Victorguard Care plc

Willow Bank Care Home

Inspection report

Willow Bank Care Village
Bell Dean Road
Bradford
West Yorkshire
BD15 7WB

Tel: 01274889275
Website: www.victorguardcare.co.uk

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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 6, 14 December 2017 and 18 January 2018 and all were unannounced.

When we inspected the service in December 2014 we identified one regulatory breach which related to staff training and support (Regulation 18). At this inspection we found the provider had made the necessary improvements in this area but identified further breaches of regulations.

Willow Bank Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Willow Bank Care Home can accommodate up to 59 people across two separate floors, each of which have separate adapted facilities. The service provides care and support to older people and people living with dementia. There were 53 people using the service when we inspected. The home was purpose built and provides single bedroom with en-suite toilet facilities. There are lounge and dining areas on the ground floor.

There was no registered manager in post. The Registered Manager was dismissed for their position in October 2017. 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.

Staff were not always being recruited safely although there were enough staff they were not always deployed in a way to keep people safe and to deliver person centred care. Whilst some staff were seen to deliver caring, kind and compassionate care, there were practices in the home which did not treat people with dignity and respect.

Staff were receiving appropriate training and they told us the training was good and relevant to their role. Staff said they felt supported by the manager and were receiving formal supervision where they could discuss their on-going development needs.

People's care plans did not always provide accurate and up to date information about their current needs. Some information was contradictory. Risk assessments were being completed; however, these were not always being followed or had been completed incorrectly. This meant we were not confident action was being taken to mitigate risks to people using the service.

People's healthcare needs were being met and medicines were being managed safely.

People who used the service made some positive comments about the meals; however, we found people's

nutritional and hydration needs were not always being met. We also found people's mealtime experience was poor.

There were some activities on offer and trips out were being arranged. There were also some good links with the local community.

We found the service was working within the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported to have maximum choice and control of their lives and staff supported people in the least restrictive way possible; the policies and systems in the service did support this practice.

Staff knew how to recognise and report concerns about people's safety and welfare.

The home was generally clean, tidy and odour free. However, we did note there was an odour of stale urine in one of the lounges.

There was a complaints procedure in place and formal complaints had been investigated.

There was a lack of leadership and direction for staff, with no oversight of key issues for people's care and support. Systems and processes for monitoring the quality of the care provision were weak and there was no robust management of the service. At the time of the inspection a new management structure had recently been introduced, but it was too soon to be able to assess how effective these changes would be.

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.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not always being recruited safely. Although there were enough staff they were not always deployed in a way to keep people safe and to meet their needs.

Risks to people's safety were not always being mitigated

Staff understood how to report any concerns about people's safety.

Medicines were being managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received appropriate training and felt supported by the manager.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's nutritional and hydration needs were not always being met.

Healthcare needs were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff were caring, compassionate and kind this was not consistent across the service.

Some staff were not treating people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not receiving person centred care which met their needs or preferences.

There was a complaints procedure in place and formal complaints had been investigated.

Activities were on offer and there were some good links with the local community.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service. We identified six breaches of regulations at this inspection.

Willow Bank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 6, 14 December 2017 and 18 January 2018. All visits were unannounced. The inspection was carried out by two adult social care inspectors and two experts by experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was completed by three adult social care inspectors. The third day of the inspection was completed by two adult social care inspectors

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams.

The provider had completed a Provider Information Return (PIR).The PIR is a document which gives the provider the opportunity to tell us about the service. We used information the provider sent us in the PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included eleven people's care records, five staff recruitment records and records relating to the management of the service.

We spoke with 11 people who used the service, ten relatives, one health care professional, seven care workers, two chefs, two activities co-ordinators, two housekeepers, the handyperson, administrator, deputy manager, quality manager and acting manager.

Inadequate

Is the service safe?

Our findings

There was a recruitment and selection policy in place. The quality manager told us as part of the recruitment process the previous manager should have obtained two references and carried out Disclosure and Barring Service (DBS) checks before all staff commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people.

We looked at the employment files of five recently employed staff and found the correct procedure was not always followed. This meant we could not be confident only people suitable to work in the caring profession were employed. For example, we saw an undated letter had been sent out to one applicant offering them a post which thanked them for attending an interview on the 10 June 2017. However, when we looked at their application form we found it was dated the 13 June 2017, three days after the interview date. We also found that although the start date for the applicant was 4 July 2017, one reference had not been received until the 7 July 2017 and the second reference was not dated. In addition, the DBS was dated 31 July 2017. This meant the applicant had potentially been allowed to start work without written references and a satisfactory DBS being received.

We found in other employment files key documents were not dated or references had been received and accepted from individuals not shown on the application form without any evidence they had been contacted to make sure of their origin.

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

This was discussed with the quality manager and provider who acknowledged the correct recruitment procedures had not been followed by the previous registered manager. They confirmed they were now addressing this matter and in future the recruitment and selection procedure would be closely monitored through the internal systems in place.

When we visited the service on day three of the inspection, although no new staff had been recruited, we found the acting manager had introduced a recruitment checklist in order to ensure the correct documentation would be in place.

We were concerned about some of the moving and handling practices we saw on the first day of the inspection. We saw three people being moved by staff using a 'stand aid' hoist. None of these people were wearing shoes or socks and none could stand upright to use this method of transfer properly. The slings being used were under people's arms which meant they were pushing up on people's shoulder joints. We asked the acting manager to make sure peoples moving and handling needs were assessed by a suitably qualified person as soon as possible. We also made three safeguarding referrals to the local authority because of our concerns.

We saw staff trying to move one of these people from the wheel chair to an easy chair. As staff tried to move

them from the wheel chair they struggled to move the person's feet from the foot rest. They explained to the person they needed to move their feet and the foot rest fell off. Staff struggled to move this person successfully and left them in the wheel chair.

