St. Vincent Care Homes Limited

St Vincent House - Gosport

Inspection report

St Vincent House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 7, 9 and 10 February 2017. The inspection over these three days covered the hours of 10:00am –11:30 pm. St Vincent House – Gosport provides personal care and accommodation for older people including older people living with dementia. The home is registered to accommodate up to 34 people. During the inspection 32 people were living at St Vincent House – Gosport. The home cares for a diverse group of people whose ages and needs vary greatly.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in March 2016 and at this inspection they were given the overall rating requires improvement. At that time we had found the provider was in breach of five regulations regarding the lack of personalised care, risk assessments and mental capacity assessments. Records were not well maintained, staff had not received regular supervision or been given the training they needed to ensure they could meet all people's needs. During this inspection we found there had been some improvements but breaches of three regulations remained and a further two regulation breaches were identified.

Staff understood the principle of keeping people safe, but we witnessed examples of where not all people were safe. This was not due to staff awareness but more of an issue regarding there not being enough staff to meet people's diverse needs. Risk assessments had been completed but these had not been updated as people's needs and subsequent risks changed. For example, people had a risk assessment for falls, but if a person had regular falls this had not been updated to take into account the elevated risk.

Recruitment checks had been completed before staff started work to ensure the safety of people. Medicines were administered and stored safely.

Staff had knowledge of the Mental Capacity Act and people's records showed people's capacity to make specific decisions had been assessed. There was room for improvement as the decisions needed to be incorporated into the specific sections of the care plan.

People enjoyed their meals and were offered a choice at meal times. People were supported to access a range of health professionals, although there was concern staff were not always taking on board the learning offered by health professionals.

People did not always have their needs planned in a personalised way, which reflected their needs were being considered and met. This meant staff may not always have the best information on how to meet an individual's needs and preferences.

People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

People felt the staff were caring, kind and compassionate. However, we made some observations where staff could not be consistently caring in their approach, mostly due to staffing levels. The home had an open culture where staff felt if they raised concerns with the registered manager she would listen; although there were concerned the manager did not have the authority to make necessary changes. Staff were clear about their roles. Records were not always accurately maintained and this was a reflection of an ineffective quality audit process.

We found three repeated breaches and two new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments had not always been updated to ensue all staff were aware of the risks facing people.

Staffing levels did not ensure the needs of people could be met at all times.

Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staff were aware of what constituted abuse.

Medicines were safely stored, administered and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received supervision and felt supported. There was a training programme but there was concern training was not embedded into practices in the home.

Staff had a good knowledge of the Mental Capacity Act 2005 and the need for best interests decisions

People received support to ensure they ate a balanced diet.

People were supported to access a range of healthcare professionals.

The home was well maintained and had been decorated recently.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring and understood how to ensure people's privacy and dignity was maintained. However the diverse needs of people and the lack of staff on duty at times meant people did

not always have their privacy and dignity maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager operated an open door policy and was approachable. However it was not clear they offered leadership within the home.

The service did not have an effective quality assurance system to ensure people received a high quality service. Records were not always accurate and well maintained.

St Vincent House - Gosport

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 7, 9 and10 February 2017 and was unannounced. On one day there were two inspectors and an expert by experience, who focused on spending time with people to ascertain their views on living at the service. On the other two days there was one inspector. We visited the service between the hours of 10:00am and 11:30 pm over the three days.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff. We received written feedback from two health and one social care professionals.

During the inspection we spent time talking to fourteen people, four visitors, three professionals, ten members of care staff, deputy manager, registered manager, a member of the provider's management team and the nominated individual. We looked at the care records of seven people and staffing records of two new members of staff. We saw minutes of staff meetings, residents meetings, policies and procedures, reports by the provider and the complaints log and records. Certain policies were sent to us following the inspection. We took copies of the duty rota.

Requires Improvement

Is the service safe?

Our findings

People told us they liked living at the home. We were told, "I like it here" and "The staff are brilliant." Another person told us they were cared for very well, but they also said some people who were not as able were not cared for as well as they were.

At the last inspection in March 2016 we found people did not have risk assessments to identify all the risks facing a person. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement was made and the provider sent us an action plan in April 2016 detailing how they would meet this requirement. At this inspection we found the provider had taken action and had identified where people needed risk assessments. However the risk assessments had then not been used as a working document and had remained unchanged in people's records when the risks had changed.

