Mr & Mrs S Kejiou

Parsonage Lodge EMI

Inspection report

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Ratings

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

Overall summary

This inspection took place on 26 and 28 May 2015 and was unannounced.

At our last inspection on 8 and 9 December 2014 we found five breaches of regulations. These breaches had a moderate impact on people using the service. At this inspection we found continued breaches and further breaches in other areas. Improvements had not been made.

Parsonage Lodge EMI provides care for up to 14 older people living with dementia. The accommodation is arranged over three floors and people's bedrooms and communal bathroom facilities were available on each floor. People could access the garden. There was a stair lift available to the first floor; there is also a stair lift to the second floor.

There was a manager registered with Care Quality Commission (CCQ), but they were not in day to day charge of the service. They told us they visited the service on a daily basis and had appointed a manager to oversee the daily running of the service. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered

Summary of findings

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 provider, who is also the registered manager, was not aware of their responsibilities and did not carry out checks to ensure that people received high quality care and support. Shortfalls in care provision were not identified and followed up. The registered manager did not understand current legislation and did not always follow the guidance, such as 'Guidance on How to Meet Regulations', which is a good practice guide issued by CQC. The registered manager had not notified the CQC of significant events that happened at the service.

The service lacked leadership and direction. The registered manager did not take responsibility for the running of the service. Staff were not aware of their accountabilities. Staff made decisions about people's care without asking for their consent and there was not an open and transparent culture. Audits and checks did not pick up shortfalls. Actions were not taken to make improvements in the service.

People's dependency needs were assessed, but there was no system in place to assess how many staff were needed in accordance with the people's needs. The allocation of staff was inconsistent. Staff rotas showed that there should be a third member of staff on duty between 10.00am and 4.00pm. Sometimes there were only two members of staff on duty during this period and on occasions care staff were also covering cooking and cleaning duties during this shift. Four people needed the support of two staff so at times when only two staff were present people were at risk of not receiving the support they needed and had to wait for help.

Staff recruitment procedures were not thorough and not all of the required information was obtained in line with the provider's policies and procedures. Staff had not received all the training they needed to give them the skills and knowledge to provide safe care and this was a continued breach of Regulations. New members of staff received an induction but were not given supervision during their induction and other staff were not regularly supervised. Staff told us that felt supported and could speak to the manager and ask for advice at any time.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We were told that DoLS applications had been made, but these had not been received by the DoLS authority. These applications had not been followed up by the manager. Systems were not in place to obtain consent from people or from those who were legally able to make decisions on their behalf and this was a continued breach of Regulations.

At our last inspection we identified that risks to people's health and wellbeing were not consistently identified, managed and reviewed. There was a continued breach of Regulations at this visit. Accident and incidents were not monitored, assessed and analysed. Care plans were not consistent with the risk assessments and did not always contain clear guidance about how to support people. Care plans did not take into account people's likes, dislikes and preferences. Information from health care professionals was not updated into the care plans and advice given when people were discharged from hospital was not followed up.

People did not have the opportunity to make decisions about how their care was delivered and when they received it. People were not supported with their continence in line with their care plans. People had not been asked when they would like to get up and some staff made these decisions for people. People did not have an opportunity to contribute to the running of the service and have a say about different things.

People's health care needs were monitored on a daily basis. GP's were contacted when people were unwell. People were supported by appropriate equipment and by the district nurses to reduce the risk of developing pressure sores. People received their medicines when they needed them.

People enjoyed their meals and said they liked the food. Food was prepared to meet people's specialist dietary needs. There was a wider range of activities for people to take part in.

People told us they did not have any complaints. The registered manager had investigated a complaint as requested by the local authority.

Summary of findings

Records were kept about the care people received. Some records were not accurate and did not provide staff with the information they needed to assess people's needs and plan their care. Staff rotas were not accurate and did not show who was on duty and when.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against Mr & Mrs S Kejiou to protect the health, safety and welfare of people using this service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not safe.

There were not always enough staff with the right skills and experience to meet people's needs and provide their care. Recruitment checks were not thorough.

Risks to people were not always assessed. When risks had been assessed, there was not always clear guidance about how to reduce the risk of harm. Accident and incidents were not monitored, assessed and analysed to show any patterns.

Staff knew the signs of abuse and what to do if they were concerned about people's safety.

People received their medicines when they needed them.

Is the service effective?

Inadequate 

The service was not effective.

Deprivation of Liberty Safeguards (DoLS) applications were not followed up. Staff were not following the principles of the Mental Capacity Act 2005.

Staff had not received the training they needed to provide safe and effective care. Staff were not given supervision on a regular basis.