On the second day of the inspection we were told the moving and handling assessments had been reviewed. However, when we looked at them we found no updates had been made.

On day three of the inspection the team leader told us in their opinion the stand aid was still the most appropriate equipment for transferring the above service users. This was discussed with the acting manager at the time of inspection and we requested that a further assessment of their needs was made. Following the inspection we received the following information we received further information from the acting manager which confirmed that safe moving and handling practices had not been in place at the time of our inspection.

We saw another person being moved from a wheel chair into a chair using a hoist after lunch in the lounge. Staff tried to transfer this person while another person was in a wheel chair next to the hoist. This meant there was very little room to manoeuvre. When staff transferred this person in to the chair the safety straps got stuck in the hoist and pulled the person forward tightly. They winced in pain. Staff struggled to free them and did speak to the person gently and explained what had happened. This person was not happy and told them so.

Risk assessments were in place where areas of potential risk to people's general health, safety and welfare had been identified. However, we found care plans contained conflicting information about people's needs. For example, in the front section of one person's care plan it stated they walked with the assistance of one carer. The mobility care plan also reflected this information. However, we saw in the review information they were no longer mobile and required the assistance of two staff a stand aid and a wheelchair.

The fact they were no longer mobile would have increased the score on their pressure ulcer risk assessment. However, this had not been done by staff. We spoke to a senior care worker who agreed the score should have been increased. If risk assessments are not accurate they will not be informing staff of the action they need to take to mitigate risks to individuals.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the nutritional care plan for one person had not been updated after a significant deterioration in their general health which meant they were now receiving palliative care and were on permanent bed rest. We spoke with relatives visiting the person and they told us at every meal time staff still brought a full meal to their room even though they were unable to take even small amounts of fluids without choking. When we looked at the nutritional care plan and other care plans relating to the persons care and treatment we found they had not been updated to reflect the person's current needs. This was discussed with the quality manager who took immediate action to resolve this matter.

The weight records for one person showed they had lost 9.2kgs from January – November 2017. Their nutrition and hydration care plan had been written in September 2017 and stated the following, "[Name] has a good to moderate diet intake, [Name] has, however, lost weight month after month. This is most likely to be [Names'] reluctance to get up for breakfast in a morning." We could find no evidence within the care file of this person being seen by a GP. However, the deputy manager told us they must have been as they had been prescribed a nutritional supplement drink.

Prompted by feedback from the second day of the inspection on day three we found a discussion had been held with the person's GP regarding their weight loss. The GP had carried out a review of their medicines with a view to making them less lethargic in the morning. The GP had been due to visit the home but was unable to get there because of the weather conditions they had therefore contacted the home by phone. The record of the discussion with the GP showed they had instructed staff to ensure when this person was awake and compliant they must ensure they got sufficient to eat and drink. We saw there was a food and fluid chart in place which had been completed correctly but did indicate there were problems in the morning. We were concerned that had Inspectors not brought this to the attention of staff this action may not have been taken.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us generally they received their medication on time. These were some of the things they told us, "Four times a day I have pain all the time they give me paracetamol when I require it." "I get them (tablets). If there is an emergency at night I often don't get them until around 11.45pm, there is often only one staff giving out medicines at night." Relatives told us, "They give her them at a certain time." "I presume she does have no problems with her health since she arrived here."

On day two of the inspection we looked at the medicines management systems and found they were not always being managed safely. However, on day three we found improvements had been made guidance had been put in place regarding the administration of 'as required' medicines and for medicines which need to be given at specific times . We were concerned that the medicines systems in place were not sufficiently robust to ensure these issues were identified and addressed prior to this Inspection.

Medicines were stored safely and storage for medicines classed as controlled drugs was compliant with current legislation.

We observed a senior care worker administering medicines. They wore a tabard which informed people they were administering medicines and should not be interrupted. We saw they were kind, caring and took their time. They knelt beside or sat with people until they had taken their medicines, offering encouragement when needed. We were told all the staff involved in giving people their medicines had competency assessments. When we looked we found only one competency check was up to date.

Medication administration records (MARs) were consistently signed demonstrating people received their medicines as prescribed. Most MARs had photo identification, but this was missing for some. A recent admission had a hand written MAR in place. The MAR had been checked by a second person to ensure all information was entered correctly.

Safe stock control measures were in place. The person responsible for medicines administration counted boxed medicines each time these were administered, including when PRN medicines were offered. This ensured any discrepancies were identified and actions taken immediately. We checked a number of stock balances and saw these corresponded to what should have been present.

Separate printed medication administration records were in place for topical medications such as creams and lotions. These were printed by the pharmacist and included a body map of where cream or lotion should be applied. These MARs were kept in people's bedrooms and completed by staff when they had applied the cream or lotion. These MAR's were inconsistently completed so there was no assurance creams and lotions were being applied as prescribed. On day three the acting manager told us they were auditing

these records and improvements were being seen.

Some people were prescribed medication to be given on an 'as required' basis. We found there were no robust person centred protocols in place to ensure these medicines were given consistently and appropriately. We observed one person being administered 'as required' medication without being asked. The senior care worker told us this was because the person always wanted it in a morning although her care plans did not reflect this. We saw another person had been prescribed 'as required' medicine for anxiety. There was no guidance for staff as to when and what circumstances this should be given. This meant there was a risk of inconsistent administration of these medicines. On day three we found the necessary guidance had been put in place.

Some medicines were prescribed with particular instructions about when they should be taken. For example, some medicines needed to be taken half an hour before food and other medicines needed to be taken at specified times throughout the day. We found these instructions were not always being followed. On day three we found there was a new procedure in place for administering medicines required to be taken before or after food.