For example, one person was being cared for in bed. However their risk assessments did not relate to this aspect of their care. They referred to the person still being mobile, how they should be supported with their mobility and the risks associated with them sitting in the lounge. In another example a person's food and fluid intake was being monitored but their intake had not been identified as a risk. When looking at their food and fluid chart it was clear over a three day period their food and fluid intake had been very minimal, however there had been no action and no risk assessment put in place to make staff aware of the risks facing this person, so they could take action to minimise the risks.

We were made aware at least two people did not have appropriate slings in the home to ensure they could be moved safety. Slings are pieces of equipment used to support people to move and it is essential that they are appropriate for the person so as not to place them at risk of harm. Even though the registered manager was aware slings were needed, they had after five days of being aware still not managed to get the correct slings so people could be moved safety. Risk assessments were not in place to reflect this situation and staff had moved one person in a manner which was not safe for them or the members of staff involved.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a tool to assess the staffing levels needed and advised they relied on information from the registered manager regarding staffing levels. A two week rolling duty rota was used to identify who was working. This identified the registered and deputy manager worked Monday Friday 8am-4pm. Eight staff were rotared 8am-2pm and 5 staff were rotared 2pm-8pm. This included a head of care and senior care staff. However there were also recordings daily in the diary of staff working which differed from the duty rotas. This meant we could not be confident the rota was accurate in showing who and how many staff were working at any one time.

At the time of the inspection, at certain times of the day one person had been identified as needing the support of one member of staff. The duty rota did not identify which member of staff would be providing this

support. Throughout the inspection we were told by staff and people there were not enough staff to meet people's needs. Our observations supported these claims. We saw on regular occasions throughout the day and night people asking for assistance but there were no staff to respond to these requests. At night time three people were asking to go to bed, but there was no staff to support these people. When later one of these people were asked by staff to go to bed they declined, but the other two people accepted. An agency staff member who was supporting the person, who needed the support of one care staff, asked us if we knew if the person they had just assisted to bed wore continence aids. We advised we did not know, but this demonstrated the staff member did not know how to support the person.

During the day one person asked the inspector to go to the toilet. The inspector alerted a member of staff, but this person was not assisted to the toilet for another one hour and forty five minutes. We saw one person go into other people's rooms which were occupied. This was of concern as some of these people in their own rooms were unable to request support of staff. One person interrupted other people having conversations and in-house activities which created an atmosphere where people were getting cross, but there were no staff available to diffuse the situation. We also observed this person would invade the space of people in the communal areas and it was left for other people to tell them to move on behalf of the people who could not do this for themselves as no staff were available. Staff were aware of the situations and thought at times people were not always safe, but at the same time they told us they were meeting the needs of other people living at the home. They advised they had reported this to the management but felt there was only so far the manager could go. When we reported this to the provider they said they were disappointed as they had specifically asked the manager what was needed and stated that they had and would further increase the staffing numbers on duty to meet people's needs.

The lack of sufficient numbers of staff to meet people's needs to ensure their safety was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the principles of safeguarding people and understood the procedures regarding keeping people safe. However, as detailed above whilst they were aware of these principles they did feel at times people were not safe. However this was not because they were not aware of the safeguarding principles it was because of the currents needs of people and the staffing levels. The registered manager reported appropriately safeguarding concerns to the relevant authorities and worked with the local safeguarding team.

We looked at the recruitment records of the last two members of care staff recruited. We found photo identification was available for all staff employed and two references were obtained as detailed on staff member's application forms, to ensure the suitability of staff and the safety of people. We found relevant checks had been undertaken to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded. Staff confirmed they did not start work until all recruitment checks had taken place.

We reviewed documents relating to the ordering, storage, administration, recording and disposal of medicines at the home. Medicines were ordered on a twenty-eight day cycle and most were delivered in multiple dosage system (MDS) packs with a person's medicines organised according to time of day. Medicines were stored in a locked cabinet. We checked the balance of several people's medicines and found this to be correct. Monthly audits were completed and we found where errors were identified appropriate action had been taken. For example, the audit in November 2016 had identified some missed signatures, we

could see the staff were identified and spoken with. The audit also stated that recording of topical (to a person's skin) applications was better than it was previously. PRN protocols for medicines that were to be given 'as needed or as required' were available. The information included information such as the conditions under which the medicine should be given and the maximum dose in a twenty-four hour period.

