Mr & Mrs J Dudhee

Cheam Cottage Nursing Home

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 30 May and 1 June 2017 and was unannounced. At our last inspection on 9 November 2016 we found the provider had taken action to address two continued breaches of regulations that we found in June 2016. However, they remained in breach of the regulation in relation to dignity and respect. We judged that the provider required more time to fully meet this regulation, which we looked at during the current inspection.

Cheam Cottage Nursing Home is registered to provide nursing and personal care for up to 19 people. At the time of our inspection there were 13 people using the service. There was a registered manager in post. 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.

At this inspection we found a number of risks to people's safety. The provider did not record or appropriately respond to allegations of abuse, which meant people were not adequately protected from abuse and ill-treatment. Staff did not always follow risk management plans to protect people from the risk of developing pressure ulcers. Equipment used for the same purpose was worn out or not being used correctly and was not providing effective pressure relief. Pressure ulcers and wounds were not appropriately recorded or risk assessed and people did not have wound management care plans. This meant people were at unnecessarily high risk of developing pressure ulcers or of existing wounds deteriorating further. We also found other risks were not properly assessed and managed, such as risks associated with people using bed rails. Equipment used for assisting people with moving and handling was not always checked and serviced regularly to ensure it was safe to use.

Staff were not always recruited safely. The provider did not obtain all of the documents and information the law requires them to have for all new staff, to help ensure those recruited are suitable to care for people.

Medicines were generally managed safely, although information in care plans about medicines people were taking was not always up to date. This increased the risk of errors or of miscommunication with healthcare professionals.

Although the provider demonstrated at our last inspection that they had made improvements to the service, we found at this inspection that they had not been able to maintain these. As a result, people were and remained at risk of experiencing poor care and treatment that compromised their rights and failed to meet their needs. The provider's audits and checks did not contain sufficient detail to be effective in identifying and addressing shortfalls in the quality of the service. Consequently, they had failed to identify the areas of concern we found at this inspection. Where concerns were identified, these were not addressed in a timely manner.

The provider carried out surveys to obtain the views of people who used the service, but these were not effective or reliable because they were completed by staff and did not necessarily reflect people's own views. The provider did not attempt to make the process more accessible for people with complex communication needs.

Staff did not have the training they needed to provide effective care to people with pressure ulcers and wounds or to people living with dementia, although staff were satisfied with the support they received in other areas. The provider sought advice about good practice from reputable sources.

Staff did not always give people the support they needed to understand and make choices about their care. Staff did not always support people in a way that promoted their privacy and dignity as they were sometimes left with food on their hands or wearing stained clothing and staff did not always knock on people's doors before going in.

People's care plans were not always sufficiently personalised to give staff the information they needed to meet people's individual needs. The care plans contained generic information that did not necessarily apply to everyone. Although some also contained personalised information about people's personal care needs and preferences, others did not. People sometimes did not have care plans for certain aspects of their care such as wound care or diabetes management. Information about the care people required was often out of date or had not been included. Staff did not in practice always give people the support that was indicated by their care plans.

Some people were satisfied with the activities on offer but others were not. Activities were not person-centred and people often did not get anything to do if they did not want to take part in what was being offered to everyone.

Staff made an effort to keep people informed about what they were doing while carrying out care related tasks. They took time to get to know people and learn about their life histories and showed an understanding of how to meet people's emotional and cultural needs.

People had enough to eat and drink and received support to attend healthcare appointments.

We found the provider was meeting their legal requirements in terms of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

There were enough staff to care for people safely and staff were able to respond appropriately to behaviour that challenged the service.

In total, we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection, we have imposed a condition on the provider's registration, which states that they may not admit people to this home without prior written permission from CQC. We are also taking further action against the provider for repeated and serious failures to meet eight regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within

this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

The provider did not take appropriate steps to safeguard people from abuse.

Risks to people's safety, particularly the risk of developing pressure ulcers, were not properly assessed and managed.