One person who used the service said, "No, I don't feel safe here because I can't see very well. They don't tell me what's going on. I don't think there are enough staff, there are times when they are run off their feet." "I'm not happy here, it's the way it is. We are sat in here until 21:00 hours every night, it's ridiculous. We used to be able to go to bed earlier but not now. There should be more staff. What annoys me they are together and they don't mix. They just like to go out there together for a cigarette."

The deputy manager told us sufficient staff were employed for operational purposes although in line with other care services recruitment was on going. At the time of inspection the service was recruiting for both care assistants and senior care assistants on day and night duty. The deputy manager confirmed that to ensure staffing levels were maintained permanent staff members would work additional hours, bank staff were employed from other care homes operated by the same provider or agency were employed. They confirmed that if bank or agency staff were employed they tried wherever possible to use the same staff member to ensure people received continuity of care.

The staff we spoke with told us following a recent change in policy they were now split into three teams of two. Two teams assisted people on the first floor of the building and one team assisted people living on the ground floor. In addition, a staff member worked 8am until 1pm specifically to assist with the meal time service. Elizabeth wing, the specialist dementia care unit had its own designated staff team. In addition, we were told a new 'Team leader' post had been introduced to improve communication within the home.

Staff told us they felt the new arrangement worked well and there were sufficient staff on duty to meet people's assessed need. However, we had concerns about how the staff were deployed.

For example, on the first day of inspection we found while care staff were busy assisting people to get up and dressed and the senior care assistant were administering medicines there were periods of time when there was only the activities coordinator assisting people in the main dining room and adjoining lounge area. We observed one person who was sat with a relative became distressed and called out for assistance but there were no staff in the vicinity. A staff member did eventually arrive and the person's needs were met.

Following the lunchtime meal we found the level of activity in the main lounge became chaotic with people being brought in to the area in wheelchairs. Whilst staff were using a mobile hoist to assist a person the activity coordinator was setting up floor games for people to participate in. There appeared to be a lack of

leadership and coordination which ultimately led to an incident whilst one person was being hoisted.

Two relatives we spoke with also raised concerns about the staffing levels at the weekend which they considered were not always adequate to meet people's needs. One relative said 'During the week there is normally staff around but at weekends you have to go looking for them. I don't think they always cover shifts if someone rings in sick."

On the first day of the inspection on Elizabeth wing there was one senior care worker and two care workers on duty. During the morning there was also one of the activities co-ordinators present on the unit who helped with breakfast and general supervision as well as providing activities. On the second day of our visit this person was on holiday and their duties had not been covered by another staff member. This meant the three staff on duty were trying to get people out of bed, washed and dressed. Serve breakfast, offer general supervision and reassurance. We saw one person who used the service seeking the company of staff constantly during the early part of the morning. Staff were patient and each time took them to the lounge to sit down. As soon as staff left they got up again and this process was repeated a number of times. Because staff did not have time to spend with them this resulted in them becoming quite cross.

On the first day of the inspection one of the activities co-ordinators had told us this person liked listening to music. We asked staff if they though putting some music on may help as the TV was on but no one was watching it. One of the care workers did this and sat with the person until they settled. We then saw the person sitting tapping their hand to the music and relaxing. We concluded if an additional member of staff had been present during the morning this person's needs could have been met in a more timely way. After we told the quality manager about the activities co-ordinator role not being covered they sent another care worker to assist, which we saw, gave staff more time to spend with people.

In one person's care plan we saw to keep them and others safe they needed regular staff support. We saw they were left alone in the lounge with no staff supervision. This potentially put both them and the other people sat in this area at risk.

We concluded staffing numbers and deployment of care workers needed to be reviewed to ensure care workers were available to offer support in a timely way.

On day three of the inspection we found there had been no increase in staffing levels. However, the acting manager had looked at the way staff were deployed during the day to make sure staff were always available in the lounge areas.

The acting manager told us the new system of splitting the care staff into four staff teams was now fully embedded and working well and the new role of team leader continued to be developed.

In addition, the acting manager had carried out an analysis on people's dependency based on their needs and the number of staff required to assist them and was confident the home was correctly staffed.

At lunchtime the fire alarms sounded and this was not part of a planned test. The inspection team went to the main entrance where the fire panel was located. No one told them what was happening or what action was being taken. After it had been established it was a false alarm we spoke to the handy person. They told us the procedure was the most senior person on duty would send two members of staff to the 'zone' indicated on the fire panel to see if there was a fire or if it was a false alarm. We saw this was the action indicated on the displayed fire procedure.

We looked at the emergency folder which contained people's 'Personal Emergency Evacuation Plans' (PEEPs) on the second day of the inspection. We found one PEEP was still in the folder but the person was no longer at the home. There was no PEEP for another person who had been admitted at the beginning of the week or the person who had been admitted on the day of the inspection. This was brought to the attention of the team leader who said they would update the file straight away. On the third day of inspection we found PEEPs were in place for everyone who lived at the home.

We saw incidents and accidents were accurately recorded and included a description of the incident and any injury, action taken by staff or management and recommendations to prevent reoccurrence. We saw that these records were analysed and reviewed as part of the internal audit system. Monitoring accidents and incidents can assist management to recognise any recurring themes and then take appropriate action; helping to ensure people are kept safe.

We saw between 12 April 2017 and the 31 May 2017 there had been 40 recorded falls during the night some of which were for the same people. As a result of this the registered manager in post at that time had, after discussion with the night staff determined that the one hourly observation checks done by night staff could be disturbing some people and making them 'wondersome.' As a result the night staff had been advised to only carry out observation checks on a two hourly basis. Subsequent records showed the number of falls during the night had reduced. Additional measures had also been introduced for individual people such as the introduction of pressure/falls mats and bed rails. The training matrix also showed that all staff had updated their falls training in July 2017 facilitated by the falls prevention team.