Requires Improvement

Is the service effective?

Our findings

Relatives told us people got a choice at mealtimes. Most people told us they enjoyed their meals. A relative told us they asked staff "to get [the persons] eyes tested which they did and now they now have glasses." Another person told us "My relative has the district nurse for their legs, and staff phone the doctor if they need to see someone."

At the inspection in March 2016 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regarding staff not receiving regular planned supervision and receiving relevant training. We made a requirement and we received an action plan from the provider telling us they had planned supervisions for staff. At this inspection we found the provider was now compliant with this regulation.

Staff told us they were supported in their roles and could access the registered manager and deputy at any time. Staff received planned supervision at regular intervals, which were both on an individual and group basis. The manager confirmed any staff who were new to care, were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Two staff were currently undertaking the Care Certificate. The provider had engaged with a company which provided a range of E learning training. This involved staff having to learn a subject on-line and then complete a questionnaire, which was marked externally to the home. If the member of staff scored over 80% they were deemed competent. If however they did not reach this score they would have to re-do the training. Professionals from the Local Authority's Home Improvement Team also provided support and training to the staff. However, they raised concerns that the learning they provided was not being embedded into practices into the home. They gave an example of caring for people's skin integrity.

At the last inspection in March 2016 we identified a breach regarding the lack of assessing people's capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement was made and the provider sent us an action plan in April 2016 detailing how they would meet this requirement. At this inspection we found the provider had taken appropriate action and was now compliant with this regulation.

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.

Staff had knowledge of the Mental Capacity Act and were able to relate it to most practices within the home. Mental capacity assessments had been carried out appropriately, but there was a need to ensure these assessments and best interests decisions had been included into the appropriate sections of the care plan.

For example, where someone had a device which alerted staff when they moved or had a crash mat by their bed, this needed to be incorporated into their care plan.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We could see applications had been made appropriately to the local authority when it was considered necessary to deprive a person of their liberty. In some people's records the information needed to be updated to show the Deprivation of Liberty had been granted.

Most people told us they liked the meals and they had a choice at meal times. The chef told us people were consulted about their likes and dislikes and meals were monitored to see if the majority of people liked them. The chef also told us people were consulted over when they would like their main meal of the day and people had chosen to have their main meal at tea time which we were advised was working very well. One person told us they did not like certain meats and their choices were supported. There were lists of people's choices and dietary needs in the kitchen. At meal times people were supported in a respectful and calm manner. On a couple of occasions there were examples which required staff to pay more attention to detail. For example one person told us, "I can't drink my coffee, there no sweetener's in it." On another occasion we saw a service user remove a number of lumps from their mouth after being supported at lunchtime, which the staff member had failed to notice.

People had access to a range of health care professionals. We were advised by the manager if people requested they needed support from a health professional a referral would be made. Care records made reference to health and social care professionals working with people. Healthcare professionals told us they were called into the service appropriately, although at times they said there was an over reliance on health care professionals.

The home is a large building where people have access to all areas. There had been recent decoration of the lounge and people's bedrooms and we were advised this was done in consultation with people. We noted that some of the chairs in the lounge had been replaced, however these seemed low and we observed people struggled to get out of them. The occupational therapist advised they had made the same observations. The home had one large lounge and dining room and two smaller lounge areas, one in the conservatory. The more physically able people made good use of the space in the home. One person spent time in the conservatory informing us they enjoyed the peace and could watch the television uninterrupted. In the large lounge the television was situated so that not all people in the lounge could see the television and when people walked in the lounge they would obstruct people's view of the television. People could access the gardens in the home, but consideration needed to be given to ensuring people had the appropriate clothing when it was cold outside. On three occasions we observed people go outside without coats; also on occasions the doors to the garden were left open which made that part of the building cold.

Requires Improvement

Is the service caring?

Our findings

People told us they enjoyed living at the home and that staff were kind and caring. A person told us "I have to look at the overall view. They're very good." Another person told us that "Normally it's all right" at the home.

