Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
Liverpool
L14 9QN

Tel: 01512590617

Date of inspection visit:
12 February 2023
13 February 2023
14 February 2023
16 February 2023

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17 August 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Finch Manor Nursing Home a residential care home providing personal care and nursing care for up to 89 people. The service provides support to older people and younger people requiring nursing care. At the time of our inspection there were 87 people using the service. Accommodation is provided on the ground floor of the building which was accessible to all.

People's experience of using this service and what we found
People's safety was not always appropriately managed. Identified risks to people were not always considered or planned for. Medicines were not always managed appropriately. Staff supporting people were not familiar with individuals' needs and there was a lack of guidance and support available to these staff. Cleanliness and infection prevention and control procedures were not effective, with many areas of the service requiring cleaning. There was a lack of management of staff and no effective oversight of staff recruitment and information relating to agency workers.

Detailed information about people's eating and drinking needs and preferences was not always available. This resulted in staff supporting people who were not aware of people's dietary needs and preferences. Newly recruited staff and agency staff were not aware of people's needs and wishes.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Information available to staff was limited and failed to give sufficient guidance on how to engage with people. This was reflected in staff carrying out task based work and not involving people in making choices or decisions. Food choices were not always available or consistent for everyone.

People's care and support was not planned in a person-centred way which promoted their choice, control or preferences. Staff supporting people did not have access at all times to effective, person-centred care plans. Records were not always fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed. Audits and checks in place had failed to identify areas of improvements needed identified during this inspection. Staff were not always clear about their roles and the support people needed. No systems were in place to ensure that people were supported by staff who had information and guidance to meet the needs of people.

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

Rating at last inspection
The last rating for this service was inadequate (published 19 January 2023)

At this inspection we found the provider remained in breach of regulation.

This service has been in Special Measures since 19 January 2023. During this inspection the provider demonstrated that improvements have not been made.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about staffing; management of the service and the quality of care delivered to people. A decision was made for us to inspect and examine those risks.

The overall rating for the service has remained inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe; effective; caring; responsive and well-led sections of this full report.

Following feedback during this inspection the provider took action to address the most serious risks identified through this inspection process.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Finch Manor Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, consent, risk assessments, nutrition and hydration, staffing and governance at this inspection.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe section below.

Is the service effective?

Inadequate

The service was not effective.
Details are in our effective section below.

Is the service caring?

Inadequate

The service was not caring.
Details are in our caring section below.

Is the service responsive?

Inadequate

The service was not responsive.
Details are in our responsive section below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led section below.

Finch Manor Nursing Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors visited the service on Sunday 12 February 2023. Two inspectors visited on Monday 13 February, Tuesday 14 February and Thursday 16 February 2023.

Service and service type
Finch Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Finch Manor Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought and considered feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service about their experience of the care provided. We spoke with 15 members of staff including care staff, the chef and 2 members of the senior management team. We reviewed a range of records. This included people's care and medicines records. A variety of records relating to the management of the service, including monitoring and reviewing information. After the inspection we reviewed additional information sent through to us by the senior management team.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems in place to identify, assess and monitor risk were not effective.
- People's needs were at risk of not being met. In one area of the service the nurse call bell sounder system was not working. This resulted in staff not being alerted when people had called for assistance.
- Systems in place for the monitoring of people's air pressure mattresses were not effective. The monitoring failed to check that the mattresses were inflated to the correct setting for people to receive appropriate pressure relief.
- Safety monitoring and management of the environment was not effective. For example, one external fire exit was blocked by chairs and a bush and another exit was blocked by chairs.
- People's meals were seen placed in front of people and left for a length of time for food to go cold. No checks were carried out on the temperature of food people were offered.
- Identified risks to people failed to demonstrate that all areas of the person's needs and wishes had been considered when assessing people's care and support. Information recorded was contradictory, not complete or missing from the risk assessments and guidance to staff in place.

Effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback during this inspection the management team took action to address the most serious risks identified.

Staffing and recruitment
At our last inspection systems were not in place for the safe recruitment; support and deployment of staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- People were not supported by a sufficient number of experienced and supported staff.
- The service was consistently reliant on agency staff to meet the needs of people. We saw examples of

agency and newly recruited staff working with a language barrier and no direction or guidance as to how to meet the needs of people.
● On occasions we saw that the deployment of staff around the service did not meet the needs of the service. For example, staff were seen to have their breaks at the same time which resulted in limited staff being available to meet people's needs in some areas.
● Recruitment procedures were in place, however, records failed to demonstrate that all of these procedures had been followed. This included a lack of recorded statutory checks.
● A lack of oversight and planning of staff rotas resulted in no records being available to identify what agency staff were working in the building on the first two days of this inspection.

Systems were not in place for the safe recruitment; support and deployment of staff. This placed people at risk of harm. This was a continued breach of regulation 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback during this inspection the provider took action to ensure clear records were in place in relation to agency staff working within the service.