We saw the provider had a policy in place for safeguarding people from abuse which provided guidance for staff on how to identify different types of abuse and the reporting procedures. The service also had a whistle blowing policy which provided guidance to staff on how to report matters of concern. In addition, the quality manager told us they operated an open door policy and people who used the service, their relatives and staff were aware they could contact them at any time if they had any concerns.

The staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local authority's Adult Protection Unit and the Care Quality Commission if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the quality manager knowing that they would be taken seriously.

We looked at the safeguarding file and found the Commission [CQC] had also been notified of all referrals made by the service to the Local Authority Safeguarding Unit.

In one person's care plan we saw they had been found on the floor in one of the lounges. The fall was un-witnessed by staff. The person told staff another resident had done it and later said it had been a gang. They sustained a skin tear and a lot of bruising. This incident was not reported to the safeguarding team or the Commission as required. This was an isolated omission.

The quality manager was holding money for some people who used the service. We saw receipts were obtained for any purchase made. We found the system robust which showed us people were being protected from financial abuse.

The service was split into a residential unit and Elizabeth Wing. The accommodation in both was arranged over two floors. On both units there were lounge and dining room facilities. All of the bedrooms were single

occupancy with en-suite facilities.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

The home was generally clean, tidy and odour free. However, we did note there was an odour of stale urine in one of the lounges. We saw staff had access to personal protective equipment, such as gloves and aprons and were using these appropriately. Two of the housekeepers told us they had cleaning schedules and had all of the necessary colour coded equipment. People who used the service told us, "When I have a bath (once a week) they change my bed." "The cleaning here is better than it was." "It [the cleaning] has improved recently they have some good cleaners now."
"It seems to be when there is a smell it is dealt with."

We saw at the last food standards agency inspection of the kitchen they had awarded the home five stars for hygiene. This is the highest award that can be made. This showed us effective systems were in place to ensure food was being prepared and stored safely.

Requires Improvement

Is the service effective?

Our findings

We spoke with the two chefs on duty and found they were knowledgeable about people's specific dietary requirements and had their own file in the kitchen with information relating to this. The cooks confirmed senior staff kept them up to date with any changes in people dietary needs and they were able to provide a range of special diets on request.

We were informed that menus were completed by the catering manager employed by the organisation and rotated on a three weekly basis and people who used the service had input in to menu planning through the regular 'residents' meetings. Generally people using the service told us the meals were good and there was a choice on offer every day.

We found that an assessment of people's nutritional needs and food preferences had been completed as part of an assessment of their care needs.

The quality manager told us if they had any concerns about people's fluid and food intake or if someone had experienced significant weight loss they were put on a 'food and fluid' chart.

On Elizabeth Wing there was no information on display about what meals were on offer on the first day of our visit. The senior care worker told us it would be roast dinner as there was always a roast on Wednesdays.

At 8:45am on the first day we saw four people sitting at the dining tables on Elizabeth wing. No one had a drink in front of them. One person told us they had been up for ages and had not had a drink yet. The senior care worker then made people a cup of tea. There were fruit juices in the kitchen but no one was offered these. We asked where breakfast was and the senior care worker told us they were waiting for the trolley to come up from the kitchen. At 8:50am one person was swearing and saying they were hungry and wanted something to eat. We asked the senior care worker if they had cereals available and after this people were offered cereals. However, they had to wait as there were no cereal bowls in the kitchenette and one of the activities staff had to go and get some from the main kitchen. It was 9:00am before the person got some cornflakes.

There was cooked breakfast and porridge available when the trolley arrived from the kitchen. Two people were asked what they wanted and both said they would like egg and bacon. When their plates arrived they had been served bacon, egg, sausage, beans, tomatoes and toast. Some people were not offered or shown what was on offer for breakfast.

At lunchtime all of the roast pork dinners arrived ready plated and were served from the hot trolley. People were not told what there was to eat or offered an alternative choice. This meant people who used the service could not choose the elements of the meal they wanted/liked.

One person was given a beaker of tea at breakfast time, which we saw they did not drink. Mid-morning they

were given another beaker of tea which again they did not drink. They were not offered anything else to drink until lunchtime when they were given a beaker of juice. We did not observe the whole of the lunchtime meal but the deputy manager told us they drank all of the juice.

We brought our observations to the attention of the quality manager and following discussions with staff they told us the person did not like tea and preferred juice. We asked why the person had been given tea to which there was no satisfactory answer. This person's fluid intake was not being monitored and staff reported the person drank well; however, this was not the case from our observation.

At lunchtime we saw a meal was placed in front of the same person who made no attempt to eat. The deputy manager stopped and gave them a forkful of food and then left. A care worker did the same as they came through the dining area. The senior care worker then sat with the person and assisted them with their meal.

On the second day of our inspection we looked at this persons eating and drinking care plan. In one section it stated they liked tea with milk and no sugar. In another section it stated, "[Name] rarely drinks tea but when they do they prefer it black with no sugar." In another section of the care plan it stated they liked to drink orange juice. On the third day of the inspection we looked at this persons eating and drinking care plan again. The plan had been reviewed but no changes made to the type of drinks the person liked.

We also saw one person who used the service had fallen asleep in the residential lounge area with a beaker of tea in her hand. This happened both in the morning and following the serving of drinks in the afternoon. On neither occasion did they drink the tea. Although staff were present in the lounge area on both occasions they did not encourage the person to drink.

