

Viewpark Care Home Ltd

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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?	Requires Improvement ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

This inspection took place on 23 and 24 May 2018 and was unannounced.

Viewpark Care Home Limited (Viewpark) 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. Viewpark accommodates up to 27 people in one adapted building. Bedrooms are located on two floors, with a passenger lift between floors. There are two dining rooms, two lounges, and a conservatory. The home is situated in a residential area of Moston in north Manchester. At the time of our inspection there were 13 people living at the home.

Our last inspection of Viewpark took place in January 2018 when we rated the home Inadequate overall, and identified multiple breaches of the regulations. At this inspection we again found evidence of limited improvements. However, there were still considerable improvements that needed to be made to the service. We found improvements had been made and the provider was now meeting the requirements of the regulations in relation to employment of fit and proper persons, safeguarding, need for consent and the duty of candour. However, there remained ongoing breaches of regulations, including in relation to staff training, person-centred care, good governance and multiple breaches in relation to safe care and treatment. We also identified a new breach of the regulations in relation to treating people with dignity and respect. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to the back section of reports after any representations and appeals have been concluded. We also made a recommendation that the service strengthens their practice in relation to implementation of the Mental Capacity Act 2005.

There was no registered manager in post. The former registered manager had left the service in March 2018. Shortly after this CQC completed enforcement action to cancel their registration as a manager at this home. The provider had employed a new manager. However, they told us they did not intend to register as the manager of the home, and did not plan on staying in post long-term. 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 directors of the company that owns Viewpark were not actively involved in the day to day running of the home, and a family member of the directors was acting on their behalf. The manager told us they did not feel they were provided with enough support or resource to enable them to make the significant improvements required at the home. Whilst the provider's representative was actively involved in the running of the home, they did not have a background in social care provision and so were still learning about how to run a care home.

We found the provider had made some improvements to procedures in place to help ensure people were kept safe. For example, risk management in relation to pressure ulcers and providing the correct consistency

of food and fluids to people had improved. However, we continued to find examples of when staff had not taken reasonable actions to reduce potential risks. An inspection of a bath chair had found it to be unsafe to use. However, there was nothing in place to inform staff or others of this, and there was a risk it could have been used inadvertently. Water temperature records showed some outlets were too hot, and could present a risk of scalding. There was no evidence that staff had taken any action to address this issue, or control the risk this presented to people prior to us raising the concern.

Recording and monitoring of accidents and incidents had improved. However, there was scope for monitoring of any trends or patterns in accidents to be strengthened. Staff identified ways to help keep people safe and prevent a re-occurrence of any accident. However, staff followed identified risk reduction measures inconsistently. For example, one person should have had hourly observations from staff to help manage their falls risk. However, staff had incorrectly understood that these checks had been discontinued.

There were continued concerns in relation to the way the service managed medicines. We found some people had run out of stock of pain relief, and staff did not have sufficient knowledge about how people's medicines should be given. For example, staff did not understand requirements in relation to rotation of medicines applied by a patch, which is required to reduce the risk of skin irritation. Staff had also failed to ensure there were adequate gaps between administration of doses of paracetamol, which could have a negative impact on people's health.

We found some areas of the home where good standards of cleanliness had not been maintained. We also found a seat protector that appeared to be wet with urine was left in communal areas for several hours until we brought this to the attention of staff. We found few, and at some points in the inspection, none of the hand sanitiser dispensers were working. This would increase the risk that good hand hygiene would not be maintained, resulting in an increased risk of spread of infection.

There had been a continued embargo on placements at the home by the local authority since our last inspection. The manager told us they had found it hard to recruit staff with the required skills for the job, and the home was using agency staff to cover any shortfalls on the rota. During the inspection we saw staff were attentive and had time to spend with people. However, on the afternoon of the second day of our inspection there were two agency staff on duty, along with a senior member of care staff and a newly recruited member of staff. One member of agency staff needed a lot of direction from the senior carer, and we questioned the skill mix of the staff team at that time. The provider told us this was not usual to have such a staff team on duty, and rotas confirmed this.

Staff had received training in a variety of relevant topics, including recent training in use of thickening agents and pressure care. However, not all staff had received training that it would be important for them to receive to help ensure people received safe and effective care, such as safeguarding and infection control training. No progress had been made since our previous inspections in relation to providing staff with training in end of life care.

We also identified concerns with the way the provider had promoted staff to new roles. We reviewed records relating to one staff member and found no evidence that the provider had given reasonable consideration as to whether the staff member was competent and had the skills to undertake the new role. They had also not assessed whether the staff member required any additional training or support to enable them to work effectively in this new role.

Staff understood the principles of the Mental Capacity Act 2005. We saw staff asked people for their consent before providing any care, and respected people's wishes. Staff routinely offered people choices such as

what they had for their meals. However, documentation in relation to best-interests decisions needed to be strengthened.

There were several adaptations to the home to make it more accessible to people living with dementia. However, limited opportunities were made available for people to access any outside areas during warm weather. Staff also told us the large garden at the rear of the home was not used as the ground was uneven and presented a trip hazard.

Entertainers visited the home, and staff supported people to take part in ad-hoc activities such as 'singalongs' or they provided colouring materials for example. However, there were limited opportunities for people to access their local community or activities outside the home.

The manager was in the process of re-designing people's care plans. We found there were multiple versions of care plans, which made it hard to tell which was the most up-to-date information. Whilst people's care plans contained information regarding their preferences and social histories, there was no evidence to support that such information was used in a meaningful way to enable staff to provide person-centred care.

Permanent staff knew the people living at the home well. We saw staff interaction with people had improved, and we observed staff acting in kind and caring ways that showed consideration for people's wellbeing. However, improvements were needed to the way staff upheld people's privacy and dignity. For example, we found people did not have their own personal toiletries, and instead used stock from a communal supply. We also observed one person was spoken to in a derogatory manner by another person living at the home. Staff did not appear to be aware of this and did not intervene.