Staff were caring in their interactions with people. It was clear they knew people well and there was a lot of banter between people and staff. Staff treated people with kindness. However, there was concern that due to time pressures there were occasions when people were not cared for in a manner which could be described as caring. For example, one person was sat in the dining room but they were sat on three pressure relieving cushions and their feet were not able to touch the floor. This was not a safe practice and therefore did not provide appropriate care for the person. We were told by the provider this was the person's choice and they were deemed to have capacity. Details were recorded in their care plan. In another example a person was sat in the lounge and was clearly distressed. One staff member came over and talked to the person, and then another staff member came over and recognised the person was not sat on their pressure relieving cushion. Once this was noted the cushion was found and the person was supported to sit on it. However, this had not happened in the first place and it had taken the person to become distressed before staff found the cushion for the person. On another occasion a person asked to go to the toilet, despite staff being alerted the person spent considerable time waiting to be assisted to the toilet.

Relatives told us the staff were caring in their approach. They felt able to speak to all staff about the care of their relatives. The registered manager advised us she had supported two people to receive support from an advocacy service.

Staff were aware of the need to support people in a dignified and respectful manner. Staff were friendly but respectful in their approach to people. Staff could explain ways in which they ensured people's privacy was maintained and staff had received training in this area. Whilst staff were aware of how to support people with their privacy there were still occasions when people's privacy and dignity was not respected. This was not due to a lack of consideration by staff, but because there were not enough staff to ensure people's privacy and dignity were maintained at all times. For example, one person was seen on two occasions to go into people's bedrooms uninvited. On both occasions the people whose room they entered were in bed which was not respectful of their privacy or dignity. In the lounge areas there were people who were confused but caused distress to other people, by invading their personal space or constantly needing attention. One person told us they felt sad that one person needed all the attention. Another person became verbally cross with a person who kept asking them repeated questions. There were not always enough staff to ensure all people's privacy and dignity was promoted at all times.

Care records were maintained in a central place in the home where they were locked away. Staff had access to the code and were aware of the need to ensure confidentiality of the records was maintained.

Requires Improvement

Is the service responsive?

Our findings

Comments from people were mixed. One person told us, "I love to play board games with my [relative]." When asked if they played with other people and staff we were told, "Not really, they're not really interested." They went on to say the staff were too busy. A relative told us they were involved when a person who had recently come to stay at the home told us, "Yes they've involved me." "The deputy manager visited [the person] at home". The relative told us, "I feel I've made the right decision for [person]."

At the last inspection in March 2016 we identified a breach regarding the care and treatment of people not always being person centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement was made and the provider sent us an action plan in April 2016 detailing how they would meet this requirement. At this inspection we found the provider had not taken appropriate action and was still not compliant with this regulation.

It was clear there had been a lot of effort put into the development of care records since our last inspection. They were neatly presented and divided into each relevant section. However, care plans had not been used as a working document and were therefore not always up to date, which meant people may not have their needs met appropriately. For example as people's needs changed the relevant sections in the care plans had not been updated. Staff were clear about certain people's needs, which were not reflected in people's care plans. This was important information which not only affected the person but potentially other people in the home. This could have resulted in both the person concerned and other people not receiving care to meet their needs. One person had lost weight over the last five months, but their care plan reflected their weight was 'stable' and the risk was identified as 'low', which the management agreed was not an accurate reflection of their needs. In another example a person had four recent falls, however their mobility assessment had not been updated to reflect their needs had changed. This meant staff who consulted care plans and agency staff would not have an accurate plan of how to respond to people's current needs.

The care and treatment of people was not always person centred. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were physically more able made use of the environment and the space. One person enjoyed doing large jigsaws and they had been provided with a jigsaw case so they could carry it around safely and work on it where they pleased. Space had been found for one person's musical instrument and one person had been supported to find a computer course which was of interest to them.

The home had a complaints procedure, which people and visitors were aware of. People and relatives told us they felt comfortable speaking to any staff if they had a complaint or concern and felt confident the complaint would be looked into by the registered manager. Complaints were logged and we were able to see these were responded to within the provider's timescales and were investigated by the management team.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in March 2016 we identified a breach regarding the lack of well-maintained records. This was a breach of regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. A requirement was made and the provider sent us an action plan in April 2016 detailing how they would meet this requirement. At this inspection we found the provider had not taken appropriate action and this breach was repeated. There is a new breach regarding ineffective quality assurance processes.