We saw one person's risk assessment had indicated they were a high risk nutritionally and they only weighed 32.4kgs. We saw they had been seen by a dietician and their care plan stated, "Small portions, little and often. High calorie snacks between meals, 2-3 cups of whole milk a day. Prescribed ensure juice and pro-cal shots." We looked at the records of their food and fluid intake over two days. There was no evidence of whole milk being given or of high calorie snacks being given between meals. On the third day of inspection we looked at records and found they had been receiving their pro-cal shots and Ensure drinks. We looked at the food and fluid charts for three days, there was no evidence of whole milk being given or high calorie snacks being given between meals. However, records showed their appetite had increased and this person had gained weight.

We saw all of the fluid charts in use stated people's intake should be at least 1000mls a day. The Royal College of Nursing's Hydration Best Practice Toolkit for Hospitals and Healthcare recommends people having 30mls of fluid per kilogram of weight. This meant each person's desired fluid intake would be different.

We saw one person's fluid intake one day was 795mls and 670mls on another day. Based on the above calculation with their weight being 32.4kgs their fluid intake should have been 972mls or over.

When people were prescribed dietary supplements this was recorded on their medication administration record [MAR]. Senior care staff who administered medicines were also responsible for giving people their dietary supplements and recording this on the MAR. One person who had been prescribed dietary supplements had not received these for two days as the stock had run out. Care staff were responsible for recording the amount consumed on peoples fluid monitoring charts, however, these charts had not been consistently completed.

We concluded peoples nutritional and hydration needs were not always being met.

This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection a new admission arrived at lunchtime. Care workers did not know they were coming and did not know anything about them. One care worker spoke to them but had no time to spend with them as it was lunchtime. The care worker spoke to one of their colleagues to try and decide if they should bring the person into the dining room or leave them to have lunch in the lounge. We looked at this person's needs assessment and saw it contained only minimal information and was not sufficient to devise a care plan from. This demonstrated a lack of person centred care.

On day three of the inspection we looked at this person's care plan and found risk assessment in place. Although these were still very much a work in progress there was sufficient information within the documentation to enable staff to provide personalised care.

The care plan was person centred and showed their likes and dislikes. For example, the type of food they preferred and the time they liked to retire to bed and get up in the morning.

There was also evidence to show staff had contacted their GP regarding a review of their general health and they had been seen by the chiropodist since our last visit. The team leader told us this person had settled in very well and we saw they appeared happy and content on the day of inspection.

The quality manager told us all new staff received comprehensive induction training and there was an expectation that all new staff employed with no previous experience in the caring professional had to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We were told the organisation had a designated training officer who had overall responsibility for ensuring staff training was up to date and the majority of training was completed in-house although some training specific to people's needs was provided by external training providers. We looked at the staff training matrix and found staff received appropriate training to meet people's assessed needs. The training matrix indicated how often staff were required to update their training and there were triggers in place to ensure they did so. However, we found eight senior staff members had not updated their First Aid and Basic Life Support training within the three year timescale. This was discussed with the deputy manager who took immediate action to address this matter.

The deputy manager told us the service had recently moved away from distance learning and wherever possible provided staff with more face to face classroom based training. This was so that staff could interact with their peers and the trainer could be confident individual staff members had fully understood the course content.

December 2014 we found the provider was in breach of regulation 18 (Staffing) because staff training was not up to date and some staff did not receive appropriate support through supervision. On this inspection we found improvements had been made.

We saw individual staff training and personal development needs were identified during their formal one to one supervision meetings with the manager. We saw that supervisions were structured and all members of the staff team including the catering and housekeeping staff received formal supervision. In addition, we

saw each staff member had an annual appraisal which looked at their performance over the year.

People who used the service told us their healthcare needs were being met. One person told us, "They all come in [healthcare professionals]. Optician twice a year and if you want a Doctor, they get one." They added one day they were in pain and staff got the Doctor, "I had a pain in my side and I wanted to see a doctor. I complained in the morning and the Doctor came that afternoon. I was really happy it showed they care." One visitor told us that recently their relative had required a doctor. "She had a gooey eye they phoned the Doctor and she got some drops." Another relative said that they got invoices for the dentist and chiropodist so she gets to see them. "There was an issue on Sunday and they got the Doctor on Monday." They were happy with this arrangement.

A district nurse told us staff were vigilant in relation to people's healthcare needs. For example, if they suspected someone had a urinary tract infection they would get a sample and test it. This meant early treatment could be sought. They also explained if care workers had any concerns which were not urgent they wrote them in the district nurse communication book. District nurses visit the service on a daily basis so could look into any concerns in a timely way.

On the second day of the inspection we sat in on the staff 'handover' at which staff were made aware of any changes in people's care and treatment requested by other healthcare professionals. Staff told us they always followed the guidance and advice given by other healthcare professionals and worked in partnership with them to ensure people received appropriate care.

In the care records we looked at we saw people had been seen by a range of health care professionals, including GPs, community mental health team, district nurses, dieticians, opticians and podiatrists. We concluded people's health care needs were being met

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was acting within the Mental Capacity Act. People's capacity to consent to their care and support arrangements was assessed.

Where people lacked capacity and it had been assessed that the accumulation of restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made. There were two current authorised DoLS in place with other applications awaiting assessment by the local authority. Both of the authorised DoLS had conditions attached to them which had been met by the service.

One of the senior care workers told us one individual received their medicines covertly, for example, disguised in food. Information from the GP, pharmacist and family was present to demonstrate this best interest decision. A care plan was also present explaining how medicines should be administered.

The quality manager knew which relatives or representatives had Lasting Power of Attorney (LPA) in place. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no

longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare. This showed us the quality manager understood their responsibilities to act within the legislation.

The accommodation was spacious, with wide corridors, which provided easy wheelchair access. We saw clear signage on bathroom and toilet doors and people's bedroom doors had a photograph and name of the person to help them identify their room.

Requires Improvement

Is the service caring?

