recorded.
- Staff explained that following their MCA training, capacity assessments had been completed for all people. In discussion, the staff recognised that this did not follow the principles of MCA that capacity is assumed and agreed they would review this practice.
- The provider had installed CCTV in all communal areas of the home, including the lounge, dining room and corridors. The staff told us this had been in operation but that this was currently not being used as the system needed to be repaired.
- However, staff confirmed that they had not considered people's consent to being filmed and there was no information recorded within the Statement of Purpose about how the CCTV would be used and information retained. There was no information about the use of CCTV in the home.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living at the home.

Staff support: induction, training, skills and experience
•□Staff had received an induction and further training. However, we found this was not always effective and people were not always supported to receive care in accordance with best practice guidelines.
•□Staff had not received training to support people with complex behaviour and we saw this placed people at risk of harm.
•□Training had been organised for staff in supporting people who were living with dementia. Staff explained they were looking forward to attending this training as they did not always understand how to provide this care to ensure people received suitable support.
•□Staff had received training to support people to move. We saw where people were assisted to move with a mechanical hoist, the staff knew how to operate this safely and how to position people's slings to ensure they were comfortable and safe. Staff explained that competency assessments were carried out to ensure they continued to support people safely.
•□However, we saw on one occasion, one person was supported to move in their chair in a way that was not safe and may place them and staff at risk of harm. We addressed this during the inspection to ensure people's safety.
•□This is an area that requires improvement.

Supporting people to eat and drink enough to maintain a balanced diet
•□People were asked what they would like to eat and staff were aware of people's preferences. However, we saw one person had not received their preferred breakfast. They told us, "I like toast for breakfast, but it doesn't look like I'm going to get that this morning." We saw this option was not provided.
•□The daily menu was written on a white board outside of the dining room, although the writing was not clear and small and there were no pictures or photographs to support understanding.
•□Some people needed a specialist diet and referrals had been made to health care professionals. We saw assessments had been completed and food and drink were prepared in the recommended way, such as providing a soft diet, to ensure this met people's identified needs.
•□People could choose what they wanted to eat, or drink and were generally complimentary about the food that was provided and the choice available. People told us that the cook spoke with them to ensure they were happy with the choices available and the quality of the food.
•□Where people needed their weight monitoring, this was recorded, and referrals made to health professionals if there were concerns about people's weight loss. People were provided with a fortified diet and we saw this had reduced further weight loss.
•□A record was maintained of what people had to eat and drink where the staff were concerned. We spoke with the staff about the need to ensure there was guidance about how the amount of fluid people needed based on their size and weight.

Adapting service, design, decoration to meet people's needs
•□The home enabled people to move around easily, whether this was independently or with the use of mobility aids.
•□However, consideration had not been given to how people may need signs or pictures to help them to move around the home or to understand their environment.
•□The bedroom and bathroom doors were all the same colour and people's bedroom were not clearly identified to help people living with dementia to navigate around the home and find their bedroom.
•□Some toilets and bathrooms need attention to ensure infection control standards were maintained and needed to be decorated.
•□One ground floor toilet had a thick wire hooked over a rail to hold the toilet roll. Staff explained a new holder had been purchased, although it had not been fitted to ensure this was safe and suitable.
•□People were able to have a key to their bedroom and where it was locked, the domestic staff asked if they

could enter and sought permission to clean their bedroom.
•There was an attractive and accessible garden for people to use and people spoke positively about how they enjoyed looking at the plants and wild life who visited the garden and told us they spent time outside when the weather was warmer.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Before people were admitted to the home, assessments were undertaken to determine whether the service could meet their needs. People told us they were given the opportunity to look around and make a choice of whether to move there.
•Care plans were developed from these assessments and the provider had developed a new electronic care planning system.
•People generally had information recorded about how they wanted to be supported. However, where people had complex behaviour there were no plans or risk assessments in place to guide staff about how to support them to keep safe.
•Where people had plans about how to keep safe and the use of any sensory aid, we saw care was not always given that matched their plan to ensure consistent and effective care for people.