Health care needs were monitored on a daily basis and people were supported to access their GP and district nurses. Advice and guidance was not always followed or updated into the care plans.

People enjoyed the meals and were given choices of food.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Staff did not always talk to people in a respectful way.

Staff knew people and knew what they liked and did not like, but did not always offer people choices.

Staff had good relationships with people.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not always receive the care and support they needed in line with their assessed needs. Care plans did not reflect people's care needs accurately.

People had opportunities to take part in some activities. There was little stimulation at other times to keep people occupied at other times.

Summary of findings

People told us they did not have any complaints. The complaints procedure was on display but could not be accessed by everyone.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager did not understand their responsibilities and had not supported the manager in their role.

People were not involved in developing and improving the service.

The registered manager had not assessed and monitored the quality of the service. The manager carried out audits and checked, but these did not pick up the shortfalls.

Records about the care people received and staff that were on duty were not accurate and up to date.

Parsonage Lodge EMI

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 26 and 28 May 2015 and was unannounced.

The inspection was conducted by an inspector and a specialist adviser. The specialist advisor had experience of services that provide care and support for people living with dementia.

We asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We carried out this visit at short notice because we had received some concerns about the service. The PIR was not due to be returned before we visited.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission and information from the local authority safeguarding team. A notification is information about important events, which the provider is required to tell us about by law.

Most people using the service could not tell us about their experiences. We used the Short Observational Framework for Inspection (SOFI) because many of the people receiving care at the service had dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed how people spent their day and how they were supported.

We spoke with three people and two relatives. We spoke with the provider, who is the registered manager, the manager and five staff, the cook and the cleaner. We had information from the local authority safeguarding team, a commissioning officer and a visiting GP.

We looked at records relating to four care staff, six care plans, and audit and monitoring records, medication records, staff rota, policies and procedures and training records.

The last inspection was carried out on 8 and 9 December 2014 when we found breaches of five regulations.

Requires improvement

Is the service safe?

Our findings

Two visitors told us they thought their relatives were safe. They told us that they felt staff made sure people were cared for safely and that they were not put at risk. When people walked to the dining room, staff made sure that they were supported to do so safely.

People were not always kept safe because there were not always enough staff on duty and staffing levels were not planned in accordance with people's needs. People's physical, health care and emotional needs and been assessed, with the majority of people assessed as having high needs in one or more of these areas. Four people needed the support of two staff to move and walk around and to help with their personal care.

The manager, who was in day to day charge of the service, told us that there were two care staff on duty at all times and an extra member of staff was rostered to work between 10.00am and 4.00pm. There was a cook who worked five days a week between the hours of 10.00am and 1.00pm, and a cleaner who worked between 7.00am and 11.00am for five days a week. Rotas showed there was no consistency to the number of care staff on duty. Some days there were three members of care staff on duty on other days there were only two. When the cook was not working, there were no arrangements made to cover their shift and so care staff that were rostered on duty to provide care took over the cooking duties which took them away from providing care to people. There had been occasions when there were only two members of care staff on duty and one had to cook, which left one person to care for 12 people. When the cleaner was not working, care staff had to do the cleaning duties, which reduced the amount of care hour's staff provided.

There were staff vacancies at the service and agency staff were being used. The manager told us that they used the same person wherever possible and that agency use was low. On the first day of our inspection we arrived at 7.45am. There were two members of care staff on duty, one was an agency member of staff and the other was a new member of staff, who had been working at the service for two months. There was no induction for agency staff and they said they did not have the opportunity to read care plans.

The new member of staff told us that they had not had chance to read the care plans. When staff are not familiar with the support people need there is a risk people will not receive the care they need safely.

On the first day of our inspection, one person was unwell and at times during the day was confused and tried to stand. The manager and staff told us that this person was 'usually mobile', but on this day they were very frail and did not have the strength to stand. Every time they tried to stand they were at risk of falling. A new member of staff was allocated to stand with this person to try to prevent them from standing up, in order to keep the person safe. The member of staff did not know what to do and as all the other staff were busy; there was no one they could ask. The inspector advised another member of staff that this member of staff needed assistance.

Staff were constantly busy and did not always have time to offer support or help people to the toilet on a regular basis. When activities were not offered, people spent their time in their chairs with very little interaction from staff. People spent their time sitting in the same place and either sleeping or looking around. One person said, "Staff are ok. They are busy".