Our findings

People who used the service and relatives had mixed views about the staff. Their comments included, "I think there are one or two staff who are really nice and caring but I'm not so sure about the others."

People were not always treated with dignity and respect. Some people who used the service had not been supported adequately with their personal appearance. We saw men had not been shaved, some people had dirty fingernails, some people were wearing dirty clothing and some people had not had their hair brushed or combed. Two hours after lunch, we saw one person who used the service had pieces of carrot in their neck area.

At breakfast time on Elizabeth Wing the dining tables had not been set with any tablecloths, cutlery, crockery, serviettes, condiments or sauces. People who used the service were given cups of tea without any saucers. One person asked for some tissues and was given toilet paper. Two people ate their cooked breakfast with their fingers but did not have anything to wipe their hands with after.

A care worker put 'Smooth' radio on in the dining room during breakfast, without consulting any of the people who used the service about what they might like to listen to.

In the residential lounge during the morning drinks service we saw a member of kitchen staff gave one of the people who used the service [who was visually impaired] two wafer biscuits in their hand. This person was not offered a choice of biscuit and they declined the wafers. The wafers, which had been touched by the staff member and the person who used the service, were placed back in the box of biscuits.

A care worker was accompanying a district nurse who had come to administer people's Flu vaccinations. We saw some people were taken to their bedrooms, however, we saw vaccinations administered to three people in one of the lounges. No attempt was made to preserve people's privacy.

One person who used the service was shouting out in the dining room. They were not happy that a person was seated near them and wanted them to be moved. Staff went to talk to them and told the person to, "Be Nice." Staff did not move the person away from the table.

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
On day three we spoke with the acting manager and provider about mealtime and they acknowledged improvements were needed to make mealtimes a more sociable and relaxing experience for people. The provider told they had ordered new tables clothes but they had not arrived therefore they intended to have them made for both units. They confirmed that tables would be set with cutlery and condiments prior to the mealtime service.

People who used the service and relatives made the following positive comments about the staff, "Yes the staff are caring, they are always asking me if I am alright." "[The staff] are very kind, I help myself they always

keep an eye on me." "The staff seem to love [Name]. They have a joke and look after him well." "The staff are fantastic with [name]. They seem to look after her very well". "The staff are wonderful with the people and so patient. I think it's the best place for [Name]."

We saw some caring interactions between staff and people who used the service. For example we saw care workers moved one person to make them more comfortable in their wheelchair and adjusted their feet on the foot rest. They then asked a person if they wanted the toilet. Another care worker brought a person into the dining room in a wheel chair. This person was being quite loud and was shouting out. The care worker was kind and patient. They addressed the person by name and spoke quietly and calmly and the person calmed down.

One relative we spoke with told us they had been involved in the care planning process and invited to attend a review meeting. They said, "I have always been heavily involved in [Name of person] care and support and on admission I made it clear to the manager that I wanted to be kept fully informed of any changes to their care plan. I am happy to say I have been and I am pleased with the way things have worked out."

One person who used the service said they were supported with their independence and could go out whenever they wanted. "I tell them where I am going and what time I will be back."

We saw staff encouraging people to eat and drink independently

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the quality manager, staff, people and visitors demonstrated that discrimination was not a feature of the service.

Requires Improvement

Is the service responsive?

Our findings

We spoke with one person who used the service and they had difficulty hearing us. We looked at their care plan and saw they needed a hearing aid for their left ear, they were not wearing this. The care records in their bedroom indicated the last time staff had had assisted them with their hearing aid was on Sunday 3rd December 2017. A senior care worker told us the hearing aid had been broken when they had worked on Saturday 2nd December 2017. The hearing aid could not be found on the first day of our visit and no request had been made to have it repaired or replaced. Having been prompted by our feedback after the first day of inspection on the third day of inspection we saw this person was wearing their new hearing aid.

We spoke with another person who used the service and their visitor. They told us two of their hearing aids had been lost. We saw there were two empty boxes in their bedroom which should have contained hearing aids. They told us they could not hear properly and we had to speak into their left ear as that was the better ear for them to hear us. They also told us their glasses had gone missing and the pair in their bedroom were not theirs. They told us they could not see out of them. We looked in this person's care plan which confirmed they needed glasses and a hearing aid.

We spoke with this person and their visitors again on day three. The visitors told us that the person's hearing aids or glasses had not been replaced. The person who used the service told us, "I can't see or hear anything. There is no lock on my door, people keep taking things." We spoke to the deputy manager who informed us the person's hearing aid had been replaced but they keep taking it out and leaving it places. The hearing aid was currently in an envelope in their care plan file. We checked the records which showed us no contact had been made with the optician.

A relative told us, "[Name] has two pairs of glasses that have gone missing and the pair in her room was not hers. I took them to staff. Two sets of teeth have also gone missing we have asked for a referral to the dentist that has not happened." On the third day of inspection we checked this person's care records and found new glasses had not been ordered and no referral to the dentist had been made.

A care worker told us there was a problem with glasses, hearing aids and dentures going missing.

We saw one person sitting in the lounge at lunch time; their trousers were wet as they had been incontinent of urine. A care worker came and put an apron on them but did not notice they were wet. The person was then assisted by a care worker with their lunch. It was one hour and ten minutes before they were taken to the toilet and changed.

We saw one person who used the service had a very 'runny nose.' After lunch staff had left them sitting in the lounge but had not left them with any tissues so they were unable to wipe their nose. This was very undignified for them.