Whilst there had been some improvements to how the provider and manager monitored the safety and quality of the service, there remained concerns in this area. The audits and checks carried out had not identified all the issues we found, such as in relation to medicines management. Other audits had identified issues, but had not resulted in improvements.

The overall rating for this service is 'Inadequate' and the service remains 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?

The service was not safe.

Medicines were not managed safely. For example, two people had no pain relief medicine in stock. Staff were not always aware of requirements in relation to the timing of medicines administration.

There were not robust procedures in place to ensure risks arising from the use of the premises and equipment were adequately managed.

Staff assessed risks to people's health, safety and wellbeing. However, they were not consistently following the steps identified in people's care plans to help ensure they were kept safe.

Inadequate ●

Is the service effective?

The home was not consistently effective.

There was no evidence that staff member's skills, competence or training needs had been considered when they had been promoted to new roles.

There were some adaptations to the home to make it more accessible to people living with dementia. However, there were limited opportunities for people to access outside areas of the home during good weather.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). However, the provider needed to improve processes in relation to records in this area.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

Interactions between people living at the home were not always respectful. Staff were apparently not aware of this and did not intervene when we heard a person being spoken about in a derogatory way.

Requires Improvement ●

Staff interaction with people living at the home had improved. We saw staff took time to sit and chat with people. However, this was not always the case with non-permanent agency staff.

People did not have their own toiletries such as soap and shampoo. They instead used a communal stock of these products. The manager began to address this when we made them aware of this issue.

Is the service responsive?

The service was not consistently responsive.

There were ongoing issues in relation to care planning and assessment. Whilst people's preferences, interests and social histories were recorded, this information was not routinely used to help provide a person-centred service.

Staff arranged activities on an ad-hoc basis, and entertainers also visited the home. There were few opportunities for people to get out of the home or to take part in their local communities.

Records of complaints were not always available. However, the provider had investigated and taken action in response to complaints.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Adequate improvements had not been made since our last inspection to ensure the service was complying with the requirements of the regulations.

The manager felt they did not receive sufficient support to enable them to make the required improvements at the home.

There had been some improvement to the system of audits and checks. However, these had failed to ensure all issues identified during this inspection, and our previous inspections had been rectified.

Inadequate ●

Viewpark Care Home Limited

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 23 and 24 May 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and a medicines inspector.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, and feedback, complaints and concerns we had received about the service since our last inspection. We also reviewed any statutory notifications sent to us by the service. Statutory notifications are information a provider must send us in relation to deaths, serious injuries, safeguarding and other significant incidents. On this occasion we did not request a provider information return from the service. A provider information return gives us some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We sought feedback from the local authority contracts and quality monitoring team and Healthwatch Manchester. We received a response from Healthwatch Manchester who told us they had not received any feedback about this service.

During the inspection we spoke with five people living at the home and one person's relative who was visiting at the time of the inspection. We spoke with eight staff members, including the provider's representative, the manager, four care staff, a domestic and the chef. We carried out observations of the care and support people received in communal areas.

We reviewed a range of records relating to the care people were receiving. This included eight people's care plans, daily records of care, accident records and medication administration records (MARs). We also looked at records relating to the running of a care home, including; records of training and supervision, six staff member's personnel records, records of servicing and maintenance of the property and equipment and complaints records.

Is the service safe?

Our findings

At our last, and previous inspections of Viewpark Care Home, we found that adequate steps were not being taken to assess and manage risks to people's health and wellbeing. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, and action had been taken to address some of the specific concerns raised during our previous inspections. However, issues remained in relation to the assessment and management of risk, which meant the home was still in breach of this regulation.

At our previous inspections in August 2017 and January 2018 we found staff were not following guidance from speech and language therapists in relation to the texture and consistency of food and fluids they gave to people with swallowing difficulties. We found staff had received further training in relation to the use of thickeners. Records demonstrated that staff were now following any professional guidance in place for the few people at the home that required modified texture food or fluids. Issues identified at our January 2018 inspection in relation to the management of risk of pressure ulcers had also been addressed. Staff were now following measures identified in people's care plans and risk assessments to help reduce the likelihood of them developing a pressure ulcer. For example, records showed staff supported people to reposition frequently when this had been identified as a way of helping manage the risk of pressure ulcers.

As at our last inspection in January 2018, we found staff assessed risks to people's health and wellbeing. For example, risk assessments had been completed in relation to risk of falls, skin breakdown, malnutrition, specific health conditions and moving and handling. However, we found staff were still not consistently following all agreed measures to reduce the risk of harm to people using the service. For instance, one person had sustained several recent falls, and staff had taken appropriate actions such as liaising with this person's GP and requesting a medicines review. The risk assessments also directed staff to maintain an awareness of this person's whereabouts and to place a sensor mat by them when they were sat in their lounge chair. This was to alert staff should they try and get up and mobilise without assistance. On the first day of our inspection we observed that this person was left unsupervised for a period of 20 minutes without the sensor mat in place before a member of care staff noticed this. A second person had also been identified as being at risk of falls, and they had sustained a recent injury from a fall. The manager told us they had put in place that staff would check on this person's wellbeing every hour to help manage their risk of falls. This was also recorded in their risk assessment. However, staff had discontinued these checks two days earlier. They had incorrectly understood that the checks were only required over the weekend.

We also found staff did not have a thorough understanding of the home's falls and accident procedures, such as in relation to how and where they would keep records of post-incident observations. Post incident observations help ensure staff are able to identify any delayed signs of injury that might require further help or advice to be sought.