Consistent numbers of suitably qualified, competent, skilled and experienced staff to keep people safe and meet their needs had not been deployed. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely to make sure they were suitable to work with people who needed care and support. Prospective members of staff were asked for a five year employment history rather than a full employment history as required by schedule three of the regulations. Employment histories were not detailed and there were unexplained gaps with no written evidence to show that these gaps had been questioned. The provider's recruitment policy stated that 'two verbal and two written job references will be obtained from the most recent employer and the second nominated referee'. None of the recruitment records we looked at had two written references and although we were told verbal references were applied for these were not recorded.

Prospective members of staff were subject to a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent

Is the service safe?

unsuitable people from working with people who use care and support services. Most staff did not start work until a satisfactory DBS check had been received. Guidance from the DBS states that 'in exceptional circumstances' new members of staff can start work on receipt of a 'DBS Adult First Check'. This is a fast track check to make sure prospective members of staff are not on an 'adults barred list' and advises employers whether staff can work 'supervised' or whether employers should wait for the full DBS check. It is not intended as a replacement check. Due to a large turnover of staff, the manager had requested a 'DBS Adult First Check' for one new member of staff. This had been received and stated that this member of staff was safe to work 'under supervision'. However, this member of staff told us that they had helped people to the toilet on their own and had therefore helped people without being supervised, which did not follow the requirements of the 'DBS Adult First Check'.

The provider had not made sure that staff were recruited safely. This is a breach of Regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in December 2014 we found that risks were not assessed and managed which was a breach of regulations. At this inspection the breach continued and had not been addressed.

Some people needed support to move around and this posed risks to people. Risk assessments did not always say how many staff were needed to support people to move around safely. Information about the use of transfer aids did not detail what transfer aids should be used such as a hoist or handling belt. Staff did not always follow good practice, or know what to do, when they tried to help people to move position or stand. One person had been sitting in a slouched position throughout the morning. Staff tried to help this person to sit in a more upright position. The person did not want to move and kept repeating "I can't do it". Staff were unsuccessful in helping the person move. Later in the day staff tried to help this person up from their chair. The person kept telling staff they 'could not do it' (get up). Staff tried to encourage them to stand up, but the person said that they 'could not'. One member of staff said, "We will have to use a handling belt, but I don't know how we are going to do this". The person was anxious when staff used the handling belt.

There was no risk assessment about the use of a handling belt or instruction about what staff should do if the person refused help. The risk assessment stated that this person 'needs minor guidance to transfer occasionally'. Staff were not sure of the most appropriate way to help this person in a safe way to reduce the risk of harm.

Staff, however, were aware of people who were at risk of falls and people who had poor mobility. Staff told us how they used hoists for people. They were able to explain which sling and strap they used.

One person had been identified as being at high risk of falls and their risk assessment said 'requires total assistance when walking outside'. The care plan stated that this person should 'be observed when walking outside' and required 'minimal assistance' which contradicted the risk assessment. Staff told us that the person needed to be supported in the garden as they were 'at risk of falls'. The guidance on how to reduce the risks to the person was not clear.

One person had been referred to the falls clinic and recommendations had been made. One recommendation was that the person should wear 'hip protectors'. The manager told us that the person 'doesn't like to wear the hip protectors and sometimes removed them'. There was no risk assessment associated with this and no record of the person being offered or refusing to wear the 'hip protectors'. The person was not wearing hip protectors and the risk assessment was last updated on 5 November 2014. Another person had been risk assessed as being independent with personal care and requiring only minimal support. The daily records showed that this person needed full assistance with dressing, all aspects of personal care and with incontinence management.

Three staff told us that one person sometimes tried to remove their clothes so they were at risk of having their dignity compromised. On the first day of our inspection, when we arrived we observed this person sitting in an armchair in a state of partial undress. Staff had made no attempt to cover the person. There was no risk assessment to help protect this person against the risk of having their dignity compromised or how loose clothes would affect their mobility.

Accidents and incidents were not monitored, reviewed and assessed to look for any patterns and causes. Accidents were entered onto the computerised care plan programme

that the staff used. There was no consistency to where these were recorded. Sometimes they were recorded in the daily notes and other times in the events records. Accident records did not always record an outcome to show how the likelihood of reoccurrence could be prevented or reduced. Body maps did not always correspond with the accident record The manager confirmed that there was no system for reviewing accidents so they could be analysed.

There were personal emergency evacuation plans (PEEPS) in place on the computerised care plan programme. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service in the event of an emergency. Some people had been assessed as being unable to evacuate the building and other people had been assessed as being able to evacuate when they heard the alarm. A member of staff told us that some people did not know what the alarm was, because when they had fire drills, people ignored the alarm. There were no hard copies of the PEEPS available for staff in the event of an emergency. There was a list that staff could 'grab' in the event of a fire, which identified who was in the service and what their immediate mobility needs were. The information on one of these lists was not up to date, and had the name of someone who no longer used the service and did not have the name of someone who had recently moved in. It was not placed near the door so was not readily available for staff to take this with them in an emergency to check people had been evacuated safely.

