

Tamaris Healthcare (England) Limited

Howdon Care Centre

Inspection report

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Ratings

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

Summary of findings

Overall summary

Howdon Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is divided into four units and has a large kitchen and laundry area. At the time of our inspection 59 people with physical and mental health related conditions were using the service.

This unannounced comprehensive inspection took place on 17, 18 and 19 April 2018. This meant that the provider, staff nor people who used the service knew we would be arriving. At the last focussed inspection in November 2017, we identified four breaches of regulations which related to safety, people's nutritional needs, staffing and the governance of the service. We asked the provider to take action to make improvements. We found whilst improvements had been made to the care of people with nutritional needs, insufficient improvements had been made to the service to ensure compliance with all of the health and social care regulations.

This is the second consecutive time the service has required improvement. 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.

A new care manager was in post who managed the service on a daily basis. They had been employed at the service for approximately three months. The care manager was in the process of applying to become the 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 regional manager had only been assigned to oversee Howdon Care Centre four weeks prior to this inspection.

We undertook an observation around the home to look at the issues which had been highlighted to the provider at our last inspection. Whilst we found some action had been taken; we found the checks on the service were still not robust enough to ensure compliance with all of the regulations. Issues remained at the home which had either not been wholly addressed or had not been properly monitored to ensure that staff had complied with the tasks delegated to them.

The provider indicated in an action plan that the care management team deployed to Howdon Care Centre carried out daily, weekly and monthly checks of the quality and safety of the service and together with the care manager they were confident that issues had been addressed. We did not find adequate evidence to corroborate these checks had consistently taken place or were completed robustly enough to identify the continued issues we highlighted during this inspection.

Record keeping was poor throughout the service. The lack of accurate and thorough details recorded within documents meant that neither we nor the provider were able to ascertain if issues had been correctly identified and followed up properly with the necessary action. We found multiple incidents had not been fully investigated, escalated internally or reported to the relevant external authorities as required.

Accidents and incidents, some of which were of a safeguarding nature had been identified by staff and recorded on a central system, however they had not been identified by the care manager as reportable events and therefore people had been placed at risk because proper safeguarding procedures were not followed. More serious incidents which are required by law to be notified to CQC had also went unreported. Furthermore, due to poor record keeping and auditing, accidents and incidents were not properly monitored to look for trends or reduce the risk of similar occurrences.

Risk assessments were not always in place or did not accurately describe people's current needs. We also found some care plans were out of date and did not reflect the care or treatment people required. This meant people were at risk of harm through not receiving the appropriate care and support.

Medicines were not always managed safely. Although there was little impact on people receiving their medicines correctly, we found multiple issues with record keeping which placed people at risk of not receiving the right medicines at the right time. We found some people's medicines had been out of stock for up to two weeks before a resolution was sought.

Staff training was overdue for some staff and refresher courses in key topics had not been routinely carried out. Staff who should have completed a robust induction programme, known as the 'Care Certificate' had not achieved this. This demonstrated that the provider had not assured themselves that people were supported by staff who had the skills and competence to provide safe care. In addition, 25 staff supervisions were overdue and annual appraisals had not been conducted recently. This meant that staff had not been formally supported in their role or given a recognised opportunity to talk about their issues and any plans for development.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. However, we found the authorisations had not been properly monitored and some granted applications had expired and no new application had been made.

Consent was not always appropriately gathered from people or relatives (acting legally on their behalf) and it wasn't always recorded in line with the principals of the MCA. This meant that people's rights, particularly of privacy may have been infringed. For example, a public Facebook page had been set up which contained photographs of people taking part in activities without the appropriate consent.

We were concerned about the amount of personal information which was displayed in a profile outside of people's bedrooms. The information was intended to help staff get to know people better. However, we considered that the decision to display this in a communal area was not carried out in people's best interests and some people's profiles contained confidential information which was not necessary.

People's needs and plans of care were inconsistently reviewed and not always routinely updated to ensure they reflected people's current needs and preferences. This meant that some vital information about changes to need and support may have been missed by staff. Whilst we found most care plans contained person-centred information, other care plans were much briefer and more task based, with less specific information to guide staff.

Complaints were not managed in line with the provider's complaints policy. Although complaints had been recorded on the central system, they were not properly investigated and detailed investigation notes were not made. We found that the procedures were inconsistently followed meaning some complainants were not aware if their complaint was being addressed or if there was an outcome. We also found that complaints were not responded to in a timely manner.

The premises were maintained to a decent standard and we found the home to be clean and tidy. Domestic staff were on duty during our inspection and we saw they were designated responsibility for specific areas of the home.

Following the latest fire and legionella risk assessments, actions which had been identified had not all been completed in a timely manner. This was addressed during the inspection. We noted that emergency pull cords had been tucked out of the way in two units of the home, however risk assessments were not in place to describe the alternative measures.

Staff continued to be safely recruited and we considered that there were enough staff employed at the service, due to the home not being full. How dependant people were on support from the staff was monitored to ensure staffing levels remained appropriate. However people and relatives perceived the home to be short staffed due to the frequent use of agency workers.

Improvements had been made to the general care of people with high risk nutritional and hydration needs. However, we raised concerns about the care of individual people who were at risk from diabetes, weight loss and malnutrition.

A hot meal was prepared at mealtimes; we saw some people had asked for alternatives which they were given. The food looked appetising, healthy and well balanced. People told us they enjoyed their meals. Special diets were catered for and the kitchen staff were familiar with people's dietary requirements.

People told us they felt safe living at Howdon Care Centre. Most relatives confirmed this. The majority of staff were trained in the safeguarding of vulnerable adults and through discussion they were able to demonstrate their responsibilities with regards to protecting people from harm. Policies and procedures were in place to support staff with the delivery of the service.