We found that risk reduction measures that were in place were not always accurately reflected in people's care plans. Some people had pressure sensor mats in place in their bedrooms for example. Staff used these to alert them if those people fell from bed or attempted to mobilise without the assistance they required. However, these measures were not always reflected in people's care plans. One person's risk assessment

indicated they should sit on a pressure relieving cushion. We saw they were not sat on a pressure relieving cushion, which staff told us was because they declined to do so. However, neither their care plan, nor risk assessment reflected this or demonstrated that staff had considered alternative ways to reduce risk. These issues would increase the risk that staff, and in particular any new or temporary staff, would not be aware of the measures in place to help keep people safe. We also found some risk assessments did not demonstrate staff had given adequate consideration factors that might present risks to people's safety. For example, one person had a risk assessment in place in relation to them using bed-rails. The risk assessment tool directed staff to carry out a further assessment as to whether bed-rails were appropriate due to the person experiencing confusion. This could present risks that the person might try and climb over the bed-rails to get out of bed for example. However, the decision had been made to use bed-rails without any further evident consideration of this issue that may have meant bed-rails were unsafe to use.

The provider was failing to ensure adequate steps were taken to assess and reduce risks to people using the service. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff recorded accidents and incidents that occurred within the home. We found the manager had considered what necessary and reasonably practicable steps could be taken to reduce the likelihood of any accident re-occurring. For example, there had been an incident in February 2018 when a vulnerable person had left the home for a short period of time. This person had been supported back to the home a short while after leaving, and they were unharmed. As a result of this incident, the manager had introduced a procedure where staff waited by the front door during any deliveries. This had been communicated to staff, and the person's risk assessment had also been revised following the incident. The manager had also reported this concern to safeguarding and the CQC.

We identified concerns about the safe handling of medicines at our previous inspections in November 2016, August 2017 and January 2018. As a result of those inspections we found the provider was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had still not made sufficient improvements in the safe handling of medicines. This meant there was a continuing breach of this regulation which continued to place people's health at risk of harm.

At this inspection we found there were shortfalls in managing medicines for all 12 people whose records we reviewed. The shortfalls included those identified at previous inspections and some new concerns which placed people's health at risk of harm. Not all people had an adequate supply of all their medicines. Two people had been unable to have their regular pain relief for up to four days because their paracetamol had run out. Another person had run out of their laxative for four days. This meant these three people may have suffered unnecessary pain or effects of constipation which could place their health at risk of harm. We looked at the records about creams and the stocks of creams. The records showed that staff were applying creams. However, we were unable to find some of the creams for three people. This meant either that the records were not accurate and the creams had run out, or that creams were being kept elsewhere, despite staff telling us all creams were kept in the medicines trolley.

Medicines were not always administered safely. The records for two people who were taking Paracetamol four times each day showed that they were given doses of Paracetamol unsafely because the doses were given too close together. Over a period of four days both people were given their tea time doses and bedtime doses at time intervals ranging from two and a half hours to three hours. The safe time interval for the administration of Paracetamol is four hours. They were also given their morning and lunch time doses too close together, on those four days, ranging from 10 to 45 minutes too early. If people are given doses of

Paracetamol too close together their health could be at risk. One person was prescribed a shampoo to be used twice a week. The records showed the shampoo had only been used three times in 23 days. Another person was prescribed an antifungal cream to be used twice daily. The records showed that out of 12 days the cream was only applied correctly on five days. If treatment is not given as prescribed people's health is placed at risk.

Some people were prescribed medicines that needed to be given at specific times with regard to food. Staff told us that they gave all medicines together because they were unaware they needed to be given at specific times. This meant that they administered medicines which must be given with food at the same time as medicines that must be taken before food. If medicines are not given at the correct times they may not work properly. Some people were prescribed pain relief patches that needed to be changed every seven days. The manufacturer's information stated that it was important to change the skin site where the patch is applied every week making sure that at least 21 days pass before the same site is re-used. The records showed that the same sites were reused every seven days which could cause uncomfortable skin irritation. One person looked after their own inhaler however there was no risk assessment in place to show they could do so safely. There were also no checks made to monitor that they were using their inhaler properly.

At our previous inspection January 2018 we found that medicines which were prescribed "when required" did not have protocols, to ensure they were given safely and consistently. During this inspection we saw that some protocols had been put in place so that those medicines could be given safely. However, when the wording on the label stated that the medicine could be given "up to 'X' times daily" staff told us they did not realise that that a protocol was needed to make sure the medicine was given consistently and safely.

Some people were prescribed medicines with a choice of dose, but there was no guidance available to help staff select the most appropriate dose. Staff told us that they did not refer to bowel monitoring charts when selecting doses of laxatives this meant there was a risk that people would receive inconsistent treatment. We also saw that staff failed to record the actual dose given to people which meant that not all medication could be fully accounted for.

These concerns in relation to the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection in January 2018 we found the provider did not have adequate processes in place to help ensure people were protected from the risk of financial abuse. We found this to be a breach of Regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and was meeting the requirements of this regulation.

Since our last inspection in January 2018, the service had not notified us of any safeguarding incidents. However, we were aware of one safeguarding alert raised by other persons directly with the local authority. We discussed this case with the manager who provided details of actions that had been taken to address the concerns raised. We saw that where the service was involved in helping people look after their finances, that staff kept any cash securely in a locked safe. Since our last inspection, the provider had introduced new procedures to ensure there was an audit trail to evidence how people's money had been spent. This included each person having a book that detailed any money taken in or out of their account. Two members of staff signed this record every time money was taken put in, or taken out of a person's account, and it was audited by the provider. Staff also kept receipts for any money spent, and statements were available to evidence how people's money had been spent.