The provider did not always take appropriate steps to protect people from the risks of being cared for by unsuitable staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although staff received support in other areas, they did not always have the training they needed to care for people effectively.

People only received care they consented to or, if they did not have capacity to consent, this was agreed in line with the requirements of the Mental Capacity Act (2005).

People received enough food and drinks to meet their needs and had support to attend healthcare appointments.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The care provided did not always show due regard for people's privacy and dignity.

Staff did not always give people the support they needed to understand and make choices about their care.

Staff took time to get to know people and build relationships with them.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned in a person-centred way and staff did not always support people in line with their care plans. Care plans were not always completed and did not always contain the up-to-date information staff required to support people in line with their needs and preferences.

There were activities on offer but these were not person-centred and did not suit everyone who used the service, meaning some people did not have enough to do.

People's cultural and religious needs were met.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have an effective system for assessing, monitoring and improving the quality of the service. They did not identify any of the concerns we found at this inspection.

Where the provider made improvements, these were not sustained and did not address shortfalls in a proactive way before they became concerns.

The provider did not use effective methods of gathering people's views about the service they received.

Cheam Cottage Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 May and 1 June 2017 and was unannounced. It was carried out by an inspector and a specialist advisor, who was a tissue viability nurse.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, notifications the provider is required to send to us about events that take place within the service, information received from commissioners and a provider information return (PIR). The PIR 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.

During the inspection we spoke with three people who used the service, four members of staff and the registered manager. We looked at nine people's care plans, three staff files and other records such as maintenance checks, audits and staff rotas. After the inspection we spoke with commissioners, social workers and healthcare providers who were involved in the care of people who used the service.

Inadequate

Is the service safe?

Our findings

Most people we spoke with told us they felt safe using the service. However, one person told us, "I'm not safe here," and made allegations of physical abuse against staff and the registered manager. When we informed the registered manager that we had reported these allegations to the local authority safeguarding team, the manager told us we should not have done so because the person had a history of making false allegations. Although the person's care plan mentioned their behaviour was sometimes "unpredictable" due to a neurological condition, there was no mention of them ever making allegations of abuse and no evidence that the provider had ever documented any allegations of abuse from this person. The person had no risk assessment or management plan relating to the risks of them being abused or of making false allegations and the local authority was not previously aware of any history of allegations from this person. This showed that the provider was not taking all allegations of abuse seriously, which put people at increased risk of abuse and ill-treatment.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had done some work with staff on identifying, assessing and managing risks in response to concerns we previously raised. However, we found there were widespread and serious shortfalls in this area.

For example, the risk of people developing pressure ulcers was not adequately managed. Several people's risk assessments indicated they required pressure relieving cushions in order to reduce this risk but nine out of 11 pressure relieving cushions we looked at were unfit for purpose because they were worn out and no longer providing adequate pressure relief, or were presenting an infection control risk as they were stained with urine. One person, who already had a pressure ulcer, was lying on a pressure relieving mattress that was set to the wrong weight setting so it did not provide them with effective pressure relief. Four people's pressure area risk management plans stated they needed to change position every two hours but records for each person showed this was not always done, particularly at night time. This meant that people were at unnecessarily high risk of developing pressure ulcers or having existing pressure ulcers deteriorate further.

We observed that one person had a dressed wound, but this was not recorded in their care notes so there was no reliable way for staff to track the progress of its healing. The registered manager told us the wound was a result of self-injury and the person often had these. However, because there was no risk assessment or other documentation related to self-injury, staff did not have the information they needed to manage risks such as those of infection or tissue damage safely and consistently. Because staff were not recording the person's wounds there was also a risk that other causes of injury, including abuse, would not be identified if they occurred.

We also found that risk assessments and risk management plans were not always completed when other assessments identified they were needed. Examples included people using bed rails and people at risk of malnutrition or dehydration.

Although medicines were generally managed safely, care plans did not contain details of what support people needed with their medicines. For example, one person's care plan stated that staff should "apply cream" but did not specify which cream, how often or where to apply it. Another person's care plan contained out of date information about two medicines the person was no longer taking. This meant there was an increased risk that people would not receive their medicines as prescribed.