We saw care workers treated people with dignity and respect. Staff displayed kind and caring attitudes towards people. Everyone we spoke with said the staff were friendly and nice to them. We saw people enjoyed a positive relationship with staff and it was apparent that they knew each other well.

Activities were plentiful and the two activities coordinators were enthusiastic and dedicated to provide meaningful and stimulating activities for people to participate in. Community outings, group activities and one to one sessions took place which reflected the interests and hobbies of the people who lived at the home.

We have identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Three of which have continued from the last inspection. We also identified one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Serious incidents of a safeguarding nature were not dealt with in line with internal and external processes to ensure people were kept safe. Investigations had not always taken place to reduce the risks of similar occurrences.

Risks people faced in their daily lives were not always assessed and reduced. Medicines were not managed safely and properly.

Whilst the service deployed enough staff to meet people's needs, people and relatives had a perception of the service being short staffed and agency workers were frequently used.

Inadequate ●

Is the service effective?

The service was not effective.

New staff had not completed a robust induction programme and existing staff were not kept up to date with training.

Staff supervisions and appraisals were not routinely carried out and many staff had not received any formal support for months. Staff competency checks were missing.

Consent was not always obtained in line with the Mental Capacity Act 2005. Staff did not always follow the principles of the MCA.

People with specific nutritional needs did not always experience a positive outcome. However, most people were served well balanced meals and were given choices.

People had access to external healthcare professionals although this was not always in a timely manner.

Inadequate ●

Is the service caring?

The service was not entirely caring.

The provider did not enable staff to provide a wholly caring

Requires Improvement ●

service due to the shortfalls throughout the management of the home.

People told us staff were nice to them and treated them with respect.

We saw people's privacy and dignity was protected.

People and their relatives told us they had been asked to provide information about their likes and dislikes and were involved in the planning of care.

Is the service responsive?

The service was not always responsive.

Complaints were not always managed in line with the provider's established process which meant complainants were not informed of the actions taken to address their issues and they were not dealt with in a timely manner.

Information about people's current needs may have been missed because care plans were inconsistently reviewed and not kept up to date. End of life care plans were not routinely in place and staff had not received training in this aspect of care.

Most information in care plans was person centred and specific to each individual to ensure staff could meet people's needs, wishes and preferences.

Meaningful activities took place which met with people's interests and hobbies.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Audit and governance systems were ineffective. The service had continued to breach regulations from our last inspection and other areas of the service had failed to appropriately meet people's needs in a safe, effective and responsive manner.

Record keeping was poor. Issues raised during internal and other external audits has failed to be entirely addressed. The provider had poor oversight of the service.

There was no registered manager and the care manager had not acted with integrity and professionalism when dealing with some serious incidents.

Inadequate ●

People, relatives and staff felt the home's atmosphere and staff morale had improved in the last four weeks.

Howdon Care Centre

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 site visit took place on 17, 18 and 19 April 2018 and was unannounced. The inspection consisted of two adult social care inspectors, two specialist advisors and one expert by experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. One specialist advisor on this team was a qualified nurse and the other was a speech and language therapist. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Howdon Care Centre, including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

Additionally, we liaised with the local authority contracts monitoring and safeguarding adults teams and the local NHS clinical commissioning group (CCG) to gather their feedback about the service.

During the inspection we spoke with twelve people who used the service and twelve relatives to gain their opinion. We spoke with staff, including the care manager, the regional manager, the resident experience manager, a nurse, two care home assistant practitioners (CHAP), three care workers, two activities coordinators, one domestic and the maintenance person. We spoke with a managing director from the provider organisation during our inspection feedback.

We reviewed a range of care and management records maintained about the quality and safety of the service. This included looking at six people's care records, three of which were 'pathway tracked'. This meant we examined all of their records, spoke to the person and/or their relatives and we spoke with the

staff who supported them regularly. We also looked at 10 people's medicine records in depth. We checked seven staff files which included recruitment and training information.

Is the service safe?

Our findings

At our last inspection, we identified a breach of Regulation 12 which related to the safety of the service and the care people received. Despite the provider addressing some of the specific issues we raised, we found that not enough improvement had been made and other aspects of the service had failed.

During this inspection we looked at a specific incident which had occurred in April 2018 whereby the service was left without a qualified nurse on duty overnight. This had posed a very serious risk to people who required nursing care. For example, people who may have needed 'as required' medicines, people who are dependent on insulin, people who required the administration of controlled drugs and people who received catheter care did not have access to the appropriate nursing care.

The care manager and a Care Home Assistant Practitioner (CHAP) were on duty, however neither were qualified to carry out the tasks required to safely meet people's needs. The care manager left the service at midnight, leaving the CHAP as the most senior person in charge of the home. There was no impact on people who used the service, however providers are required to have staff with the relevant skills, qualifications and competence to safely meet people's needs on duty at all times.

We found 14 incidents of a safeguarding nature which had not been notified to the local authority safeguarding team or to the Care Quality Commission (CQC) as necessary. These incidents were identified from reviewing the provider's accidents and incidents report for March 2018 and the complaints file. We found there was no cross reference to a central safeguarding file which only contained four other incidents in total.

The incident involving the service being left without a qualified nurse was not initially reported to the local authority safeguarding team or CQC. It was also not reported internally using the provider's safety escalation process. This incident was highlighted by a whistle-blower at the service who contacted the local authority and CQC to inform us. In turn, the local authority alerted the provider to the incident. The provider was then able to investigate the matter and take the appropriate action, which they did.