We looked at the services safeguarding policy and found this was not fit for purpose. The policy referred to the responsibilities of a 'domiciliary care manager' and 'operational service manager' in assessing and investigating allegations of abuse. These were positions that did not exist within the service. The policy also failed to refer to important matters that should be considered when making a safeguarding referral or investigating a safeguarding concern, such as people's mental capacity. Despite the organisations documented safeguarding procedure not being robust, staff were aware of their responsibilities in relation to safeguarding vulnerable people from harm. Staff were able to tell us how they would identify potential signs of abuse and neglect, and they were aware of the correct reporting procedures to follow.

At our last inspection in January 2018 we found the provider did not have robust systems in place to ensure staff were of suitable character for the roles in which they were employed. We found this to be a breach of Regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting the requirements of this regulation.

We saw staff had applied for their jobs by completing an application form. In one case we noted that a full employment history had not been obtained as required, and highlighted this requirement with the provider. They subsequently provided us with evidence that they had obtained this required information. Staff had been interviewed to help determine whether they had the required skills and competence for the role. Required checks of identity had been completed, and a Disclosure and Barring Service (DBS) check obtained. A DBS check can provide details of criminal convictions and whether the applicant is barred from working with vulnerable persons. We had concerns at the last inspection that when DBS checks showed the applicant had prior convictions, that due consideration had not been given as to whether this meant the applicant was unsuitable for the role. At this inspection we did not see any records where the returned DBS check showed the applicant had prior convictions. We were therefore not able to assess the adequacy of the procedure the provider was now following in relation to this aspect of recruitment.

Improvements were required to ensure the premises and equipment were safe. We found the front door was secured on both days of our inspection. Staff also kept doors leading to areas with potential hazards such as the laundry and sluice rooms safely locked. Servicing and required checks had been carried out of the gas, electrical, fire and water systems. The home had a fire risk assessment that had been completed by a third party in May 2017, and this had been reviewed in May 2018. We saw that actions identified in the fire risk assessment had been marked as completed, and a spot check of some of these actions confirmed this. For example, we found that door closers were working, and on this visit, there were no clothes stored on the top of dryers in the laundry.

The home had a legionella risk assessment, and had taken steps to reduce the risk of legionnaires disease. This included flushing infrequently used outlets, and monitoring the temperature of hot and cold-water supplies. However, we saw that the temperature monitoring records showed that hot water was not always distributed at a hot enough temperature to adequately control legionella. We also saw that the temperature of hot water from one of the showers tested had repeatedly been recorded as being above safe limits, and was in the range of 58.1 to 61.1 degrees Celsius. This meant there was an increased risk that people living at the home could be scalded. We made the provider aware of this concern and they informed us they would fit a thermostatic valve that controls the water temperature. They also informed us staff were monitoring the temperature of the outlet using a thermometer before supporting people with bathing.

We saw that a competent person had completed the required periodic inspections of lifting equipment including hoists and the passenger lift. However, the bath chair lift had been assessed as being unsafe. There was only one bath at the home, and we saw there was nothing to inform staff or people living at the home that the bath chair was unsafe and should not be used. We raised this immediately with the provider

who told us no-one currently living at the home requested a bath so the chair had not been used. They put a sign up to help ensure people were aware not to use the chair until it had been repaired.

These issues relating to the maintenance of safe premises and equipment were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the spread of infection were not adequately controlled, and we noted areas of uncleanliness around the home. For example, one shower-room contained cracked wall tiles that appeared dirty and would have been difficult to clean. One person's bedroom we looked at had a strong odour of urine, and the flooring was not properly fitted and was lifting in areas around the edges. We saw from records that this room had recently received a deep clean, but this had not addressed the issue. The manager acknowledged that this flooring may need replacing to remove the odour. We also observed one person's wheelchair was dirty, and some of the toilets were not clean during the afternoon of the first day of our inspection. On the first day of our inspection we found a wet chair protector mat, which had an odour of urine and was touching a soft toy bear. Four hours later, the mat had not been moved, and was not moved until we brought this to the manager's attention.

We found none of the dispensers containing hand-sanitiser were working on the first day of our inspection. On the second day of our inspection we found one working dispenser, although the dispenser by the entrance to the home remained out of order. We heard the provider checking that staff were carrying bottles of hand-sanitiser. However, this would not have addressed the issue that sanitiser would not have been readily available to other people visiting the home, including relatives, friends and professionals.

These issues demonstrate that the provider was not adequately controlling risks relating to the spread of infection. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection there had been a reduction in the number of people living at the home from 17 to 13 people. The number of staff on duty on nights had also reduced from three to two. However, there was no documented assessment to demonstrate that the reduction in staffing had been due to a reduction in the overall level of support required by people living at the home. During the day we saw there were sufficient staff to meet people's needs in a timely way. Other than for a relatively short period following meal-times, we saw communal areas were usually supervised by staff when occupied. The provider had informed us following our last inspection that they had changed the way staff took their breaks to help ensure there was always adequate staffing cover. We observed staff talking with one another to ensure people were not left without support at hand for significant periods of time.

On the afternoon of the second day of our inspection, we saw that the staff team consisted of a senior carer, two agency care staff and a new staff member on the first day of their induction. The senior carer briefed staff in relation to people's needs. However, we saw that one member of agency staff needed a lot of direction from the senior member of care staff whilst they were also trying to support other people. We questioned the manager and provider about whether they felt the skill mix of staff on duty was adequate to meet the needs of people living at the home. They acknowledged that it had not been ideal, but assured us it was not a regular occurrence to have such a staff team on duty together. We confirmed this by looking at the staff rotas. The manager spoke about difficulties they were experiencing recruiting suitable, experienced care staff. This had led to an increased use of agency staff at the home. One member of staff commented; "Shifts are always covered, but agency staff don't know people as well as we do."

Is the service effective?

Our findings

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 authorisation 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.