Preventing and controlling infection
At our last inspection effective systems were not in place to prevent and mitigate risks of infection control. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● There were shortfalls in the management of prevention and control of infection.
● Cups and plates were seen to have been 'rinsed' and were visibly unclean in small sinks around the building with no appropriate drying facility.
● Areas of the service were visibly unclean. Small kitchen areas had a buildup of debris on equipment, surfaces and floors. Communal bathrooms and designated sluice rooms were being used to store people's wheelchairs; empty bins and continence products.
● Food products stored in the small kitchen areas were undated or out of date.
● Aprons; gloves and hand sanitizers were available throughout the building. Two members of staff were seen to wear masks under their chins on several occasions throughout the inspection.

Effective systems were not in place to identify, prevent and mitigate risks of infection control. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback during this inspection the management team took action to address the most serious risks identified.

Using medicines safely
At our last inspection we recommended the provider consider current guidance on administering medicines and act to update their practice. The provider had not made improvements.

● People's medicines were not always managed safely.
● Prescribed thickener for use in drinks was not always used solely for the person it was prescribed for.
● People who were prescribed 'as required' or PRN medicines had protocols which gave guidance of how and when to give these medicines. However, we saw these medicines were not always reviewed on a regular

basis which resulted in a lack of monitoring of usage.

Effective systems were not in place to ensure that people's medicines were reviewed and managed appropriately. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All medication administration chart entries had been signed following administration of the medication.
● Staff responsible for the administration of medicines had completed medicines training and had their competency checked.

Following feedback during this inspection the management team took action to address the most serious risks identified.

Learning lessons when things go wrong
● The senior management team had recently introduced a new system for recording and reviewing incidents and accidents within the service.

Systems and processes to safeguard people from the risk of abuse
At our last inspection systems and process in place monitor and record safeguarding concerns were not effective. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● A system was in place to report and monitor safeguarding concerns.
● Safeguarding concerns raised by the service were reported to CQC. This was an improvement from the previous inspection.
● Training records showed the majority of staff employed by the service had completed their annual safeguarding training.

Inadequate

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

- People did not always have their nutritional needs and wishes met.
- Staff were not aware of all people's dietary needs. Catering staff had no access to written information regarding people specific dietary needs and choices.
- Specific dietary guidance was not always followed for people. For example, we saw people served their meals without the support they needed to eat.
- People were not always supported to eat and drink enough. For example, people requiring encouragement to eat their meals were given no encouragement or other alternative foods were not offered.

Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection we recommended the provider consider and implements current guidance and best practice for the assessment and ongoing review of people's needs. The provider had not made improvements.

- People's needs and wishes were not always assessed in full.
- People's needs were not fully assessed, reviewed or documented to inform staff of what care and support they required.
- Assessment information provided by other agencies involved in people's care and support was not always considered in the development of care plans.

Effective systems were not in place for the assessment and ongoing review of people's needs. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At our last inspection effective systems were not in place to ensure people's care was delivered by appropriately trained, skilled and experienced staff. This placed people at risk of harm. This was a further breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● People were not always supported by staff who had the relevant skills; communication; training and experience to meet their needs.
● Information about the agency staff and self-employed nurses working at the service was not always available. For example, profiles for agency staff were not always available to demonstrate safe recruitment; their experience, training or support needs. There was a lack of information as to the training and experience for nurses.
● We saw examples of staff not being aware of, or seeking information around, people's needs and wishes.
● Newly recruited and agency staff were not familiar with the people they were caring for.

Effective systems were not in place to ensure people's care was delivered by appropriately trained, skilled and experienced staff. This placed people at risk of harm. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The majority of staff employed at the service had undertaken their training scheduled by the provider. This was an improvement from the previous inspection.

Following feedback during this inspection the management team took action to address the most serious risks identified.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we recommended the provider consider and implements current guidance and best practice for the implementation of the MCA. The provider had not made improvements.

● We found the service was not working within the principles of the MCA.
● Information relating to the implementation of the MCA on behalf of people was difficult to locate and at times gave conflicting information.

● A system had been developed to track people's DoLS applications and status. We found the information on the tracker was not up to date or effectively capturing all of the information required.
● There was evidence of on-going assessments of capacity and best interest meetings occurring. However, we found that not all best interest decisions had included the views of significant others nor did they contain consistent information from other available records.
● Specific conditions on people's DoLS were not monitored.

Effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
At our last inspection we recommended the provider consider and implements current guidance and best practice for the implementation of the MCA. The provider had not made improvements.

● People's living environment was not always planned effectively.
● There was insufficient seating in the lounge and dining areas around the service. Dining tables and chairs were limited, and people were not encouraged to sit comfortably. For example, people were seen sitting sideward at a small table when eating their meals.
● Internal doors were opened by keypads which prevented people from having freedom of movement around the service.
● There was a lack of signage and direction within the building which created a lack of orientation for both people using the service and visitors.

We recommend the provider consider and implements current guidance and best practice for orientation around the building and considers best use of the space available to support people using the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Systems were in place for people to have access to the healthcare support they required. GP services and associated health care professionals visited the service on a regular basis to monitor people's health.
● Advice and guidance provided by health care professionals following people's appointments was not always incorporated or available in people's plans of care.