Two complaints received by the service from relatives also indicated that safeguarding incidents had taken place. Neither of these concerns were reported to the local authority or CQC which meant these people were left at risk if the issue was not thoroughly addressed to ensure their safe care and treatment. Another allegation of care workers sleeping on duty was not investigated or dealt with properly. Again, this issue had not been internally escalated to the provider or dealt with in accordance with company policy. This meant people had been placed at serious risk of further harm because established safeguarding systems had not been used effectively to protect service users from the risk of further or avoidable harm and/or abuse.

We found that an appropriate and robust investigation had not taken place for the majority of the incidents we highlighted; therefore, neither we nor the provider could ascertain if people had been fully protected from the risk of harm or abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safeguarding service users from abuse and improper treatment.

The management of medicines was not always safe and proper. We found multiple medicines had been out of stock for some people. For example one person who was at high risk of weight loss did not receive their prescribed food supplements for two weeks and another person who suffered from osteoporosis did not receive their Alendronic acid for three weekly doses.

For one person who received a medicine administered as a patch, a system was in place to record the site of application and the days when the patches were renewed or replaced; however, staff had not fully completed this and there was no site recorded as to where the patch was applied on 9 April 2018. This is necessary because the application site needs to be rotated to prevent skin damage. A 'daily patch check record' was in situ, however there was an absence of recordings on 10, 14 and 15 April 2018.

We looked at 10 people's medicine administration records (MARs) and found they were not completed properly and some were not accurate. This meant that neither we nor the provider could be assured that people had received their medicines correctly. For example, one person was prescribed medication for Parkinson's disease, and received their medication six times a day; it was not clear from their MAR if they had received this on time, which meant they may not have been able to manage their symptoms fully or be able to move. Two people's MARs showed the dose of a medicine had changed. It was not clear when the dose had changed and who had authorised this. Nine out of the 10 medicines records we reviewed did not contain a recent photograph of the person to reduce the risk of medicines being given to the wrong person. There were gaps in the recording on five people's MARs and there were multiple anomalies with insulin administration charts.

Some people received support with medicinal creams (topical medicines). However, there were inconsistencies in the way topical medicines were recorded and neither we nor the provider could not be sure it was in line with how they had been prescribed.

Medicines which required cool storage were kept in a refrigerator and stored in a secured treatment room. However the temperatures of the room and of the refrigerator were not consistently taken and therefore we nor the provider could be sure that medicines had always been stored at the correct temperature. This is important because some medicines lose their effectiveness if stored at an incorrect temperature.

Two people we reviewed had diabetes. We reviewed their care records and found they both contained inaccuracies. For example care records stated in multiple places that one person was currently supported to administer insulin, including in an evaluation carried out in April 2018. However the insulin medication had been stopped by a GP in March 2018 as noted in a professionals communication record. This was further confirmed by the care manager and the regional manager. This meant that staff would not be able to provide safe care and treatment, particularly in relation to safely managing their diabetes therefore potentially exposing people to a risk of harm.

Another person we reviewed was at risk of pressure damage and had grade three and four pressure sores at the time of our inspection. We noted that the pressure relieving mattress setting was not recorded on care records, neither was it on the mattress audit used to monitor all people's mattresses. This meant the mattress was not checked regularly putting the person at potential risk of further skin damage. We asked staff to check the mattress settings and it was identified that the setting was incorrect for this person. We were not able to ascertain if the pressure damage already suffered was due to these checks not being completed. Staff conducted an urgent mattress setting audit throughout the home and told us it has been

added to the audit document. As this had not been identified by the staff, we were not confident that people's pressure care needs were met thus exposing them to serious risk of harm.

During a tour of units three and four of the home, we noted that emergency pull cords were placed out of reach in most people's bedrooms and communal areas. When we asked the care manager why this was, we were told it was because "people do not have the capacity to use them, they are mainly for the staff." We found there were no specific risk assessments to identify who was at risk and what other control measures were in place. We also found there were no specific mental capacity assessments for this or best interest decisions in relation to the cords being placed out of reach.

In addition to this, we found some pull cords in communal toilet areas had been cut off at the ceiling. Therefore, there was no way for people to summon help in an emergency from these rooms.

The only fire escape available at the rear of the home was through a locked gate. The gate led out onto council owned land in a nearby housing estate. We saw the grass was long and there was debris including a very large tree branch blocking the escape route. This was a tripping hazard and people who required the use of a wheelchair would not have been able to use this exit promptly, therefore exposing them to risk of harm in terms of a safe evacuation in an emergency situation. The provider arranged for this to be removed immediately and arranged for a site visit from the local fire service to take place.

Actions plans held at the service were not completed following a fire risk assessment dated 28 February 2017 and a legionella risk assessment dated 31 October 2016 which meant neither us nor the provider were sure if the issues identified had been actioned. We highlighted this to the regional manager who arranged for the central maintenance team to review this. They found that some of the issues had been actioned; however there were still outstanding actions which the home's maintenance staff were tasked to address on 20 April 2018. This meant people had been placed at potential at risk of harm due to unresolved issues in relation to fire safety and the safe provision of water.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Safe care and treatment.

Risks were assessed to ensure people were safe and where possible, actions were identified for staff to take to mitigate these occurring. For example, from the records we viewed we saw risks such as moving and handling, mobility, falls, use of bed rails, risk of falling out of bed/chair, bathing, nutrition and hydration, choking, continence and skin integrity were identified. However, these risks had not been consistently reviewed on a monthly basis.

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped staff identify the level of risk. The Waterlow scale is used to assess people's risk of developing pressure damage. The MUST tool is used to monitor weight and manage weight loss or obesity. For one person assessments were inconsistently reviewed and updated which meant they did not reflect the person's current level of risk.