At our inspection in January 2018 we found the provider had made an inappropriate DoLS application, and was not meeting conditions associated with people's authorised DoLS. We found this to be a breach of Regulation 13(1)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and the service was meeting the requirements of this regulation.

Since our last inspection the provider had reviewed all DoLS applications to ensure they were appropriate and contained sufficient information to allow the supervisory body (local authority) to make an informed initial assessment. This had including re-submitting applications that had previously contained limited or incorrect information in them. At the time of our inspection, no person living at the home had an authorised DoLS as the applications were still awaiting assessment.

At our last inspection in January 2018 we found the provider was not acting in accordance with the Mental Capacity Act 2005 and associated code of practice. We found this to be a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service was meeting the requirements of this regulation, although there was scope for the service to further strengthen their approach in documenting capacity assessments and best-interests decisions.

In common with our previous two inspections, we found staff had a reasonable understanding of the principles of the Mental Capacity Act. Staff understood that any decision they took on behalf of another person should be the least restrictive option, and should be in the person's best interests. For example, staff talked about supporting people's 'wellbeing' when deciding what support to provide to them. One person's care plan indicated their medicines could be administered covertly (without their knowledge) if required. We spoke with staff about this and they told us they always offered this person their medicines first. If they declined to take them, staff came back later and offered them again, at which point this person would usually agree to take them. This showed staff were working to provide care in a less restrictive way. Throughout the inspection we heard staff offering people choices and asking for consent before providing any care or support. When people declined support, we saw that staff respected people's decisions.

However, we found that documentation in relation to the covert administration of medicines needed to be improved. We saw evidence that this person's GP and relatives had been consulted and agreed with the

decision to administer medicines covertly if required. However, there was no information about how often this decision would be reviewed to ensure covert medicines were still necessary. We also found limited progress had been made in relation to obtaining evidence of lasting power of attorney documents (LPA) where relatives or others had such legal status that meant they had a decision-making role in relation to defined aspects of that person's care. We made the manager aware of a resource where they could obtain confirmation of LPAs from, and they informed us shortly after the inspection that they had checked for all people living at the home.

Information in people's care plans about their mental capacity and how staff could support them to make decisions, was recorded in variable levels of detail. We also saw that one person who had mental capacity had not signed forms to consent to their planned care, and other people who were indicated not to have capacity did not always have documented best interests decisions in relation to the care they received. This included when the care they received could be considered to be restrictive. For example, one person had a pressure sensor mat placed by their chair that would alert staff if they attempted to mobilise without staff assistance. Whilst staff had decided to do this in that person's best interests to help prevent them sustaining an injury, it was not clear from this person's care plan that staff had considered whether this was the least restrictive way of helping protect this person from harm, or that they had consulted with others involved in this person's care.

We recommend the provider continues to review and develop their processes in relation to documenting and recording capacity assessments and best interests decisions that is in accordance with national guidance.

At our inspection in January 2018 we found the provider was not ensuring the registered manager was adequately supported through the provision of supervision. We found this to be a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a new manager was in post at this inspection, we were not able to look for evidence of ongoing supervision provided to them. However, the manager told us they had not yet been provided with supervision at the time of our inspection. We also found evidence of an ongoing breach of this regulation in relation to the training and support received by staff.

Staff we spoke with told us they felt they received adequate support and training to enable them to meet the needs of people living at the home. The manager's regular audit of the home included a prompt in relation to training, and we saw this had led them to identify further training that might be beneficial to staff. For example, they had identified that additional training in record keeping would be useful. Staff had undertaken a range of training, including recent training in pressure ulcer prevention and care, and use of thickening agents. Thickening agents are added to the fluids of some people who have swallowing difficulties. This training had been provided in response to issues we had identified in previous inspections, and showed action was being taken to help ensure staff had the required competence to care for people safely. Staff had also been asked to review national good practice guidance in relation to the management of pressure ulcers.

We looked at the service's training matrix, which showed several courses where there was a low level of completion. For example, of fourteen care staff, nine had completed safeguarding training, seven had completed MCA/DoLS training, six had completed infection prevention and control training, and seven had completed some training in dementia. These were all topics in which staff working at the home would be required to be competent in to help ensure they could provide support in a safe and effective way that met the needs of people living there. At our inspection in January 2018 we made a recommendation that the provider ensures all staff, including care staff, involved in the preparation and service of food receive food

hygiene training. The training matrix showed four of 14 care staff had received this training.

The manager raised concerns with us as to the process previously followed to promote staff to new roles in the home. They were concerned that adequate consideration had not been given as to whether staff promoted to different or more senior roles, had the required skills and competence for that role. Our review of recruitment, training and supervision documents also highlighted these concerns. For example, we saw one staff member had been promoted to a more senior role. There was no evidence that any interview or other assessment of their skills and ability to undertake the new role had been carried out. There was also no evidence that there had been any review of the training they might require to provide assurances that this staff member was competent in their new role. This was despite this staff member having previously flagged with their supervisor that they were having some difficulties with certain aspects of the role.

The provider was not ensuring that staff had adequate training and support to enable them to carry out the duties they were employed to undertake. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular supervision. Records showed all staff currently working at the home had received a supervision within the past three months. Staff we spoke with told us received feedback about their performance during supervision, and found these discussions useful.

Prior to this inspection, CQC had received information of concern in relation to there being insufficient stocks of food at the home. We spoke with staff and people living at the home and reviewed records of food and fluid intake. These all showed that people received a varied diet, and did not suggest the home had run out of food supplies. We saw staff frequently offered people drinks, and drinks were also freely available from a dispenser in the lounge area. The manager had put a note on the staff notice board to remind them to offer more fluids and ensure people were comfortable during a recent period of warmer weather.