The above paragraphs indicate a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that a hoist kept in the home was not currently in use by any person using the service but the registered manager told us it was kept there so it could immediately be called into use if any person needed it. However, the hoist was not fit for purpose as it was visibly damaged and had not been serviced for nearly three years. The manufacturer's instructions stated the hoist needed to be serviced every six months and as such it would not be safe to use.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked recruitment records and found the provider obtained evidence of employees' fitness to work, criminal record checks and proof of identity. However, information required by law was absent from employees' files. Two members of staff did not supply a full employment history or references. One member of staff had supplied no proof of their identity or right to work in the UK other than a work permit that had expired 18 months before they started working at the service. This showed the provider had not taken appropriate action to protect people from risks associated with receiving care from unsuitable staff.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt confident in their ability to respond safely to behaviour that challenged the service and manage associated risks. We observed staff intervening when one person became visibly agitated and raised their voice in an aggressive manner. Staff redirected the person by offering them the opportunity to participate in an activity and they immediately became calm and engaged in the activity, smiling and laughing with staff.

Staff told us current staffing levels were sufficient to care for people safely and that the registered manager often stepped in if they needed extra support. We observed people did not have to wait more than one or two minutes if they indicated that they required staff assistance and there were usually staff present in communal areas with people.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the up to date training they needed to perform in line with current best practice. Although the home specialised in caring for people living with dementia, one member of staff told us their dementia training was "probably not up to date." Another member of staff said they had had training about dementia but felt there was a lot more to learn. Records showed, and staff confirmed, that staff including registered nurses did not have any training in pressure area care or wound management despite several people being at risk of developing pressure ulcers and at least two people having pressure ulcers or wounds that required care. Staff told us they wanted to know more about these areas. We also found that when asked about a pressure ulcer one person had, nurses were not able to give consistent information such as how severe the wound was and one said they did not know.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I get things I like [to eat]." Another person said the quality of the food was variable and "yesterday you couldn't eat the meat. A lady comes and asks what I want but I don't choose the chicken. You chew and chew and can't swallow the stuff." Some care plans contained details of the support people needed to eat and drink. We observed staff supporting people in line with this information when they ate meals. Staff offered people hot and cold drinks at regular intervals throughout our inspection and brought drinks promptly to people who requested them at other times. We observed staff telling people that day was expected to be very hot and reminding people to drink plenty of fluids, which they offered.

A person using the service told us, "I'm doing well here and I have put on weight. I see the doctor when I need to." There was evidence that people had contact with healthcare professionals such as doctors.

Staff told us they were satisfied with the supervision and support they received from the registered manager. We saw evidence that staff had regular one to one supervision. The registered manager told us they worked with a reputable organisation that specialised in providing advice and support to services providing care to people living with dementia. They told us they had used this advice to make the home environment and activities more 'dementia friendly.' We saw copies of magazines provided to staff with information about current research and best practice in dementia care. The registered manager had also assigned 'champion' roles to staff including dementia and food champions. This role involved the member of staff researching and being responsible for ensuring good practice in these areas, although we were not able to gauge how effective these were because the roles had been introduced recently and staff had not yet completed the training they needed to gain the necessary expertise. However, we saw evidence that current good practice in areas such as physical health, dementia and diabetes was discussed at monthly staff meetings to help staff develop a knowledge base around these areas.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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. We saw evidence that the provider carried out assessments of people's capacity and arranged for appropriate people to be involved in decisions made on their behalf if they lacked capacity.

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. 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 saw evidence that the provider applied for DoLS authorisations when required and when people without capacity to consent were admitted to the home at short notice, the provider put in place urgent DoLS authorisations in accordance with the DoLS Code of Practice.

Requires Improvement

Is the service caring?