Health condition specific risks, such as those relating to diabetes, catheter care and epilepsy had been included into risk assessments. We found one person's suprapubic catheter care plan had been re-written in March 2018 and we saw that it contained information about their catheter and how best to support the person. For one person who was living with epilepsy and we saw a care plan in place which identified control measures, such as the person was prescribed medicine for the management of epilepsy. There was information on the triggers, what the seizure might look like and when to seek emergency help. This meant

staff had the information they needed to support them to recognise if the person was experiencing a seizure.

The premises were maintained to a satisfactory standard although we did point out minor areas for improvement which were addressed by the maintenance team during the inspection. Domestic staff were on duty and we saw they were designated responsibility for specific areas of the home. We observed they followed best practice guidance in relation to the control of infection such as the use of colour coded equipment and degradable bags for soiled laundry. All staff were observed using personal protective equipment as necessary to prevent cross contamination.

Staff continued to be safely recruited using the providers established recruitment process. Staff had completed an application form, attended an interview, supplied references and had been checked externally by the Disclosure and Barring Service to ensure they were suitable to work with vulnerable people. The qualified nursing staff had been checked against the Nursing and Midwifery Council (NMC) register to ensure they were allowed to work as a nurse and undertake the tasks they were delegated responsibility for.

The provider continued to use agency staff to cover vacant shifts whilst they recruited permanent workers. People's dependency on support from staff was monitored to ensure staffing levels were adequate. During our inspection, we found the staffing levels were appropriate. People and relatives had mixed opinions about the staffing levels. The majority of people felt staff responded promptly when they pressed their buzzers. They told us, "If I need help I get it straight away"; "If you buzz they are here in two or three minutes"; "I just shout and they come in good time" and, "Short staffed all the time, when you buzz sometimes you have to wait before someone comes." Others added, "You get agency staff and you don't see the same staff"; "The main body of the staff are good (regular carers) the agency staff don't know you" and, "There are a few agency staff around." Relatives expressed similar opinions. They said, "When using the buzzer, my relative doesn't have to wait long"; "There were a lot of agency staff" and, "There wasn't enough staff at one time, I was concerned at Christmas. When I have been here recently there are enough to oversee what is going on."

People told us that they felt safe at Howdon Care Centre; however some people raised concerns about staff shortages. Their comments included, "I feel safe, no great worries"; "Oh I do (feel safe), no concerns"; "Yes (safe), I get on alright with them (staff) all" and, "Reasonably safe, they have had a shortage of staff." The majority of relatives consulted considered their relative to be safe; however a few also mentioned staffing levels. They told us, "Very safe here"; "I trust the carers"; "I feel that my relative is very safe here" and, "There was a mass exodus, lots left (staff). None at all (safety concerns), as a family unit we are happy and there is no smell or odour in here."

Is the service effective?

Our findings

At our last inspection, we identified a breach of Regulation 18 which related to the staffing at the service and a breach of Regulation 14 which related to nutrition. The provider had focused on the specific issues we raised, however we found that not enough improvement had been made and now other aspects of the service did not meet with the regulations.

CQC expect providers to introduce the 'Care Certificate' for new staff employed after 1st April 2015. The Care Certificate is a benchmark for induction of staff who are new to the care industry. Whilst it is not mandatory, providers should be able to demonstrate that staff are competent in the standards. Although this had been sourced for 26 eligible staff, only one staff member had completed it. We found 21 other staff were overdue completion. Some of which had been employed for over two years. The guidelines suggest the 'Care Certificate' is completed within the first 12 weeks of employment.

The service's training matrix showed gaps in care workers skills regarding nutrition, challenging behaviour, documentation/record keeping and end of life care. We confirmed this was correct by cross referencing the information with individual staff records and we discussed this with members of the care management team who confirmed that some training had not been delivered. This meant that some staff had not been supported to participate in training which would be beneficial to them in their role in order to meet the needs of the service users they cared for.

We found that staff supervisions and appraisals had not been routinely or consistently conducted with staff. Since the summer of 2017, none of the staff whose files we reviewed had received a supervision or appraisal. This was further confirmed by regional manager who told us 25 supervisions were overdue and no recent appraisals had been completed by the care manager or management support team. This meant that staff has not been appropriately supported in their role to ensure they remained competent. The lack of staff appraisal demonstrated that any training, learning or development needs had not been formally identified, planned for or supported.

We reviewed medicine competency records which had been carried out with permanent nursing and senior care staff. We were told all eligible staff had completed a recent check however the records for six staff were missing. This meant we were unable to check if people were at risk of receiving care from staff who were not fully trained, competent or supported to deliver safe care and treatment.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Staffing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can 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 found that mental capacity assessments and best interests' decision making was not consistently carried out in line with the principals of the MCA. For example, one person who lacked mental capacity did not have a recent capacity assessment or an appropriate best interest decision around receiving the flu jab. We found a handwritten note from a relative which read, "I consent to [person] receiving the flu jab."

We found that DoLS applications were not always carried out in a timely manner. For example, one person's existing DoLS authorisation had expired on 2 January 2018 and we saw that a fax had not been sent until 26 February 2018 to extend this. Another person's DoLS authorisation needed to be reviewed on 18 November 2017; however, the nurse on duty was unable to find a fax confirming that an extension had been requested or granted, they told us that they would follow this up with the care manager immediately. This demonstrated that people were at risk of receiving care and treatment which they had not lawfully consented to.