People's care plans reflected any dietary requirements and preferences they had. We found staff were aware of these preferences. We saw that staff asked people for their choice of meal in advance. During meal times, staff checked whether people wanted more to eat they asked people whether they had enjoyed their meals. One person said their meal was "beautiful" and agreed to a second helping. Since our last inspection the provider had recruited a new head chef. They had introduced new forms and paperwork to help ensure staff were aware of people's dietary requirements, such as if they required modified texture foods or a diabetic diet. We saw that people received the support they required to eat and drink over the meal time, though there was a lack of atmosphere in the dining area. One person commented, "We should have some music on. It's boring."

We saw that any support people required in relation to their physical and mental health was assessed and recorded in their care plans, along with any wider social care support needs they had. At our previous inspection we found that whilst there were comprehensive assessments in place, that the care people needed because of any health care needs were not always well documented. We found this was still the case, although the manager had started to introduce new care plans to try and address this issue. There had been no new admissions to the home since our last inspection due to an ongoing local authority embargo. However, the manager commented that they felt some previous placements had not been appropriate, or the assessments not adequate. As a result, they were considering whether people required reviews from social services to determine if their needs would be better met in an alternative home.

Staff supported people to access healthcare services as needed. However, we found records of people's appointments were not always readily accessible. The manager had recognised this issue, which they told

us was due to the staff using the general communication book inappropriately. They had introduced a new record form and briefed staff on the importance of recording people's health appointments and outcomes on the correct sheets to ensure this essential information was easy to locate.

There had been adaptations to the environment to make it more accessible to people living with dementia. However, there was scope for the provider to make further improvements. We saw communal rooms had pictorial signs on them, and large street signs were used to help people identify the main two corridors in the home. Since our last inspection, 'memory boxes' containing personal effects had started to be used. Along with the different colours used on people's bedroom doors, this would help people to identify their rooms. We saw table cloths in use during the meals were patterned with red dots on a white background. This caused confusion for one person who we observed trying to scoop up the dots with a spoon whilst eating their meal. We discussed this with the manager who told us they had also identified that the table cloths should be replaced because of their potential to distract or confuse some people living with dementia.

The weather was warm and sunny on both days of our inspection. However, we saw people were offered very limited opportunity to access outside areas, other than for a short period on the first day of the inspection. The home had a small enclosed front garden that was accessed through a conservatory. There was also a larger garden at the rear of the property. Staff told us people living at the home did not use this garden however, as the ground was uneven and there were trip hazards.

Is the service caring?

Our findings

At our last inspection in January 2018 we noted that staff missed opportunities to interact and engage with people living at the home. The manager told us they had also noticed a lack of interaction at times. They told us they had been encouraging staff to sit and speak with people, including when they were writing up people's care records for example.

At this inspection we saw an improvement in staff member's engagement with people. We observed staff had time to spend chatting socially with people, and staff were attentive to people's needs and wellbeing. For example, we saw one staff member sat discussing a magazine article a person was reading. Another member of staff noticed that a person looked 'fed-up' and sat down with them to check they were okay. The one exception to these positive observations was on the afternoon of the second day of our inspection. At this time we observed one of the agency staff on duty to be stood in the lounge area without interacting with anyone.

Whilst we saw found some positive examples of how staff worked to ensure people's dignity was respected, we also found improvements were needed in this area. We saw one person's care plan stated they liked to have a daily shave, and records showed this was done. We saw the family member of someone who previously lived at the home had sent a letter of thanks to staff at the home for the support they provided to their relative and for the 'care and dignity' they showed them. However, we also identified concerns in relation to steps taken by staff to ensure people were treated respectfully and with dignity.

We saw that plastic cups and plates were used, which could be seen as being more suitable for young children. During the meal-time on the first day of our inspection we observed that one person who had some difficulties eating their meal was sat with two other people who appeared to be more independent. We heard these two-people making derogatory comments towards this person whilst they were eating. Staff appeared to be unaware of this issue and did not intervene. We also found that most people did not have any toiletries in their rooms or en-suites, including shampoo, toothpaste and soap. We asked staff where these products were kept and were shown a cupboard that contained items that were used communally. This meant people were not being offered a choice, nor their preferences respected in relation to use of hygiene products. The manager started to take action to address this issue during the inspection by obtaining and labelling people's personal products.

These issues relating to lapses in treating people with respect and dignity were a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with knew the people they supported well, including information about their interests and social histories. However, the manager also told us they were struggling to recruit people with the right qualities to work as care staff, which meant the service had also started to use agency staff. The manager told us that where possible they always tried to use the same agency staff to help ensure staff and people living at the home could get to know one another. We saw care plans listed people that were important to the person being cared for including family, relatives and advocates. Staff were also aware of any such

relationships that people had, and records showed that people regularly met with friends and relatives where they were involved in their care.

Staff told us they would support people to be as independent as possible by providing them only with the support they needed. One staff member talked about allowing people to do things for themselves, such as getting dressed. They told us it was important to do this, even if it took a bit longer, or if the person could 'get it wrong' sometimes. During the inspection we saw staff were mindful to ensure people's mobility aids such as walking frames were placed within reach. This would help ensure people's safety, as well as supporting their independence. People's care plans also reflected what they could do for themselves and how staff could support their independence. For example, one person's care plan stated that they could be involved in helping to pick out their clothes each day.

At our inspection in January 2018 we identified concerns in relation to staff sharing confidential information about people using the service with people who were not entitled to it, including former staff members. Information received by CQC prior to this inspection suggested that this was an ongoing issue. However, staff we spoke with understood that they should not share confidential information unless there was a legitimate and legal basis for doing so. They told us they believed the inappropriate sharing of confidential information had now stopped following changes to the staff team working at the home. We saw people's paper based care records were kept securely in a lockable filing cabinet, whilst still being accessible to staff.