Our findings

At both of our last two inspections in June and November 2016, we found a breach of regulation in relation to dignity and respect. We found at our last inspection that staff did not always inform people of what they were doing when providing care to them and that when they did speak to people, conversations were based on tasks rather than people's interests. Staff did not always respond appropriately when people presented as distressed or disorientated.

At this inspection, we found that staff spent more time engaging people in conversations about themselves and informed them of any care related tasks they were about to complete such as asking them if they wished to have their empty dinner plates taken away.

People told us, "The staff are nice to you" and "The nurses love people. They always ask how you are." However, we found that people's privacy and dignity were still not always respected. On two occasions, we saw the registered manager opening people's bedroom doors without knocking and continuing to talk about those people without acknowledging that they were inside the rooms. Staff left people wearing protective bibs over their clothes for up to an hour and a half after they finished eating and did not support them to clean food debris off their hands immediately after their meals. One person was observed wearing the same heavily stained shirt on two different days during the inspection. This may have had the effect of compromising people's dignity.

Staff showed an understanding of how to support people in a way that promoted their privacy and dignity while providing personal care. They also told us they always addressed people using their preferred names. However, this was not always apparent. People's care plans specified their preferred names but for those who favoured a nickname or shortened form of their name, their full first names were used throughout the rest of their documentation. We also observed that staff were inconsistent in whether they referred to people by their preferred names and that when we used one person's preferred name when speaking about them, the registered manager did not know whom we were referring to until we used the full version of their name.

Staff gave examples of how they had spoken with the relatives of people who did not communicate verbally, to learn more about them and how to support them to make choices about their care. We saw some evidence that people's families were involved in care plan reviews. However, this was not always the case and we did not see evidence that the provider had attempted to engage people who used the service in this process. People's care plans contained information about their communication needs and how staff should present information to help them make choices. This included the use of aids such as pictures for some people. We did observe staff speaking more slowly and clearly with some people as their care plans instructed. However, we did not see staff using pictures or other communication aids with the people whose care plans indicated they should do this. This meant some people may not have received the support and information they needed to make day-to-day choices about their care.

The service remained in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The home had a board with photographs of staff to help people familiarise themselves with those who worked there and to help build relationships with them. Since our previous inspection the provider had carried out life history work with people. They had details of people's previous employment, families and relationships, life events and other information. This was designed to help staff get to know people and build stronger relationships with them.

There was information in some people's care plans about the support they needed to meet their emotional care needs. For example, one person did not communicate verbally but liked staff to chat to them and physical touch was important to them. We saw staff chatting to the person, arranging their hair for them and touching them in a caring and affectionate manner as indicated by their care plan. During this interaction, the person's body appeared relaxed as they smiled and hugged the member of staff. This demonstrated that staff had taken the time to build a positive caring relationship with this person and to understand how to communicate with them.

Inadequate

Is the service responsive?

Our findings

People had an assessment on admission to the home, which was used to complete a care plan. People had personalised documents in their file entitled "Important things to help me have a good day." These covered details such as wearing clothes that person found comfortable, having a hot drink at certain times or having staff speak calmly to them at all times. However, the files also contained generic information such as a list of signs of ill-being and wellbeing, which may not have applied to everybody and may have meant there was a risk that staff would misinterpret or not notice signs of ill-being that were specific to individuals.

Some care plans contained personalised information around people's preferred routines, dietary needs and general day to day preferences. For example, one person's care plan had details about what assistance they needed with various personal care tasks and what they could do without support. However, this was not always the case. In some care plans this information was absent or not personalised. All people who were assessed as being at risk of developing pressure ulcers had plans indicating the same frequency of repositioning, despite their individual differences. A person who had a pressure ulcer did not have a care plan instructing staff how to promote healing and protect the person from the risk of deterioration. People with diabetes, continence issues and other health conditions did not have care plans detailing the specific support they needed to manage these. We also found that in several cases there was no information about what support people required to complete tasks such as washing, dressing or using equipment such as hoists, nor about their preferences with regard to these tasks. This meant people were at risk of not receiving care that met their individual needs and supported their preferences.