During the inspection we were informed by the activities coordinators that the home had a public 'Facebook' page which had been set up by the activities coordinators to showcase the activities people had taken part in. Facebook is a social networking website which allows posts and photographs to be shared with its members. The page had not been managed or overseen by anyone on the management team and therefore both the care manager and the regional manager told us they were unaware of the photographs of people which had been publicly posted on the page. We asked for copies of consent forms to show that consent had been obtained by the people in the photographs. The consent forms provided did not specifically give consent to post photographs on any social media websites. We found no best interest decisions had been made with regards to the people in the photographs who lacked mental capacity and assessments had not been carried out in line with the principals of the MCA. The regional manager arranged for the page to be suspended pending further investigation and action taken to obtain the correct consent.

We saw that information contained on posters outside of service user bedrooms contained too much confidential information. For example, full names and dates of birth of people were observed on display in communal areas of the home. We found there were no specific consent forms completed or best interest decisions made in relation to displaying this type of personal information in a communal area. Therefore, the service was breaching a person's confidentiality and exposing them to risks such as identity theft and financial abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Consent.

People had not always experienced positive outcomes from the care and support they received. For example, one person who we pathway tracked was at risk of choking and weight loss. The Speech and Language Therapist's (SALT) advice detailed in their care plan was not present in their bedroom, which meant new or agency staff would not be well informed with regards to their needs if they were expected to support the person at mealtimes. Basic advice regarding the person's special dietary needs was available in a folder (known as the Diet Notifications file) kept on the meals trolley, but this didn't include information about pacing (the speed at which a person can comfortably eat), observing for a swallow or the use of a straw and small sips with drinks.

Daily recording of food and fluid included a description of everything offered to this person but no detail about how much they actually ate or drank on each occasion. Staff told us that if no other information was

recorded then that meant that they had eaten or drank the full amount offered. Recording sheets going back to the beginning of March 2018 all included the same type of information which indicated that the person had ate or drank everything offered on every occasion. This did not match with our observation during the person's lunch or from speaking to a relative who told us that their intake varied greatly. When we discussed this further with staff they agreed that the information recorded on the daily charts did not reflect the actual amount eaten or drank on each occasion and that further guidance for staff on how to record this information was needed.

This person's weight was recorded monthly within the 'Nutrition' care plan. This showed they had experienced a weight loss of almost 7KG between December 2017 and April 2018. Advice from a dietician prescribing two food supplement drinks per day was only present in the file from April 2018, indicating that it took a long time for a referral to the dietician to take place. Information recorded on the daily fluid charts from that date did not make it clear that the two drinks were given every day and on some days only one was recorded. From the records, neither we nor the provider were able to check if the person had received their prescribed food supplements as directed thus exposing them to further risk of weight loss and ill-health.

Information on the daily handover sheet regarding this person was basic and included no SALT advice, thereby relying on the familiarity of staff or a verbal handover to ensure that the correct approach was implemented at every meal. Again, new or agency staff would not be well informed with regards to the person's needs.

We saw people had their needs were assessed before they moved into the home to make sure the staff were able to care for them and they had the correct equipment to ensure their safety and comfort. Where a support need was identified a care plan was developed setting out how it could be met, although these were not always kept up to date.

People received a choice of hot and cold meals. We saw some people had asked for alternatives which they had been given. Special diets were catered for and we found that the kitchen staff were aware of people's dietary requirements and allergies. The food looked nice and was well balanced with meat and vegetable options. People we spoke with told us they enjoyed their meals. Comments included, "The food is basic home cooking, it suits me. I go in the dining room I prefer this. There are meal variations, two main courses and one sweet"; "I have food in my room, I always like it here. I find the food very nice"; "The food is good, mainly I eat in the dining room. I can eat it in my room if I want to"; "Sometimes they give you something else if you want something different, they do give you enough food. The pudding is sponge and custard, just the one (choice). I ask if I want something else. I don't like ice cream so they send up a yoghurt" and, "Food choice of two meals for dinner and tea. I don't get a lot but I get enough. I have put on four kilos in the last few months."

The home had suitable adaptations such as walk in shower facilities and bathing equipment. The home was nicely decorated but there are areas which needed updating. The rooms we were invited into contained family photographs and personal effects. People told us, "It is nice and tidy, nice and clean" and, "Yes and it is very clean. I go into the garden, mainly so I can smoke. I am usually the only one in the garden."

Best practice guidance around making the environment dementia friendly had been followed to some extent such as appropriate lighting and pictorial signage to ensure people could orientate themselves around the home. Toilet and bathroom doors which opened outwards into the corridor had signage to advise people to be careful when opening the doors. In some corridors scarves were tied around banisters and handbags were hung on the end of some bannisters to stimulate the interest of people with dementia

related conditions.

People told us and we saw in care records that they had access to healthcare professionals such as GP's and a dentist. People told us they were happy with how staff reacted when they were unwell. One person said, "The doctor has been to see about my chest. If I need one they call one." Another person told us, "A few months ago they took my temperature and called an ambulance." A third person said, "I had a fall, the nurses came from upstairs and they checked me and took my temperature."

People told us they felt looked after by the regular staff. Their comments included, "The main carers know what they are doing, the new ones don't always know"; "The agency staff don't know how the care home runs, they don't know what to do"; "Yes no complaints (about staff)" and, "I am happy with them, they know what they are doing." Relatives confirmed this. They told us, "The staff have taken time to get to know her, they know exactly how to deal with her. Never had any worries about the care"; "Always looked after"; "Yes, even if they are busy they still stay with him" and, "All (staff) do the job alright."

Is the service caring?