People's care plans prompted staff to consider any needs arising from people's race, sexuality, religion and culture for example. The manager told us there was no-one living at the home who needed any specific support in relation to their race, religion, sexuality or protected characteristics. However, they acknowledged that the focus had been on ensuring the home met equality and diversity requirements in relation to staff recruitment and employment, rather than on the needs of people using the service.

Is the service responsive?

Our findings

At our previous inspections in August 2017 and January 2018 we found issues in relation to assessment of people's needs and care planning. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found only limited progress had been made in this area, and the provider remained in breach of this regulation.

At our last inspection we noted that the provider was in the process of introducing a new format for care plans, although they had not completed work on this at that time. At this inspection, the manager was in the process of introducing another new format for care plans. This had resulted in multiple care plans being in place for some people, and it was not always clear which information was the most current. We also found information on people's care and support needs was sometimes hard to find or was missing.

For example, we found one person had no care plan in relation to oral care when the support they received with this aspect of care would have been relevant. We also noted during our tour of the home that multiple rooms contained no call bell extensions, and instead just had pressure sensor mats plugged into the call point. Information as to whether people were able to use a call bell was not contained in their care plans. This meant we were not able to determine whether call bells would have been required by these people to call for staff assistance when they needed it. Shortly after the inspection, the provider sent us evidence of new assessments in place that considered whether people needed call bells in their rooms, along with an assessment of any other equipment required to keep that person safe when in their room.

The provider had not yet resolved issues identified at our last inspection in relation to care planning. This included concerns about the variable level of detail recorded in care plans, the lack of meaningful goals and lack of evidence of involving people in developing and reviewing their care plans. People's care plans contained information on their preferences in relation to how they received their care and in relation preferred food and drinks for example. We also saw staff actively offered people choices, such as whether they were supported by male or female staff when receiving personal care. Care plans also contained information about people's social histories, interests and hobbies. However, staff did not use such information to help deliver care in a person-centred way. As at our inspection in January 2018, we saw one person's care plan stated they were unable to participate in their community, whilst another person's care plan stated they were supported to be involved in their community by talking with staff about football. This showed a lack of consideration as to how people could be supported to remain involved in their communities should they so wish. Staff also acknowledged that there were few trips out of the home, including trips to local shops, parks and other community facilities.

The provider was failing to ensure there was adequate assessment of people's needs, and that care was designed to meet people's needs and preferences. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we saw some activities taking place, which were organised by staff on an ad-hoc basis. This included providing people with materials to do some colouring, putting on old films, and having

'singalongs'. We also saw that entertainers regularly visited the home. However, as previously mentioned, there was little evidence that activities were planned around people's stated interests and preferences.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The provider was meeting the AIS by ensuring people's communication needs were identified in their care plans. This included how best to communicate with each person, and whether they used any communication aids including glasses, hearing aids or pictorial communication systems for example. We asked the manager how such information was shared with relevant people when appropriate. They told us people's profile documents, similar to a 'hospital passport' could be shared with relevant others. Profiles identified any communication and other support needs that person had. However, the manager also acknowledged that work was required on these documents to bring them up to a consistently good standard.

We saw the home's complaints policy and procedure were displayed close to the entrance. This would help ensure people understood how they could raise any concerns or complaints they had. Records of complaints showed the provider had identified complaints and had completed investigations when required. We saw there was no formal record in relation to one complaint CQC had been made aware of directly. However, we saw that appropriate actions had been taken in relation to the complaint. We also saw the provider had left themselves a note prior to our inspection, to type up a record of the complaint and their findings.

At the time of our inspection, the home was not providing end of life care to anyone. However, the service had provided end of life care since our previous inspection in January 2018. We found no progress had been made in relation to the training of staff in relation to this aspect of care. Staff told us they felt confident providing end of life care, and were aware of a range of professionals they could contact for support as needed. This included a person's GP and palliative care nurses for example.

Is the service well-led?

Our findings

Since our inspection in January 2018, the former registered manager had left employment with the home in March 2018. Shortly after this in May 2018, CQC concluded enforcement action to cancel their registration as a manager at this location. The provider had recruited a new manager who had been in post for eight weeks at the time of our inspection. However, they told us they did not intend to complete an application to register with CQC to manage the home, and did not intend to remain as the manager of the home in the long-term. It is a condition of the providers registration with the CQC that there is a registered manager in post. We will continue to monitor this, and may take further action if sufficient steps are not taken to ensure the service is managed by a registered manager.

The manager in post at the time of our inspection told us they did not feel they received sufficient support to enable them to make the improvements required of the home. The director of the company and nominated individual were no longer actively involved in the day to day running of the home. A family member/shareholder was now acting as the provider. They did not have a background in the provision of residential social care services, and were still learning about how to run a care home. There was no administrative support, deputy, team leader or similar role to support the manager in their day to day duties. The manager felt they did not have adequate resource to enable them to drive and sustain long-term improvements. They also told us that while they had some experience of 'turning around' poor services, they had not had to manage improvements on the scale of those required at Viewpark. The manager also told us they had received only a limited handover when taking up the post, and they had been required to work out where things were for themselves.

The manager told us that staff morale was low, and staff told us they were worried about their jobs given the home's continued rating of inadequate. Staff told us they had previously not understood the reason for these ratings, but said that the new manager had taken time to go through the report and highlight the areas where improvements were needed. Staff told us they felt the manager and provider's representative were both approachable and told us they were both making changes to improve the quality of the service. For example, they told us new forms had been introduced to help monitor people's dietary intake and use of thickening agents. We saw the manager and provider's representative were both actively involved in supporting people at the home, which staff told us they appreciated. This also helped ensure that management was visible and accessible to staff.