We also observed that people did not always receive the support indicated in their care plans. For example, one person's care plan stated that they always needed their mobility equipment near them but this was not the case during our inspection. We observed staff turning on the radio for two people without asking them which station they wished to listen to and although both people's music preferences were specified in their care plans, the member of staff left the radio playing music that did not correspond with either of these.

Although records indicated that care plans were reviewed monthly, the information in them was not always updated to reflect people's changing needs or recommendations from healthcare professionals. One person's file contained a dietician's recommendation that the person's food should be pureed, but there was no mention of this in their care plan. Another person's care plan had not been updated with recommendations and care instructions supplied by a tissue viability nurse who had attended to them a month before our inspection. There was no information in the person's notes about the state or symptoms of the wound and therefore no way for staff to accurately track the progress of the wound's healing. This meant there was a risk that staff would not be aware of how best to meet people's needs and how to provide consistent care, because this information was not recorded in a reliable way.

One person told us, "There are plenty of games – enough to occupy you." However, another person said, "I'm bored here" and told us the activities on offer did not suit them and they did not get to do the activities they wanted to do. The person told us about two hobbies, both of which were recorded in their care plan and involved activities staff would be able to support them with at the home. There was no evidence in

activity records that the person had ever received support to engage in their hobbies since moving into the home. Records also showed that people were regularly offered planned activities but if they declined they were not offered an alternative. Staff also recorded people's actions such as pacing corridors or talking to themselves as activities when in fact they did not participate in any. This meant that for some people, who did not participate in group activities and did not enjoy colouring or board games, there was very little to do other than listen to music or watch television.

The above paragraphs indicate a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had several communal areas. These varied in atmosphere, for example having quiet music playing in one room and an activity taking place in another. This meant people could potentially choose the room that suited them best if they wished to spend time in communal areas.

There was an activities plan displayed in the dining room. This was meant to orientate people as to what was planned to happen, although it did not use an accessible format such as pictures or large print. We saw staff playing games with people such as dominoes and giving encouragement or assistance to people doing individual activities such as colouring. Staff felt the current provision of activities met people's needs although they told us there were not enough staff to support people for trips out as often as they would like.

Staff were aware of people's different cultural needs, for example if they followed specific customs due to their religious beliefs. One person told us a leader from their religion visited the home regularly to carry out services and that they enjoyed having staff at the home who spoke their native language as well as English.

The service had a complaints policy and a formal complaints register. However, we were not able to review complaints as there were none recorded and the registered manager told us they had not received any since the complaints register was opened in 2011.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2016 we found the provider had made significant improvements to raise standards in several areas where they were previously in breach of regulations. At this inspection, however, we found that several areas of concern we had raised at previous inspections, and that the provider had subsequently taken action to improve, had reverted to their previous standards and the provider was again in breach of several regulations. Additionally, this was the third consecutive inspection where we found the provider was in breach of the regulation in relation to dignity and respect. This showed that the provider did not have adequate systems in place to make and sustain improvements to the quality of the service where these were required. As a result, people were and remained at risk of experiencing poor care and treatment that compromised their rights and failed to meet their needs.

One person said the manager was "no good" and "always making excuses." However, staff fed back positively, saying they attended regular meetings where they were able to voice their opinions about the service, make suggestions and discuss the progress the service had made.

The provider carried out an annual health and safety audit to check fire safety and other aspects of environmental safety. They checked that staff had annual moving and handling refresher training and also checked required documentation in staff files was all present. However, several audits and checks did not contain sufficient detail to give the provider a reliable and accurate means of assessing the quality of the service. For example, a monthly cleaning audit had each room marked as "satisfactory" but did not specify what had been checked. Equipment checks did not list individual pieces of equipment nor contain any comments on the state of the items checked. This meant there was no way of knowing if items had been missed out during the audits and checks.