Supporting people to live healthier lives, access healthcare services and support
Staff working with other agencies to provide consistent, effective, timely care
•People had access to health professionals to help them stay well. The GP visited the home to monitor people's health and medicines and people confirmed when they felt unwell, the staff contacted the doctor or called the hospital for treatment and support.
•Where staff identified concerns with people's health and well-being, referrals were made to health care professionals including occupational therapists, speech and language therapists to ensure people received specialist support.
•Information was recorded to share with other agencies if people needed to access other services, such as hospitals.
•People were confident they received the healthcare support they needed in a timely way.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
•□People's dignity was not always promoted. At lunch time, one member of staff sat between two people supporting them to eat. They alternated between them, offering a spoon of food on each occasion. We saw at times, they needed to think about the spoons they were using to ensure people were only eating from their own plate.
•□Throughout the meal, there was no conversation with people. The staff did not inform people of what they were eating or when they would be offered another spoon of food.
•□We saw, staff did not recognise when people were refusing food and tried on numerous occasions to assist them to eat more food even though they were closing their mouth.
•□When staff stopped supporting people to assist other people, they left their meal and drink and did not let people know they had moved away or when they would return.
•□On occasions, we heard staff speak sharply with people and were not respectful. We saw complaints had been made about how staff spoke with people, but we saw improvements had not been made.
•□Some women were uncomfortable about having facial hair and their appearance. One person told us. "It would be nice to have a good wax." Staff had not offered this service to people to ensure they maintained their dignity.

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

Ensuring people are well treated and supported; respecting equality and diversity
•□The staff did not discriminate based on sexual orientation or sexual gender and consideration was given to people's preferences in relation to their diverse cultural and human rights. Staff understood how people wanted to be addressed and recognised people's different gender identities.
•□Staff recognised that people moved into the home from the local area and were familiar with local cultural differences and the terms people used when expressing themselves.
•□People were dressed in a style of their choosing and had matching accessories and people could have their bag near to them. We saw when people were supported to move staff remembered to take their personal belongings with them and asked people where they could place them, so they could reach them.
•□We saw that staff respected people's personal space and provided furniture to store personal belongings near to them.

Supporting people to express their views and be involved in making decisions about their care
•□Staff generally respected people's wishes and provided comfort when needed. For example, some people

had difficulty watching the television due to the sun; when staff noticed, they offered to draw the curtains to make viewing easier.

• One person commented they were warm, and staff offered to open a window. They consulted with others around them to ensure they would be happy and not sit in a draft.

• Where people were not able to be involved in decisions about their care, the staff had consulted with people who were important to them and understood how decisions could be made in their best interests.

• Family and friends were welcomed to the home and we saw staff knew who they were, asked after their welfare and spoke with them about significant family events. Visitors told us they felt welcomed and were able to spend time with people in private.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People could make choices about their time and how to spend their day. However, people had mixed views about the choices they had in relation to participating with activities.
- During our inspection we saw some people played a game of dominies and connect four, one person was involved with art work and other people watched the television.
- Some people told us they were did not want to participate in organised activities and were happy watching the television and talking to other people.
- Staff told us they were responsible for organising and participating in any activities when there were opportunities, although most people wanted to spend time talking with them.
- One person told us, "They sometimes put a film on the television, but after about fifteen minutes everyone has gone to sleep or is snoring, so I can't hear it anyway, so I don't really bother now."
- When people's care needs changed, the care plans were not always reviewed in line with what happened when incidents had occurred.
- Where people received health intervention the care plans were updated to reflect this advice and recorded what support people wanted. People's care plans included information about how they preferred to communicate, and we saw staff speaking with people and supporting them to make decisions.
- Where people had sensory impairment, they attended health checks and could update their glasses prescription or had a hearing aid fitted.
- The PIR recorded that dementia signage was in place around the home although we did not see this was in place or used to support people's understanding or to help them express themselves.
- The staff were aware of the Accessible information standard although they confirmed that there was no information available in other formats. However, they told us if they became aware that people would benefit from having information in a different style, they could arrange for information to be in large print.
- Care plans were now on an electronic tablet. Staff explained that this was read to people to ensure they were involved and understood their care plan.
- The staff agreed that further consultation was needed to ensure people had access to this information in a format they felt comfortable with and understood.