Quality assurance processes in the service were not established and effectively operated. It was of concern there were repeated breaches of the regulations from our previous inspection in March 2016. Whilst we could see some actions to improve had been taken, it was of concern that the providers quality audit processes had not picked up that these improvements were not still sufficient to ensure there would not be repeated breaches to ensure people were safe. For example, records were still not well maintained. Where people's needs had changed their care plans were not reflective of these changes. The weight records showed ten people had lost weight in the month of January, there was nothing to demonstrate the provider had noted this and no extra monitoring had been set up for these people. When looking at daily records of people we could see these had not been completed accurately, which made it difficult to establish people had been cared for. For example, one person had a target fluid intake of 1190mls. However their target intake had not been totalled at the end of a 24 hour period to ensure they were reaching this target. In one person's daily records we noted there were two sets of records held for the same day, which recorded conflicting information for the person's fluid intake, making the validity of the records questionable. For another person we noted the fluid intake for the person over a three day period was very low when compared to their target intake. However no one had been alerted to this and there was no plan in place to address this. The recording of 'Position/Turning' also did not reflect people were moved as necessary. For example for one person, the chart reflected in 12 hours the person had been checked on 11 occasions but staff had not changed the person's position. They recorded they had left the person in the same position for this length of time, despite their care plan reflecting their position needed to be changed. When asking for some back dated daily records staff found it difficult to locate these and for one person two days records could not be found, despite us seeing them on the previous day of our inspection. This reflected the system of recording information and storing daily records needed to be improved.

It was difficult to ascertain people had baths when they wanted. The home had a bathing rota, which appeared to be an institutionalised practice as this told people when they were to have a bath and restricted choice. However, we were advised by the management people could ask for a bath when they wanted. The recording of personal care had recently changed from paper records to an electronic record. When we asked how the service could evidence people had baths when they wanted the service recognised they could not find this information in a timely fashion from the way records were kept. Concerns were also raised by two staff that there was pressure to ensure a certain number of people were up in the morning. Staff confirmed this meant they had to wake certain people up in the morning. Records again could not demonstrate at what time each person was up each morning to demonstrate the time a person got up and to reflect this was their choice.
The lack of well-maintained records was a repeated breach of Regulation 17 of the Health and Social Care

2008 (Regulated Activities) Regulations 2014.

There was not a clear vision of delivering a high quality service which was promoted and shared with staff and people. However, people, relatives and staff spoke in a positive way regarding the management of the home. They reported they were very approachable and friendly, but said nevertheless there were concerns about the leadership. It was felt management did not always grasp the issues and respond appropriately. For example staff advised they had informed the registered manager they felt extra staff were needed at certain times throughout the 24 hour period, but this had not been responded to. Two external professionals told us they had offered and delivered training in the home. They reported the training was always greatly received, but there was a feeling they were given lip service as staff were never supported to put the training into practice.

There was a structure to the management of the home. However it was noted the registered manager and deputy were not routinely on duty in the evening or at weekends, so there was no direct leadership during this time. Staff meetings were held in the home and were at differing times to ensure all staff could attend and minuted. These always started with the fact that the meeting was a group supervision, which is not common practice as staff meetings typically cover a broad range of business and care items, whereas the function of group supervision tends to be to provide support and reflection/debrief on specific matters. There was no comments or suggestions recorded from staff. From this it was hard to evidence this was a two way process where staff were able to engage with the process or raise any issues or concerns they had.

The service was sometimes slow in identifying and responding to issues of concern. The service had started to record and monitor incidents and accidents. However, there was monitoring of the people involved following incidents and accidents. This was good practice but there was still no overall monitoring to look for emerging patterns. For example, the times and place of the fall or incident were not analysed. The deputy manager advised they were about to put this into place. It was noted some people had moved rooms; however there were no records to show there had been engagement with the people concerned or their families. Whilst we were advised of the reason for these moves, the management team agreed with us that the records should have shown this and the consultations with those involved and their views. The occupational therapist had also identified the need for slings for two people to assist with moving and handling. It was of concern the home had not identified the need for the slings, but it then also took an extended period of time to access the correct slings. Two staff members told us they did not know how to support people with moving and handling as they had not received training on the homes equipment.

This failure to ensure there were effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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 People were not receiving personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk assessments in place to ensure the safety and welfare of people .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of well-maintained records made it difficult to establish people were receiving the care they needed. There was not an effective systems to assess, monitor and improve the quality of service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of sufficient numbers of staff to meet people's needs did not ensure their needs were met safety.