Inadequate

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
At our last inspection effective systems were not in place to ensure people's autonomy, dignity and respect were maintained. This placed people at risk of harm. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

- People had not always been treated or spoken to with dignity and respect.
- People were being supported by a number of staff who did not know them well and there were barriers with language communication.
- Information available to staff was limited and failed to give sufficient guidance to staff of how to engage with people. This was reflected in staff carrying out task based work and not involving people in making choices or decisions. For example, when people chose not to eat their meal, no alternatives were offered. We asked if condiments were available to people, a member of staff told us that not everybody liked them.
- Food choices were not always available or consistent. The breakfast menu for Sunday morning stated it was a continental breakfast. We saw that this consisted of a choice of cereal or a tea cake. Staff told us that other foods could be requested from the kitchen if needed, however, there were no systems in place to inform people that alternative choices were available.
- People's recorded needs were not always considered during mealtimes. People requiring support to eat their meals were not always supported resulting in their food becoming cold. People receiving meals in their bedrooms told us that food was often cold when it was delivered. One person told us that they often had to ask for their meal to be re-heated.
- People were not always well treated. We saw that when people asked a question or were becoming distressed staff did not always respond.

Respecting and promoting people's privacy, dignity and independence
- People's privacy was not always maintained.
- People's personal information was not stored appropriately. Care planning documents were left in lounges and in an open cupboard that was accessible to all.
- The majority of bedrooms did not have any form of usable privacy locks. One person told us that they had requested on several occasions that a lock was fitted to protect their personal effects and prevent people accessing their bedroom when they were not there.

Effective systems were not in place to ensure people's autonomy; dignity and respect were maintained. This was a further breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs
At our last inspection systems were not in place to ensure that people's needs were assessed and planned for in a person-centred way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's care and support was not planned in a person-centered way that promoted their choice, control or preferences.
● Information about people's care and choices was not always recorded, was inconsistent or out of date. Information available was not sufficient and could prevent staff delivering people the care and support they needed. Records that were available failed to demonstrate people had received the care and support they required consistently.
● Staff supporting people did not have access at all times to effective, person centered care plans to offer guidance on how a person's needs and wishes were to be met.
● People did not always have access to information that met their needs. For example, menus were in small print; were out of date or not always available for people to make choices from.
● People were not always supported by staff who understood their communication needs or have an understanding as to how people expressed their needs.

Systems were not in place to ensure people's needs were assessed and planned for in a person-centered way. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback during this inspection the management team took action to address the most serious risks identified. This included the further development and introduction of an electronic care planning system.

Improving care quality in response to complaints or concerns
● A complaints procedure was in place.

● A monitoring log to record complaints received about the service was in place. This included responses to complainants and actions taken.

End of life care and support

● The care planning format gave the opportunity to record people's information as to how they wanted to be cared for at the end of their life.

● Where there was a Do Not Attempt Resuscitation (DNAR) directive was in place, the information was available in the individual's care plan.

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people
At our last inspection the provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training was available and mitigate risks to people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● People did not receive care and support that was person-centered or that was planned to achieve good outcomes.
● There was no system in place to assess, oversee and monitor the number of agency staff working within the service. Records failed to show the names of agency staff working within the building.
● Records relating to people were not fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed. Records failed to demonstrate the care and support people had received or been offered. On occasions, written information was not available, legible or consistent. This included information relating to staffing; the monitoring and management of people's skin; identified risks; nutrition and people's rights under the MCA.
● Unrecognised abbreviations were used on care records; several having more than one meaning.
● Audits and checks which were in place failed to identify areas of improvements identified during this inspection.
● An internal home improvement plan had been developed by the senior management team. The monitoring of this improvement plan was not effective as it had identified that some areas of improvement had been achieved. However, this was not evident during the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Working in partnership with others
● Staff were not clear about their roles and this put people at risk of not receiving the care and support they needed.
● There was no effective leadership throughout the service. Staff tasked with the management, oversight, directing and monitoring of staff teams were located in offices away from the areas that support was being delivered.

● No systems were in place to ensure that people were supported by staff who had the skills to meet the needs of people.
● The provider did not demonstrate oversight to ensure people received high quality care in a safe environment.
● We were not assured that all records required were completed or managed appropriately. This was due to the lack of or limited information available.
● We saw incidents when opportunities to improve care were not acknowledged. This included failure to act on areas brought to staff attention during this inspection including the removal of out of date food stuff from small kitchens around the service and ensuring people's use of the call bell system was heard

The registered provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training was available and mitigate risks to people. This was a continued breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager and support team had recently been employed at the service. They demonstrated awareness of person centred and had identified some areas of improvements needed to improve the service.

Following feedback during this inspection the management team took action to address the most serious risks identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Surveys had taken place with people to gain their thoughts and opinions on the food and service available to them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Effective systems were not in place for the assessment and ongoing review of people's needs. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Effective systems were not in place to ensure people's autonomy, dignity and respect were maintained. This placed people at risk of harm. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training was available and mitigate risks to people. This was a breach of 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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place for the safe recruitment; support and deployment of staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.