Our findings

We found that although most people and relatives made positive comments about staff, the staff were not wholly supported by the provider to deliver a caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care was restricted by safety issues, not obtaining proper consent from people, a lack of induction, training and supervision and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

Throughout the inspection staff demonstrated that they protected and promoted people's dignity and people were given privacy as necessary. We found even at times of pressure all staff spoke nicely to people and were kind, considerate and caring when they interacted with people. All the people and relatives we spoke with considered the staff respected them, their dignity and privacy. People told us, "They speak civilly. When I get washed or go to bed they shut the door" and, "We respect each other, they (carers) like me and I like them. They all knock on the door." Relatives told us, "They are always friendly and talk to my relative nicely" and, "Yes; (staff) are very polite, definitely respectful."

We asked people and relatives if the staff were caring. People told us, "I am happy here. I think so, they are very good, no-one is nasty to me"; [Staff member] brings in a metro newspaper in for me. We get on very well, she is very good"; "They (carers) are kind and friendly" and, "They are kind. They ask if I am alright, they are very good. I am happy here." Relatives added, "Very (caring), you know from the way they (staff) are with her they care. I have never seen one (carer) getting irritated with her or another resident. The staff are always here to console her"; "The staff have all been lovely, they are nice; never had any problems"; "Staff are friendly, nursing staff explain things to me and [domestic] has a bit of banter with them (residents)"; "Always a smile and hello" and, "The staff know her and she knows them. Caring, yes they (carers) put her perfume on and pamper her."

There were 'Thank you' cards on display around the home which demonstrated that relatives had appreciated the care and support their loved ones had received. A visiting health professional told us, "I am aware there are on-going concerns here. I have never seen anybody being unkind to patients. All are kind to everyone."

People and relatives told us they had been involved in some aspects of care planning. Care plans contained information about people's likes, dislikes, preferences, interests and hobbies. The regular staff we spoke with clearly knew people well and the records reflected people's life histories, past employment, family lives and relationships. This meant that regular staff could get to know people and instigate meaningful conversations.

Information, advice and guidance continued to be displayed around the home to benefit people who use health and social care services. People were given a 'service user guide' which told them what they should expect from the service.

People's care records continued to be stored securely in the treatment rooms which we saw were kept

locked when unattended. Staff maintained people's confidentiality by being mindful when they spoke to their colleagues about people's needs.

Most people had family or friends who acted on their behalf as advocates. Legal arrangements were recorded in people's care records to ensure staff knew who had the legal right to make decisions on people's behalf. The management team were aware of how to access an independent advocate if they felt it was needed. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Is the service responsive?

Our findings

We found the provider had not ensured that an established system was operated correctly in order to identify, receive, address, record and respond to complaints properly and in a timely manner. We examined the complaints information and found that the care manager was not following the company policy with regards to responding and managing complaints. A central complaints file held in the care manager's office did not correspond with information we found logged on a complaints report. The management team had not consistently used the provider's template letters to ensure complainants were appropriately acknowledged and responded to in a timely manner. Furthermore, we saw that an audit of complaints conducted by a provider representative had identified that all of the complaints received by the service were overdue a response. However, no action was recorded to identify what had been done to address this. Complaints had not been monitored over time to look for trends and identify areas of the service that may need to be addressed.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Receiving and responding to complaints.

People and relatives informed us that they knew how to raise a concern or complaint and a few told us they had done so. Most, although not all, were happy with how their concern or complaint had been dealt with. People told us, "No complaints, I would tell a member of staff"; "I would speak to the manager if I had any problems"; "I made a complaint about the food, nothing happened." Relatives told us, "No (not raised a complaint) but I would feel comfortable to, if I needed to. A resident walked in her room, they came straight away and sorted it out"; "A few weeks ago, clothes were crammed into a drawer I complained about this. The laundry girl took them away and brought them back. It has been alright for a few weeks"; "[Person] doesn't like the light off she is scared of the dark. I talked to the manager, she wrote it down. She didn't do anything. I came in and talked to the night staff they leave the light on now" and, "Last summer there were two incidents, they put an alarm on a door to deal with this."

Relatives felt that staff were responsive and that referrals were made to health professionals when appropriate. They told us they were informed about health concerns regarding their relation. Comments included, "The doctor always comes to the care home"; "They ring and tell me, for example if she has fallen out of bed and got the doctor out. They always let us know"; "If she has falls, most of the time they let me know and get her checked" ; "They had to get the doctor in; he said to keep her comfortable" and, "They inform me. This is one of the things I asked and they do." A visiting health professional told us, "I come here regularly, once and week. They send a list of patients every week and are always on the phone."

Care plans we looked at contained some person-centred information on people's support needs and reinforced the need to involve people in decisions about their care and to promote their independence. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to them. An example in one person's care plan outlined that they felt comfortable wearing 'joggy bottoms' and a short or long sleeved top. Further information detailed that they liked their hair short and confirmed their family usually gave them a haircut when they went home at weekends. Another person's

care plan contained guidance on their preferences in that they liked to wear warm slippers during the day, they liked to wear a nightdress in bed and they liked to wear perfume and nail polish. However, other care plans we looked at were much briefer and more task based, with less specific information to guide staff.

People's needs and plans of care were inconsistently reviewed despite the provider's procedure to update them once a month to ensure they reflected people's current support needs and preferences. This meant some vital information about changes to needs and support may have been missed. The nurse on duty told us that there was one nurse to write/review the care plans on the unit and they had recently been allocated administrative days to undertake this task. The nurse showed us a list of people's care plans that required updating, which included some of the areas we had identified. The regional manager showed us the 'monthly evaluation' prompts which they had planned to insert into people's care files to support staff focus on the priority areas.

The records we looked at did not routinely demonstrate that people, their relatives and staff attended review meetings. Care plan documentation was not always signed by the person where they were able, and where people were unable to sign themselves their legally authorised representative had not signed on their behalf. This meant that people may not have been consulted about their care, and therefore the quality and continuity of care may not have been maintained.