The fire safety equipment had been checked, there was a service record for fire alarms and fire door safety. Longer serving staff were able to tell us what they would do in the event of a fire, although one member of staff was unsure what to do if they needed to evacuate people from the building. New members of staff told us they were given instructions about the fire procedures but had not had the opportunity to take part in a drill as the last fire drill had taken place in March 2015.

Each person had access to a wash hand basin in their bedroom with hot water available. Water temperatures were not checked regularly and only two bedrooms were sampled each month. The temperature range that the provider followed was not within the guidelines issued by the Health and Safety Executive. They state that 'High water temperatures (particularly temperatures over 44°C) can create a scalding risk to vulnerable people who use care services'. The registered manager checked one bedroom during our visit and this showed that this was within the guidelines. We asked the registered manager to check all the other water temperatures to make sure water temperatures were safe.

The provider had failed to assess and mitigate risks to people. Risks to people were not always consistent and not all risks had been assessed. This was a breach of Regulation 12 (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were at risk of developing pressure sores. People had appropriate equipment such as air mattresses or pressure relieving cushions to reduce the risks. These were plugged in and staff checked to see that they were kept at the right pressure. The district nurses had visited and were supporting people to have healthy skin. Risks to the environment had been managed so there were no trip hazards or clutter which may cause people to fall.

Equipment such as hoists, air mattresses and the air pumps had all been checked to make sure they were safe to use. There were environmental risk assessments in place and the environment was clean. A walk in shower had been installed so that people had the choice of a shower.

People were protected by staff that knew and understood about different types of abuse and what they should do if they had any concerns. Although staff had not received training they knew how to protect people and who to report any concerns to. Staff felt any concerns would be acted on. The manager told us they would contact the local authority and talk to them if they had any concerns. Staff knew about whistleblowing procedures, and said they had not had to report any concerns to the manager.

Medicines were managed safely. Medicines were stored safely in appropriate lockable cabinets, which were clean and tidy. Medicines that needed to be stored at different temperatures were kept safe. The home used a monitored dosage system of medicine administration. Medicines were provided in four-weekly blister pack supplied by a pharmacy. Medicine administration record (MAR) charts were kept with people's medicines so staff could access the records to ensure that people received the right medicines. All the MAR charts we looked at were completed accurately, with no unexplained gaps. Checks against stocks of

Requires improvement

Is the service safe?

medicines showed that the correct amount were in place. People were given their medicines when they needed them. There was guidance for staff about medicines that people needed on an 'as and when' basis.

Medicines were checked to ensure the correct amount of stock was in place. Audits and checks had been carried out to make sure that medicines were administered safely. Only staff who had been trained administered medicines to people. The manager had identified some improvements. Night time medicines were prescribed to be administered at 10.00 pm and some people were in bed asleep at this time. People did not like to be woken to take medicines. The manager had contacted the GP about changing the times of medicines at night and was waiting for written confirmation. Some people needed creams to be applied to help their skin stay healthy. People had the correct prescribed creams stored safely in their rooms. New systems were being put in place to record the administration of creams to ensure the process was more robust.

Inadequate

Is the service effective?

Our findings

Visitors told us they thought the staff, 'knew what they were doing' and that staff, 'looked after' their relatives well. People were offered some choices, such as what they wanted for lunch, in a way they understood but other choices were limited. Staff understood people and knew how to communicate with people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The Mental Capacity Act (MCA) 2005 sets out how to act to support people who do not have capacity to make a specific decision.

At our last inspection in December 2014 the service was not meeting the requirements of the MCA and DoLS and this was a breach of regulations. At this inspection we found a continued breach of regulations. Before and after our visit we were told by social and health care professionals that they were concerned about the lack of understanding of the registered manager and manager in these areas.

People had not had their rights protected against any unauthorised deprivation of their liberties and had not agreed to the imposed restrictions. There was no information about what were the least restrictive options available. The manager, who was in day to day charge, and registered manager, had limited understanding and awareness of when and why DoLS applications needed to be made. Some people had their liberty restricted as the exits were locked and they were not able to come and go as they pleased. Some people had restrictions imposed including the use of bed rails to prevent them from getting out of bed. Assessments of the risk of people's liberty being restricted unlawfully had not been completed. The manager said that they had sent urgent and standard authorisation requests to the DoLS office, "A few weeks ago" for 11 people. They told us that four of the applications had been made because of people's poor mobility and communication needs and the remaining had been made because people could not live alone in the community. These are not valid reasons to make a DoLS application. The manager was not following the principles of the MCA by assessing people with regard to restrictions on their liberty on an individual basis.