We saw another person who used the service was wearing dirty dentures. We looked at their care plan and saw they required support from staff to clean their own teeth and to soak their dentures. We looked in their

bedroom and saw the denture pot was dry and dirty and the two toothbrushes were dry. On the second day of the inspection we found the same things when we looked in their bedroom. On the third day of inspection we looked in their bedroom again and saw the denture pot and the two toothbrushes were dry. We checked the daily records which indicated they had been supported with their oral hygiene needs. Whilst speaking to the person we saw their dentures were dirty, and they had not been supported adequately with their personal appearance. They were wearing a cardigan with a vest and no other top. We concluded they had not received the support their required to meet their oral hygiene needs.

We saw one person had been assessed as being at high risk of developing pressure damage to their skin. We saw a specialist mattress had been put in place as a result of this assessment. However, when we went to see this person, who was in bed, we saw the mattress was on the very highest setting. We spoke with a visiting district nurse who agreed for a person who only weighed 32.4kgs this would not have been the correct setting. There was no information in the care plan to inform staff what setting the mattress should have been on. If these mattresses are not on the right setting their therapeutic value can be lost and increase the risk of tissue damage.

On the first morning of the inspection we spent an hour and a half sitting in the residential lounge area. One of the people who used the service was constantly calling out for help. They were ignored by staff but settled when their visitor arrived. During this time we saw four members of staff smoking together directly outside the lounge area where the person was calling out "Help me please, help." This was discussed with the quality manager who confirmed three of the staff were care assistants on an allocated smoke break. However, they acknowledged this had reflected poorly on the service and they needed to review how breaks were allocated and taken in the future. At lunchtime on the second day we heard the same person calling out for help. We looked at their care plan which stated they would often call out for help and would need staff to sit with them to offer reassurance and then they would calm down. We saw three staff members were standing talking to each other who did not give this person any attention or reassurance.

On the second day of the inspection we saw one person coming to breakfast and they were asking for the toilet. We heard staff tell them they had already been. This person continued to ask for the toilet for a further 20 minutes before being taken.

We concluded people who used the service were not receiving person centred care which met their needs.

We found people were not supported to plan for their end of life care. For example, one person's care plan contained information about them wishing to be cremated and their preferred undertaker. There were no further details about how they wished to be cared for at the end of their life.

The service had an 'Accessible information policy,' which they had received on the first day of our inspection. The accessible information standard aims to ensure people have access to information they can understand and the communication support they may need.

We looked at the care records for one person and found the communication care plan dated 2 June 2017 stated the following '[Name of person] is registered blind and so staff will need to explain all care procedures before they are carried out so [Name of person] knows what to expect. [Name of person] is also hard of hearing and wears hearing aids. Staff are to make sure they have them in at all times. Staff will sit next to [Name of person] and hold their hand and speak clearly to them so that they know we are talking to them.' The person concerned told us, "Three of them came in early one morning to get me ready quickly and said I had an eye appointment at the hospital that morning. They rushed me off without breakfast although they did pack me up a bacon sandwich and a carton of orange juice. They don't tell me anything here. They

seem to think if they put a notice up then everyone knows what's happening but I don't because I can't see very well. Sometimes it's like getting blood out of a stone. I asked is the hairdresser coming today. When there is a room full of staff all chatting together and no one answers you." From the comments made by the person and our observations it was apparent staff were not providing care and support in line with the agreed care plan or their Accessible Information policy.

We looked at the care records for another person who had communication difficulties due to being deaf in one ear and only having 10% hearing in the other ear even when wearing a hearing aid. The person could lip read but their relatives had bought a wipe board so that staff could write things down for them thereby making it easier for them to understand what was being asked of them. However, they told us staff had never used the board effectively and it had really only been used by relatives to leave messages for staff. One relative said "It's a pity really I am sure it would have been of benefit and enable [Name of person] to communicate better with staff. However, it is a lost opportunity as their general health as deteriorated and they are now on palliative care and are not really communicating at all."

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew about their or their relatives care plans and if they were involved in making decisions about their care. These were some of the comments people made, "We are meeting up on Monday to update the care plan." "They write it down and if you are satisfied you sign it." "We have been we signed a plan about six months ago." "I had a meeting about mum a while ago that could have been it." "I do I sign it when I have read it." "Sometimes she has a key worker staff change and we were not informed."

Most people we spoke with knew who to go to if they had a complaint. They also said if they had a problem they felt they would be listened to. These were some of the comments people made, "We do, we can find out if we have to take things further." "I would speak to the manager." "Speak to staff in charge then the manager."

We saw the complaints procedure was in place. The complaints file showed two complaints had been logged in the last 12 months. Both complaints had been investigated, recommendations made and conclusions provided to the complainants.

One relative told us they had complained. "We have a couple of times they have been dealt with quickly we were happy with the outcome." This demonstrated complaints had been dealt with

We asked people who used the service and relatives about activities which were on offer. They made the following comments, "There's not much going on for them here. They don't get taken out as they don't have a minibus." "No there aren't any activities here." "Nobody has talked to me about any activities." "They are lacking in activities here. I can't see to play bingo. Why can't they do chair exercises? The only time when I have been out was when my friend took me out when it was my birthday." "In the afternoon [Name of one of the activities co-ordinators] comes to do some singing with her she likes singing." "She used to have her nails done. She does not like the bingo, she has never been out and she does like the entertainment." "I go out quite a bit I have plenty of freedom. I go to play bingo a mini bus picks me up and brings me back I go twice a week. Also once a week I go with a friend into town shopping."

We observed a game of skittles in one of the lounges in the afternoon. People who used the service got involved. Staff spoke with everyone and encouraged those who needed help to get involved. "Here [name] you have a go." "I will help you," giving a person a ball. When that person missed staff gave them another

ball.

Willow Bank Care Home had two full time activities co-ordinators. The daily activities were displayed on a board in the reception area and in the lounge and dining area of the Elizabeth Wing. The following activities were on offer for those who wished to participate; movement to music, bingo, quiz, pamper sessions (nail manicures), arts and crafts, ball games, TV/movies, board/card games, reminiscence, live entertainment, coffee and chat.