Handover meetings took place when the staff team changed throughout the day. For example, when night shift finished and day shift started. When we asked the nurse on duty regarding the format of the staff handover they told us that they used the 'handover sheet' as a prompt and verbally elaborated on specific details during the handover. The nurse told us that the new handover format had been in place for approximately 4 weeks and they confirmed which nurse and care workers had attended the handover. We reviewed some examples of the handover sheets and noted that some abbreviations had been used but were not explained. We also found that some columns were blank and some dates were missing from the handover sheets therefore it was difficult to determine which days the handover related to. There was also a large amount of entries in which we were unable to decipher the handwriting. This meant that information may not have been effectively communicated to oncoming staff and staff may not have been able to read or understand the records if they missed the handover meeting.

There was no one receiving end of life care at the time of this inspection. However, the provider offered this level of support to people and had delivered end of life care to people recently. There were no end of life care plans in place for the people we reviewed which meant information may not have been available to inform staff of the person's wishes at this important time and enable them to provide safe care and treatment. Additionally, staff had not received end of life training. The regional manager told us they would arrange for this to be resourced and delivered as soon as possible.

There were two activities coordinators employed and we found them to be passionate and committed to ensuring people lived fulfilled lives. They provided us with a hand-written activities time table and told us that copies were put into individual rooms. Activities were also displayed in the corridors. We saw there was a sensory room on the first floor. There was a variety of stimulating and meaningful activities planned to take place and we saw that people had been involved in a range of community outings, group events and one to one sessions which reflected the interests and hobbies of people who currently lived at the home.

An activities coordinator told us that the life histories of people were available for them to read and document people's interests. They told us they asked people what activities and outings they would like and they attended the 'residents/relative' meetings to discuss activities. They explained to us how activities were being adapted or altered to meet people's wishes. They said, "Some like to bake and some like to watch. It is

their choice" and, "Yesterday, no one was interested in the bingo, so we decided to make bunting for the open day at the end of the week." During the second day of inspection we observed both activities coordinators interacting with people in the downstairs lounge making fidget mitts and bunting. Fidget mitts are made of different textures. They provide a distraction for people with dementia, keeping their hands busy and relieving anxiety.

An activities coordinator told us that weekly outings took place and the home had access to transport. We saw a notice displayed in the home advertising a trip to a restaurant by the coast and some people had written their names on the posters to express their interest. An activities coordinator told us they had recently visited other public houses with residents and their relatives. Other outings included trips to the coast for an ice cream, Alnwick Gardens, Holy Island and last year staff had taken three people to Haggerston Castle holiday park, in a wheel chair accessible caravan with a hoist. We saw photographs of people enjoying these events.

People told us, "I have got quite a few friends here"; "There is a good selection of videos and DVDs, I like this film"; "Once I went to a sing along and had a bit of a carry on"; "It is lovely, I get to see singers and plays. Every Thursday I go on a trip. We went to a pub this week"; and, "I have been to baking today they give you choice of what to make I choose coconut and ginger cake and another person chose a chocolate one. I go to music and movement it is good fun, we have pom-poms. I am going to my art class today. I go to an arts and craft centre." We observed the persons art work was displayed in their room.

Relative added, "There are opportunities for [person], it is up to her if she wants to go. There are singers; she goes to baking class and in the garden. She has plenty to do"; "The activity girl is good, my relative has her nails done and she does baking. Last year they took her out, when she came back she said, 'its lovely to be back home'" and, "They prompt to her to go to activities and she has her hair done at the hairdressers."

The entries in the activity logs showed that people who were cared for in bed had also participated in activities including pet therapy, singing, talking and holding hands. The activities coordinators told us they had sang to or with people and had talked to them about the upcoming royal wedding.

Is the service well-led?

Our findings

At our last inspection, we identified a breach of Regulation 17 which related to the governance of the service. Despite the provider drafting an action plan and addressing some of the specific issues we raised, we found that not enough improvement was made and shortfalls continued throughout the service.

The findings from our inspection demonstrated multiple breaches of regulations, some of which were continued breaches from our last visit in November 2017 which meant that the areas of the service which required improvement had not been comprehensively addressed. This meant people remained at risk of serious harm or abuse.

Audits and checks on the service were not consistently or comprehensively completed. Action plans completed to address any issues that had been identified were often not followed up. This meant we were unable to ascertain if the provider had monitored progress against action plans or taken timely action without delay when progress was not achieved as expected.

Audits which had been completed were brief in their detail and in some aspects of the service the care management team had failed to recognise the issues we identified during this inspection. This demonstrated a lack of oversight by the care manager and the provider's representatives.

The care manager told us they completed a daily meeting with staff. There were only three of these meetings recorded to corroborate this, all dated in March 2018. This meant that any issues identified by the care manager during these meetings about the oversight of the service could not be monitored to ensure appropriate and timely action was taken.

The care manager told us that they had carried out more than three spot checks on the service at night. There were no written records to corroborate this. There were also six staff medicines competency records missing.

Issues and recommendations made by an external pharmacist in February 2018 were not entirely rectified. For example, in relation to monitoring refrigerator temperatures, updating photographs of people and the recording of 'as required' medicines. These issues were highlighted again at this inspection.

Two internal medicine audits dated 31 March 2018 and 16 April 2018 also identified similar issues to those which we found. Again, these had not been entirely addressed.

We found that overall record keeping was poor across many aspects of the service. For example, care plans were inaccurate and not consistently evaluated or reviewed. Some care plans were not signed by people or their representatives to give consent for care and treatment. Some care plans did not contain photographs of people. Risk assessments were missing in some of the care records we reviewed. Some risk assessments had not been regularly reviewed. Handover records were of poor quality. Care monitoring charts were not detailed or accurate, for example the food and fluid intake charts.