There were no copies of the DoLS applications in place. We contacted the DoLS office after our inspection and they told us they had not received any DoLS applications for Parsonage Lodge. There was no evidence to show what action had been taken in the meantime to look at how staff were following the principles of the MCA to ensure people were not restricted unlawfully.

The provider had failed to act in accordance with the Mental Capacity Act 2005. The risk of people being unlawfully deprived of their liberty had not been assessed. Deprivation of Liberty Safeguard authorisations had not been followed up. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a continued lacked of understanding about the Mental Capacity Act 2005 and the implications for people who used the service. Some people were able to make decisions for themselves about different areas of their care. Some people were not able to make complex decisions. Assessments of people's capacity to make individual decisions had not been completed. Although there was a very general system for every day decisions, there was no system in place to assess people's ability to make specific decisions, when they needed to be made.

The manager in day to day charge carried out a mental capacity audit for everyone on a regular basis. This consisted of a check list of twenty three different areas and included questions about people's ability to be involved and make certain decisions, understand and retain information and whether people wanted to 'go home'.

When people moved into the service a mental capacity assessment was carried out around people's capacity to decide whether they wanted to live at Parsonage Lodge or not. The records for five people were looked at with regard to their capacity to make this decision, all of these people were deemed to lack capacity. A 'best interest' decision was then taken for people to move in. There were no records of this decision and who took part in making it. The mental capacity assessment was then used throughout the care plan to judge that people lacked capacity to make all decisions in relation to their care and treatment. One

person had a best interest meeting about whether it was appropriate for them to access a health care service. This had taken place with the manager and a relative. There was no mental capacity assessment to show why this decision needed to be made for the person.

One person needed additional supplements to help them gain weight. This person had not wanted to take the supplement and it was being given covertly (hidden) in their breakfast cereal. Staff were acting on advice given by a health care professional. This was being done in the person's best interest and they took supplements in this way, but there was no capacity assessment to see if this person could agree to this. There was no best interest meeting recorded to show how this decision had been made. The manager told us 'she was not responsible for insuring the care assessment as the health professional was supposed to do so'. However, as the person in charge of making sure that people were looked after in their best interest, they had not followed the principles of the MCA.

Some people had a Lasting Power of Attorney (LPA). An LPA is a legal tool that allows people to appoint someone to make certain decisions on their behalf. There was no guidance to show if these affected how people were cared for. Care plans for two people identified that an Independent Mental Capacity Advocate (IMCA) should be accessed, but there was no record of this happening. An IMCA can be involved when a person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move.

The registered manager and the manager, who was in day to day charge, had a lack of understanding around the MCA. MCA assessments are decision specific and one assessment could not be used to cover all areas of a person's decision making abilities.

The provider did not have processes in place to make sure that care was only provided following the principles of the MCA. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in December 2014, we found that there was a breach of Regulation 23, relating to staff training. At that time we were told that a new training programme was being introduced. At this inspection we were not assured that staff had received the training they needed to provide safe and effective care.

A training programme had been purchased and staff completed each training session through the use of course material and the completion of a work book. Staff were given a set amount of time to work through each training course. Additional training had been purchased from another training organisation that provided face to face and practical training for moving and handling.

The training record we were given at the inspection was not up to date. There was a lack of certificates in staff files to show what training they had completed. We asked the registered manager to send us an accurate training record following our inspection.

The training record we received showed there were 10 care staff employed. Six care staff and the manager had completed moving and handling and medicine training in May 2015. Three care staff had completed MCA and DoLS training and four care staff had completed basic emergency first aid training, with the remaining staff still in the process of completing the work book. All care staff were in the process of completing infection control, food hygiene and safety and caring for people with dementia, but these had not been completed. Seven care staff had not completed training for safeguarding people, although staff understood what they should do if they were concerned about people's safety. There was a training plan in place with staff booked to take part in a range of training courses, although we noted that safeguarding training had not been allocated until January 2016.

People's assessed needs were not always met because the staff on duty did not always have the necessary skills and knowledge to provide effective care. Two staff, who had not completed moving and handling training, had been allocated to work a night shift together. One was a recently employed member of staff, who was new to care work, and they were allocated to work on a night shift with a member of staff who did not have moving and handling training. Most people were supported to get up by night staff and some people needed support to move with the use of equipment such as hoists. Occasions when new and untrained staff members were on duty together at night could lead to a potential risk when helping people to move safely.