Improving care quality in response to complaints or concerns

- A system was in place to record the complaints received and we saw where complaints were received, these were investigated, and people informed of the outcome. However, we saw one complaint was raised against a member of staff. The provider had investigated this incident, although not identified that this was an allegation of verbal abuse and a referral to the local safeguarding team had not been made.
- People felt comfortable telling the staff if they had any concerns. One person told us, "I would just say something if it wasn't right."

•□A complaints procedure was in place and guidance was available in communal areas of the home on how to express a concern or raise a complaint, although this was not displayed in large print or in pictorial format to help people to understand.

End of life care and support

•□There were nobody receiving end of life care at the time of our inspection.

•□Staff reported that where people had any specific wishes these were recorded to ensure their wishes could be respected.

•□Where people chose to stay in the home, staff explained that they would be supported by health care professional to support them to stay as comfortable as possible.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
Continuous learning and improving care

- On our last two inspections we found that improvements were needed to ensure people received safe and effective care. On this inspection we found these improvements were still needed.
- The overall rating for this service is Inadequate and the service has been placed in special measures.
- We found the systems to monitor and assess the service to drive improvements were not effective and lessons had not been learnt.
- The registered manager completed quality audits on how the service was managed, equipment and the premises. However, they had not identified the concerns we highlighted on our inspection.
- Systems were not in place to ensure people had an up to date care plan which reflected their needs and assessed risks.
- The new system to record people's care was not always available due to insufficient internet coverage within the home. The provider had not considered how people could access their records in a format which was meaningful to them.
- Suitable systems were not in place to ensure medicines could be audited to ensure people had received these as prescribed. The number of medicines stored in the home did not tally with the number of medicines we saw were stored.
- Staff told us that staffing in the home was organised according to the number of people using the service and had not been reviewed where people needed further support. We saw staffing was not organised to enable people to be safely supported in a respectful way.
- Where people had complex behaviour, the quality monitoring systems had not identified care had not been planned to manage risk and staff had not received training to support them safely.
- Due to the risk we identified the registered manager needed to provide additional staff to ensure all people who used the service were safe.
- The registered manager had not ensured that all incidents were recorded where people had been placed at harm or where people had shown complex behaviour.
- Where safeguarding concerns had been identified, systems were not in place to ensure staff knew how to act and referrals had not been made to the local safeguarding team and notifications sent to us.
- The quality audits had not identified improvements were needed within the environment to maintain infection control standards.

This evidence demonstrates a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives had mixed responses about the opportunities to share their views about the quality of the service provided. Staff told us that resident's meetings were not held for people to raise any concerns or to receive information about the service.
- The staff informed us that surveys were sent out to people and relatives to gather feedback about the quality of the service provided. Some people were not aware of this process and one relative told us, "I've never had a satisfaction survey to answer."
- In the office a small poster displayed the outcome of a recent survey although staff informed us this had not been designed in a larger print for people in a different format.
- We saw a recent survey had highlighted that people would like more activities that interested them. During this inspection we identified that improvements had not yet been made in this area to people's satisfaction.

Working in partnership with others

- The registered manager and staff made referrals to health and social care professionals although they had not identified where urgent referrals were required to keep people safe.
- The provider had failed to engage effectively or work in partnership with others to bring about required improvements in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of some service users was not appropriate to ensure their needs were met and care reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. Systems and processes had not been established and operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and Treatment was not provided in a safe way for service users. Risks to the health and safety of service users had not been fully assessed and the registered person was not doing all that was reasonably practicable to mitigate an such risks. The registered person had not ensured that staff had the necessary skills for providing care to a service user that was safe.

The enforcement action we took:

We issued a Notice of Proposal to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor and improve the quality of the service and assess, monitor and mitigate risks to the health, safety and welfare of service users and others who may be at risk.

The enforcement action we took:

We issued a Notice of Proposal to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in the service.

The enforcement action we took:

We issued a Notice of Proposal to cancel the registration.