We also found further evidence that audits and checks were not effective in identifying shortfalls in the quality and safety of the service. Despite carrying out weekly checks, the provider had failed to identify that pressure relieving cushions were no longer fit for purpose and that a hoist had not been serviced for three years. We also identified that there were no policies on pressure ulcer prevention and management and wound management, which would have helped the provider to ensure consistent care was given in these areas and to identify poor care more easily. The provider did not identify any of the other concerns that we found during our inspection.

Reviews of people's care documentation failed to identify missing, contradictory or out of date information. For example, one person's bed rail risk assessment had not been filled in at all but had monthly signatures indicating it had been reviewed despite there being no information to review. Another person's documentation contained conflicting information about their mobility but reviews had failed to identify and correct this. Some assessments were not dated, meaning the provider had no way of checking they were up to date. People's care records contained insufficient or inaccurate information, such as recording only approximate times when staff supported people to reposition with no clear information about what position they moved to and from. This lack of detailed and accurate information meant people were at risk of inappropriate care because records about them were not maintained to an adequate standard.

We also observed that some of people's care records, which contained confidential personal information, were kept on a table in a communal room. We noted periods of at least an hour where no staff were present in this room, meaning people's confidentiality could easily be compromised by other people or visitors accessing the records.

The registered manager told us they carried out six-monthly surveys of people and their relatives to help them assess the quality of the service and plan improvements based on people's views. However, we found the 12 most recently completed residents' questionnaires were all in the same handwriting, which the manager told us was that of a member of staff who assisted people to participate in the survey. They also confirmed that six of the 12 people whose names were on the questionnaires did not communicate verbally or were unable to answer complex questions and would not have been able to provide the responses that were written on the questionnaires. This was therefore not a reliable means of assessing the quality of the service because the answers given were unlikely to have come from people who used the service and may have been biased by the opinions of staff rather than reflecting people's true views. Because the provider did not attempt to use accessible communication methods to support people to express their views, there was also a risk that people did not have any opportunities to feed back about the service they received.

We noted that the provider had a development plan in which they recorded that they would identify staff training needs in June 2017 and arrange for these to be met by the end of August 2017. However, we found evidence that people were already experiencing poor care due to a lack of staff training. This showed the provider was not taking prompt and proactive action to address gaps in staff training before they began to impact on service delivery.

The above paragraphs indicate a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider did not ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1)(a)(b)(c) 3(b)(d)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

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	The provider did not ensure service users were treated with dignity and respect, including by respecting their privacy. Regulation 10 (1) (2)(a)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure care and treatment were provided in a safe way for service users. This included assessing risks to the health and safety of service users and doing all that was practicable to mitigate such risks, ensuring that persons providing care and treatment had the skills and experience to do so in a safe way and ensuring equipment used to provide care and treatment was safe for such use and used in a safe way. Regulation 12 (1) (2)(a)(b)(c)(e)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not take sufficient steps to ensure service users were protected from abuse and improper treatment. This included establishing and operating effective systems to prevent and investigate abuse or allegations of abuse. Regulation 13 (1) (2) (3)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that all equipment used for the purpose of providing care and treatment was properly maintained. Regulation 15 (1)(e)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

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 provider did not effectively operate systems or processes to ensure compliance with these regulations. They did not effectively assess, monitor and improve the quality of the service or assess, monitor and mitigate risks to the health, safety and welfare of service users. They did not maintain securely an accurate, complete and contemporaneous record of the care and treatment provided to each service user. They did not seek and act on feedback from relevant persons and use this to improve the service. Regulation 17 (1) (2)(a)(b)(c)(e)(f)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not obtain the information required to demonstrate that persons employed for the purpose of carrying on a regulated activity were of good character and had the necessary skills and experience. They did not operate recruitment procedures effectively to ensure that this information was obtained. Regulation 19 (1) (2)(a) 3(a)(b)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.

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 The provider did not ensure that persons employed in the provision of regulated activities received appropriate training to enable them to carry out their duties. Regulation 18 (1) (2)(a)

The enforcement action we took:

We imposed an urgent condition on the provider's registration to prevent them from admitting any new service users to the home and we have decided to cancel the provider's registration.