New members of staff worked their way through an induction. There was an in-house induction that was spread over four weeks. This included an introduction to the service, fire and other procedures, care plans and

communication. During this induction period new members of staff worked a 10.00 am – 4.00 pm shift to shadow more experienced staff. Staff were then allocated onto other shifts so they could gain more experience. Following this the manager told us that staff then moved on to the common induction standards, which had now been replaced by the Care Certificate. Some staff were starting to work through the common induction standards, although one member of staff who was new to care work and had been employed for two months had not yet started this. They told us that they had shadowed more experienced members of staff, but felt they were still 'learning'.

There were procedures in place for the supervision of staff, but these were not consistently followed. There was no supervision programme in place. The records for one member of staff showed they had last had supervision in July 2014. New members of staff had not received supervision and we were told that this took place between approximately six to eight weeks after they started work.

Staff told us they felt well supported and could 'speak with the manager at any time' and new members of staff confirmed that they worked with more experienced staff members before they were expected to work on their own. However, one member of staff, who had only been working at the service for four days was assisting people with personal care on their own.

The provider had failed to ensure that staff received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication systems were not effective. There was a handover sheet, but this did not always record the care provided and contained statements such as 'requires full support'. It did not record changes in people's needs and we were told that this was 'handed over verbally at the end of each shift'. When staff were not present at the handover meetings they did not have the information they needed. The nutritional assessment for one person stated, 'to document dietary intake for three days', from 26 May. We asked a member of staff on 28 May if there was anyone who needed to have their food and fluid recorded and they said they 'had not been told that anyone needs more monitoring with food and fluids'. The food and fluid intake for this person had not been recorded to check they were eating and drinking enough.

Recommendations and advice from health care professionals was not always acted on and followed up. One person had been discharged from hospital. The discharge sheet stated that they had been assessed as having swallowing difficulties and it was recommended that following discharge they had 'syrup thick fluids' and they should have a 'resource thickener'. This had not been prescribed on discharge, and no action had been taken to follow this up and to obtain a prescription. The manager stated that they had not been aware of this on discharge and they did not think it was their responsibility. The hospital made a referral to the speech and language therapist, at the same time as the person was discharged. They visited on 2 April 2015. They noted that this person suffered from prolonged coughing if they drank fluids that had not been 'thickened' and prescribed a 'thickener'. The thickener was not received until ten days later. Staff had not followed this up to make sure the prescription was received earlier.

The provider had not acted on information shared by other health care providers. This is a breach of Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health care needs were monitored on a daily basis and the GP was contacted if staff were concerned about anyone's health. On the first day of inspection one person was unwell. Staff contacted the GP, who visited the same day. The person was prescribed an anti-biotic and the prescription was obtained straight away. The GP told us that they were contacted if staff were worried about anyone's health. District nurses visited regularly and people had been assessed to make sure they were not at risk of developing pressure sores. Some people had lost weight. Referrals were made to the nutritionist, and staff who were aware of any advice given, supported people appropriately. Information and advice from the nutritionist was not always transferred into the care plans, which did not promote a consistent approach. Relatives told us they were kept informed if their loved one was unwell.

People told us they liked the meals. One person said, "We always get nice food". At lunchtime people were helped with their meals. One person had limited vision and a

Inadequate

Is the service effective?

member of staff sat with this person and supported them with their meal. They told them what was on their plate and helped this person patiently and in an unhurried way. People who needed a soft diet were catered for and were given meals of a softer consistency.

People had a choice of two options for the lunch time meal. People were offered an alternative meal if they did not like the one which was on offer. Drinks were offered during the day and snacks such as biscuits were given out. Staff knew how to prepare the drink for a person who needed a 'thickener' in their fluids, so they could drink this safely.

Requires improvement

Is the service caring?

Our findings

Relatives told us they thought staff were kind and caring. They said, "We like the fact that this is a small home and has a friendly atmosphere". "It is very family orientated". People we spoke with told us they liked the staff.

We observed the interactions between staff and people. When staff talked to people they were patient and respectful most of the time, but not all staff responded to people in a way that would alleviate any concerns. One person told the staff that they, 'were cold' and was told by staff, "The doctor says there is nothing wrong with you". There was no attempt by staff to check if the person was cold. Later in the day, one person asked if they could have the door open, but was told by staff, 'no', because 'they would then ask for it to be closed again'. One person had been given a cup of tea, but said they wanted coffee. Staff told us that if this person asked for coffee they would then want tea and that they 'would drink what they had'. Staff did not change this person's drink. One member of staff, however, listened to what this person had to say and changed their drink for them.