At our last inspection in January 2018 we found the provider was not aware of requirements in relation to the duty of candour. The duty of candour regulation requires that providers act in an open and transparent way in relation to people's care and treatment. It sets out requirements as to what providers must do if something goes wrong. We also found that staff had not always acted in an open and honest way. We found this to be a breach of Regulation 20(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting the requirements of this regulation.

Staff understood the basic principles relating to the duty of candour. However, we found the provider's understanding of the actions they must take, and in what circumstances, needed to be improved. This

would help ensure they could comply with the requirements set out in this regulation should any incidents fall within scope of the duty of candour.

We found evidence of an improved culture in relation to acting in an open and honest way. For example, we saw one member of staff had been involved in a medicines error, which had not resulted in any harm. We saw the staff member had reported this to their manager immediately, which had allowed them to take action to ensure the person was safe. This included contacting their GP for advice for example. The manager had discussed the incident with the staff member to help identify any factors that had contributed to the incident. They had also observed their practice in relation to medicines management before agreeing that they were competent to continue to administer medicines to people.

At previous inspections, including our last inspection in January 2018, we have found governance processes were not adequate to help monitor and improve the quality and safety of the service. We found this to be a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. While some improvements had been made in this area, these were limited in scope, and the provider remains in breach of this regulation.

The new manager had introduced a number of new audits and checks. This included health and safety audits, a kitchen audit and a weekly manager's audit that covered a range of areas including staffing, training and hospital admissions for example. Care plan audits consisted of monthly reviews carried out by staff, and these still did not demonstrate adequate consideration of the quality of care plans. The manager told us their intention was to review all care plans in conjunction with each person or their representative. However, they told us that they had not had sufficient time to make any noteworthy progress with this work given other priority areas they were working on, and due to the lack of management support.

The manager had completed monthly audits of accidents and incidents. These identified any steps taken to help ensure people were receiving safe and appropriate care, such as referrals to other health professionals and a review of the person's risk assessment. However, there was also scope for this analysis to be strengthened by considering any emerging trends or patterns across the home. For example, the provider could consider whether there were certain times of the day or certain locations within the home where accidents were more frequently occurring.

The manager and provider had completed regular audits of medicines, but these had failed to identify the issues we found. We also found the introduction of some systems had not been effectively communicated to staff, which had resulted in issues and poor-quality care. For example, we saw one person was prescribed one milkshake per day to support their dietary intake and help provide them with a sufficient number of calories. We saw there was a sheet for staff to sign to help track that this person had been given their milkshake. However, we saw a second form also in use in early May and identified two separate staff members both provided the milkshake on the same days on multiple occasions. On 17 May 2018 a revised form had been introduced, without all staff apparently being aware of this as there was a missing entry on one day. This demonstrated that change was not always effectively managed.

Other audits had identified areas where improvements were required, but the planned improvements had not yet been fully implemented. For example, there was an infection control audit that had identified some shortfalls in the cleanliness of the environment and equipment. However, there was only one member of domestic staff employed by the home at the time of our inspection, and it had not been possible to address all the areas identified as requiring action. The system of audits and checks had also failed to ensure sufficient improvements were made to ensure compliance with the regulations or to drive and sustain the significant improvements required at the home.

At the time of the inspection, the provider was not able to show us evidence that they had sought feedback from people living at the home, relatives or professionals. We were aware that the local authority had held a meeting at the home for people living at the home, although the home did not have any minutes from this meeting. Shortly after our inspection, the provider sent us examples of completed surveys they had sent out to relatives of people living at the home.

Staff did not widely understand the home's policies and procedures. Policies and procedures were also not always tailored to meet the requirements of the home. As referenced in the safe section of this report, the safeguarding policy referred to the responsibilities of staff in positions that did not exist. Other policies referred to the service as a 'domiciliary care agency' which it isn't. Having policies and procedures that did not fit the services operating model would increase the risk of inconsistencies in the delivery of service.

The paragraphs above demonstrate the systems in place to help monitor and improve the quality and safety of the service were not adequate. This was a continued breach of Regulation 17(1) 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 The provider was not adequately assessing people's needs and acting to deliver care in a way that met their needs and preferences. Regulation 9(1)

The enforcement action we took:

We undertook enforcement action to cancel the registrations of the provider and registered manager.

Action to cancel the registered manager's registration was completed on 21 May 2018. Following the closure of the home, action to cancel the provider's registration was completed on 21 May 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was not ensuring that people were always treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We undertook enforcement action to cancel the registrations of the provider and registered manager.

Action to cancel the registered manager's registration was completed on 21 May 2018. Following the closure of the home, action to cancel the provider's registration was completed on 21 May 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not adequately assessed. Adequate steps were not taken to mitigate risks to people using the service. The provider had not ensured all reasonable steps were taken to ensure the premises and equipment were safe.

Medicines were not managed safely.

Reasonable steps were not taken to control and prevent the spread of infections.

Regulation 12(1)

The enforcement action we took:

We undertook enforcement action to cancel the registrations of the provider and registered manager.

Action to cancel the registered manager's registration was completed on 21 May 2018. Following the closure of the home, action to cancel the provider's registration was completed on 21 May 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to help the provider monitor and improve the quality and safety of the service were not effective. Regulation 17(1)

The enforcement action we took:

We undertook enforcement action to cancel the registrations of the provider and registered manager.

Action to cancel the registered manager's registration was completed on 21 May 2018. Following the closure of the home, action to cancel the provider's registration was completed on 21 May 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring staff had adequate training and support to enable them to undertake the duties they were employed to perform. Regulation 18(2)

The enforcement action we took:

We undertook enforcement action to cancel the registrations of the provider and registered manager.

Action to cancel the registered manager's registration was completed on 21 May 2018. Following the closure of the home, action to cancel the provider's registration was completed on 21 May 2018.