Record keeping in relation to complaints, accidents and incidents, audits and notifications all lacked detail and completeness. We found multiple incidents of a safeguarding nature which had not been formally investigated in line with company policies and safeguarding policies.

We considered that due to the poor record keeping throughout the service and the continued use of agency nurses, temporary staff may have found it difficult to understand people's needs and they may not have been able to provide appropriate person-centred care and treatment which would keep people safe from avoidable harm or abuse.

The care manager had not acted in an open and transparent manner when asked by the local authority about the incident involving the shift in which no nurse was present in the home overnight. We found that despite being fully aware of the incident they had not escalated the matter internally or followed the agreed safeguarding protocol with external agencies. Their actions in relation to this matter placed people at serious risk and compromised the staff on duty.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The failure to notify the Commission of incidents as legally required meant that we could not be confident that the service was operated in line with the legal requirements. This had exposed people to serious risk of harm due to non-compliance with the regulations and a lack of oversight and monitoring from internal and external agencies.

This is a breach of the Care Quality Commission (Registration) Regulations 2009, Regulation 18, entitled Notification of other incidents.

During the inspection we discussed our immediate findings with the care management team and we brought several issues to their immediate attention which they promptly addressed. We later spoke with the provider representatives to discuss the inspection findings.

The current care management team continued to work in partnership with external organisations such as the local authority, local authority Clinical Commissioning Group (CCG) and the NHS medicines optimisation team. Following the inspection, they told us they were committed to working with external teams and would accept any support offered to them to improve the quality and safety of the service.

'Resident and Relatives' meetings were held and people had also been asked to provide their feedback via surveys. One relative told us, "Yes I have been asked to go (to meetings), but I have not been." Another relative said, "Definitely sent one or two (surveys)."

The home did not have a registered manager but the care manager had applied to become registered with the Commission. We asked people and relatives about the management team. They told us there had been recent changes in management, a long-standing manager had left, two new managers stayed for a short amount of time and the service was now managed by another manager. People said, "The new one I don't know"; "Not met the new manager"; "I don't see them (care manager) much" and, "[Care manager] is very nice and very pleasant. I could talk to them if I had any problems." Relatives added, "I've not met the new manager" and, "The managers have changed a few times. Today is the first time I had a conversation with [care manager], they seem lovely and resolved my problem."

People, relatives and staff told us that within the last month the atmosphere and morale in the home had

improved. One relative said, "They are working more as a team." Another told us, "You can tell staff morale has lifted."

We asked people and relatives if they thought the service was well managed. Comments included, "Yes, I think it is a very nice home"; "There are less agency staff, they (staff) are working more as a team" and, "Yes, I would recommend the home, it has friendly staff. It is clean and tidy and has good management."

Staff told us they felt some improvements had been made around the home and with the management of the service. Their comments included, "It is getting a lot better now, less tired now there are more staff"; "Only spoke to [care manager] a couple of times, seems nice and on the ball"; "The new manager is very approachable, sociable and friendly"; "We have had a lot of agency staff. It is getting better, we need regular staff. I want to get back to how it used to be. I like it here" and, "The new manager is approachable, she listens to you and is making changes in a nice way."

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to notify the Commission of multiple serious incidents of a safeguarding nature.

The enforcement action we took:

We have issued the provider with a fixed penalty notice.

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	The provider had not ensured that staff always sought the appropriate consent from people to provide care and treatment. The provider had not ensured that staff who obtain consent from people were familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005. Applications to deprive people of their liberty were not consistently carried out in line with the MCA guidelines. Regulation 11(1)(2)(3)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.

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 had not ensured that care and treatment was delivered in an entirely safe manner. The risks people faced were not always appropriately assessed.

The provider failed to do all that is reasonably practicable to reduce the risks people faced in their lives.

The provider failed to ensure that people received safe care from staff who had the skills and competence to do so.

Medicines were not always managed in a safe and proper manner.

Regulation 12(1)(2)(a)(b)(c)(g)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	Robust safeguarding procedures and process were not in place to ensure people were protected from harm. The provider failed to provide the right level of oversight. Systems and processes were not operated effectively to prevent abuse or harm to people. Incidents of a safeguarding nature were not always investigated. Staff did not follow local safeguarding arrangements to ensure incidents were investigated internally and externally.
	Regulation 13(1)(2)(3)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	Complaints were not always investigated and the necessary action was not always taken to ensure a complaint was addressed and resolved. Staff did not follow the established system to identify, receive, record and respond to complainants in an appropriate and timely

manner. The provider did not have effective oversight of this.

Regulation 16(1)(2)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and process were not operated effectively enough to ensure compliance with the regulations. The provider did not ensure they effectively assessed, monitored and improved the quality and safety of care provided to people. They also did not assess, monitor and mitigate all risks relating to the health, safety and well-being of people who used the service. Record keeping was not satisfactory. Accurate, complete and thorough records were not maintained in respect of all people who used the service, staff records and the management records. The provider's audit and governance system was not effective. Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.

We also issued the provider with a warning notice in relation to Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider did not ensure that staff were suitably, qualified, skilled and competent to meet people's needs. An induction programme was not robustly monitored and training relevant to staff roles was not always available or monitored for completion.

Staff had not always received appropriate supervision and formal support to identify their learning and developmental needs. Periodic supervision was inconsistent to ensure staff remained competent.

Regulation 18(1)(2)(a)(b)

The enforcement action we took:

We have imposed an urgent condition on the provider's registration to prevent them from admitting any new service users until the Commission are satisfied the necessary improvements have been made.