Inappropriate comments were heard when some staff walked away from people. Comments such as, 'oh you are hard work'; 'bless his little cotton socks' and 'wish me luck' were made. These comments were heard by the inspector and by people sitting in the room.

When we arrived there was a person asleep in a chair, in a state of partial undress. The members of staff on duty had not taken steps to protect the person's dignity by, for example, covering them with a blanket. Shortly afterwards, the manager arrived and when they walked through the door to the lounge they stated loudly, "Oh (person) is stripping off again". A member of staff said, "(This person) is always doing that". The manager and the two members of staff then tried to wake the person, but they could not. Staff said loudly, "You are only half dressed. You need to pull your trousers up". After five minutes a member of staff placed a blanket over the person to protect their dignity.

The provider had failed to ensure that staff spoke with people in a respectful manner. Staff did not always protect people's dignity. People's requests were not always listened to and acted on. This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans had very little information about people's likes, dislikes and personal preferences. There was very little information about people's life histories. This information was important because it helped staff to understand people's backgrounds. Care plans had a section to record if people had been involved, these sections did not show how people were supported to contribute to their care plan. The manager and staff could not tell us how people were involved in their care. They told us people were involved, but not how they supported people to do this. Some people had advocates, but the advocate's details were not recorded, so staff would not know who could speak on behalf of the person. Families were invited to be involved in care plans. Families told us they felt they were kept informed about things.

Staff did not appear relaxed on the first day of our visit. Two people were unwell and staff were rushing around and at times did not know who to help next. One member of staff needed additional support to help keep a person safe. The member of staff who helped was impatient and 'tutted' and was abrupt with the member of staff in front of the person.

Staff who had worked at the service for a while knew a lot about people. They knew what their likes and dislikes were and how they liked things done. Newer members of staff did not know people well. They told us they had not had time to read the care plans and were still 'getting to know people'. Staff had developed good relationships with people. A family member told us their relative had a, "wicked sense of humour" and teased staff. Staff responded in a good natured way and there was a lot of laughing and joking.

People were not always supported to maintain their independence. Care plans did not state what people could and could not manage for themselves. Some people spent all their time sat in their chairs. One person said, "I sit in my chair all day".

Staff were kind and caring. One person was worried about something and a member of staff sat with them and comforted them. Another person was unwell and confused. A member of staff sat with them and talked to them in a reassuring manner, distracting them and offered them

Requires improvement

Is the service caring?

drinks and support. The person became visibly calmer in response to the member of staff. One the first day of our inspection one person wanted to go out into the garden, but was unwell and had reduced mobility. Staff sat with this person and talked to them about the risk of this because their mobility was poor that day which reduced the person's anxiety.

There were no restrictions on visitors and they could visit at reasonable times. Relatives told us they could visit whenever they wanted and were always made welcome.

Inadequate

Is the service responsive?

Our findings

Visitors told they thought staff gave their relatives the support they needed. Some people said they thought the staff were, "Good". How and when staff responded to people varied throughout our visit.

We received information that people could not choose what time to get up in the morning. We were told that staff woke people rather than people waking up naturally. We arrived at 7.45 am and nine people were up and dressed and were sitting in the lounge. Six of these people had their eyes closed and appeared to be asleep. We asked staff what time people liked to get up. Staff responses varied. One member of staff said, "We start to get the 'doubles' up first. One person always wakes up at 6.30am and we get them up. Someone shares a room with them and if they are not awake, we wake them up". Another member of staff said, "We start getting people up about 5.30am to 5.45am. (Person) likes to get up early. (Two people) can be quite challenging to get up but we can usually persuade them". Another member of staff said, "I help people get up when they want. It is up to them. If they want a lie in then they can have one". There was no information in the care plans to show what people's preferences were for getting up and going to bed and staff did not record this, so people preferences and / or sleeping patterns could not be checked.

Towards the end of the first day of our inspection we noticed that three people had been sat in their armchairs in the lounge all day. The people's care plans all stated that they needed assistance with their continence needs every two or three hours. Staff had not recorded in the daily records if and when they had supported people to go to the toilet. The three people had not been supported to use the toilet for at least six hours. We brought this to the attention of staff. They told us that the reason they had not taken people to the toilet was because they needed the manager to help them. When we brought this to the attention of the manager, they arranged for people to be assisted, but staff had not previously supported people in accordance with their care plans. On the second day of our inspection we noticed that the continence records now showed when and how people had been assisted.