The activities co-ordinators had information about each person's preferred activities. Records were kept which showed which activities people had participated in and which ones they had enjoyed.

The activities co-ordinators told us about a 1940's theme day and an Elvis tribute act, which had recently been organised. We saw photographs of both events and were told they were enjoyed by people using the service and relatives. Other entertainment was provided by singers, school choir and visits from a local nursery group.

One of the activities co-ordinators had arranged visits to a coffee morning for "Children In Need" and to Nativity plays in local schools. A Christmas Fayre and Christmas party had also been arranged.

Inadequate

Is the service well-led?

Our findings

The registered manager was dismissed from the service in October 2017. The organisations quality manager had been the acting manager at the service for two weeks when we started the inspection. They were working three days a week to provide management support until a new manager was appointed. On day three of the inspection a new acting manager had been at the service for three days and it was their intention to register with CQC.

There was a quality assurance monitoring system in place designed to ensure the quality of the service and drive improvement. We saw there was an audit plan in place and a range of audits were undertaken by the manager or provider at designated intervals throughout the year.

During the first visit it was apparent that while the audits were being carried out they had not identified some of the shortfalls in the service or taken timely action to address the concerns identified. For example, when we looked at the recruitment files we identified some issues with the documentation. We spoke to the quality manager and provider about these. They told us the documents the previous manager had been using were not the most up to date. This had not been picked up by their own quality assurance system.

We saw an audit of the response times to call bells had been completed in September 2017. This had generated a notice to staff which stated 'call bells were taking over 5minutes to respond to and this was not acceptable.' The next audit in October 2017 identified response times of 5minutes, 5minutes 2 seconds and 7minutes. There was nothing recorded about any action taken as a result of this audit.

No dignity audits were taking place. The quality manager told us it was their intention to introduce 'Dignity Champions,' however, these staff members were not in place at the time of our visit on day one and two. We identified a number of issues in relation to dignity and respect as highlighted in this report.

We saw care plan audits had been undertaken and whilst they had identified, for example, missing photographs they had not identified conflicting or inaccurate information.

The staff we spoke with told us communication and support within the service had started to improve since the recent appointment of the acting manager and the introduction of the post of 'Team leader.' Staff said the quality manager and deputy manager maintained a visible presence and often spent time with them and people who used the service.

However, people told us communication within the service was not always effective. One relative told us they thought the management could be better at communication. "Communication, If you look into anything you will find it will always be communication." Another relative told us they thought communication could be improved.

One visitor told us they had made complaints a number of times about their relative's laundry just being thrown in the bottom of the wardrobe. About a couple of sets of bedding they had provided going missing

and a new coat they had bought had been lost. There was no record of these complaints in the complaints log. The relatives stated they had raised these issues with staff, however, their concerns had not been recorded or dealt with using the complaints procedure.

A new person was admitted during the inspection. Care workers did not know they were arriving or anything about them. No provision had been made for staff to spend time with them to help them settle in and make them feel welcome.

This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day three we found some of the issues we had raised following the first two days of inspection had been addressed. Issues regarding medicines management and deployment of staff had been addressed. One dignity champion had been appointed and various new checklists had been introduced. A residents meeting had been held on the 10 January 2018. Minutes of the meeting and a record of the action taken by management following the meeting were available. This included a daily audit of call bell response times being implemented from week commencing 15 January 2018.

As part of a robust quality assurance system the registered provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls

We asked people who used the service and relatives if they thought the service was well led and did they think the management were supportive. These were some of the comments they made, "The manager is lovely, she is approachable." "They have just changed the management. The cleaning is much better since the new manager came." "Now and again they can be a bit lax, I can't explain it. They know me they talk to me and make conversation. "Seem to be, no complaints." "The old manager knew me the new one I don't know. I talk to staff I feel welcome."

The quality manager was supported by a deputy manager. They explained new team leader roles had recently been introduced to assist with the day to day management of the service. Overall, the inspection team felt there was a general lack of leadership and direction for staff. For example, we saw in one person's care plan they liked sweet things to eat. We saw they made little effort to eat their main course and required the assistance from staff. However, we saw them eating chocolate pudding and custard and scraping the bowl. We asked the senior care worker if there were any 'seconds' and they told us there was always plenty of food in the kitchen. When we pointed out how much the person had enjoyed the pudding, they went off to get a second portion.

We saw staff meetings were held to ensure staff were kept up to date with any changes in policies and procedures and any issues that might affect the management of the service or the care and support people received.

We saw 'relative' and 'residents' meetings where held about every three months and people were encouraged to contribute and discuss matters. Topics discussed were staffing, complaints, menus and activities.

However, people who used the service and relatives did not seem to be well informed about residents/relatives meetings. These were some of the comments they made, "No I don't know about them." "I don't know anything about them." "I know about them I don't go very often." "I'm here most days I don't

know about them."

We did see a notice in the corridor about the last residents meeting which took place in July 2017. The outcome of the meeting had been shared with people who used the service and families on one of the notice boards. The results were displayed as, "You said, we did." For example, increase cleaning hours to reduce the smell of urine and more wheelchairs with footplates. The provider had listened and taken action. People told us the cleanliness had improved and we saw wheelchairs in use had footplates on them.

Some good links with the local community had been established. The library bus called and there were links with local schools and church. Monthly meetings were held with the district nurses to discuss, for example, how improvements could be made. It was as a result of one of these meetings the district nurse communication book had been introduced.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks Regulation 12 (1) 2 (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

	Services users nutritional and hydration needs were not being met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not being operated effectively and required documentation was not available. Regulation 19 (3) (a) and (b)

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 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning notice