Staff did not always know how to respond to people who did not want to act on their requests. One person was sitting in a slouched position in their chair. At lunchtime staff tried to encourage this person to sit up, so they could eat their meal. The person refused and the manager, in day to day to charge, spoke with the person to tell them that it was 'not good for them' to eat their meal in this position. The person continued to refuse. Staff tried again at a later time to persuade the person to sit up for their meal. The person still refused. Staff gave them their meal, and although they did not sit with the person, staff told us they monitored the person to make sure they were eating safely. There was no information in the care plan that showed how staff should respond to this person to promote a consistent care approach.

At our last inspection we found that the care plans were complicated and had 'set statements' that were not individual to people's specific needs. There had been some changes and care plans were now less complicated and in some parts gave staff guidance about how to support people in a way that suited them best. However, they were not consistent and guidance was not always followed. For example the care plan for one person stated that they could be 'abusive or aggressive'. The triggers were 'not getting an answer to a question' or 'not having chocolate on a regular basis'. The care plan stated that this person should have chocolate on a daily basis. We asked staff about this and they told us this person 'only had chocolate when the family brought it in' and 'they didn't' have any'. Staff told us that they would not supply chocolate for this person, although the risk assessment identified this as a preference and a trigger if not available.

One person did not like to have support with personal care. There was no reference to this in the care plan. The care plan stated that they preferred a shower, but staff told us they 'did not prefer a shower'. There were generic statements in care plans such as 'needs full assistance', 'needs some help' and 'promote current eating habit'. There was a lack of directions to make sure staff provided consistent and safe care. This was particularly important as new members of staff had been employed.

Information about changing needs were not recorded in the care plans. There were gaps in the care plans about people's care needs. For example one person had been assessed as needing a soft diet but this was not recorded in the care plan. Assessed risks were not always recorded in

Is the service responsive?

care plans. One person had been assessed as having high nutritional risks, but the guidance in the care plan did not reflect this. The care plan stated that the person was a low nutritional risk and 'to promote current eating habits'.

Nutritional care plans for people who were at risk of losing weight did not have guidance about how to support them to maintain and to increase their weight. The nutritional assessment and care plan for one person who had lost weight had last been reviewed in February 2015. They had then lost weight, but the nutritional assessment and care plan had not been updated. Staff told us they were, 'keeping an eye' on this person but had not been monitoring their food intake.

People did not have the opportunity to have their say about different things, including activities, the meals and how they received their care. People did not have a named member of care staff or key worker they could talk.

Care plans had not been kept up to date with any changes in people's needs and did not accurately reflect all assessed risks. People did not always receive their care in the way the care plans described or in accordance with their wishes. People and their relatives were not contributing to their care plans. This was a breach of Regulation 9 3(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said that they did not like to take part in a lot of activities. People liked to listen to music or take part in a 'sing-a-long'. When there were no organised activities, there was a lack of stimulation for people. On the first day of our visit there were no activities and people spent most of the time sitting in chairs with very little interaction from staff. New activities, including an audio book, had been purchased to give people a wider choice. Staff had tried to encourage people to take part in a range of different activities including an audio book and staff said people enjoyed listening to this. Staff had introduced reminiscence based quizzes such as 'guess the voice', 'guess what I am' and quizzes about television programmes. Records showed that these were offered on a regular basis. People were not able to tell us if they enjoyed the activities and took part in them. Relatives said they 'thought there were some activities', but 'did not know what they were'. Staff had arranged for a coffee morning and celebrated people's birthdays. One person was supported to go to church.

People had little opportunity to follow their interests or take part in social or physical activities as their choices and preferences were not recorded. Families who were visiting said their relatives didn't like to do a lot, but did enjoy talking to staff. Staff did not always have the time to spend with people on a one-to-one basis.

The complaints procedure was on display in the hallway, so was not accessible to people who could not get to the hallway. It was only available in a written format so it was not meaningful to everyone. The procedure gave timescales of when complaints would be investigated by. The manager said they had received a complaint about someone's clothes, and this had been resolved. Families we spoke with at the inspection told us they had no complaints and would be happy to raise anything with the manager.

The care plans contained a section called 'Resident's Rights'. This had information about the complaints procedure and what support people needed to access this. Staff said they listened to people's comments, but there were no records to show what people had said and if they had any concerns. There were no processes in place to regularly gain people's views in case they had any complaints.

The local authority had asked the registered manager to investigate a complaint and to send them the outcome of their investigation. The registered manager had spoken with relatives and concluded that the complaint was unfounded.

Inadequate

Is the service well-led?

Our findings

The manager spent time in the communal areas, supported people with their care needs and talked with people. People knew who the manager was. Families told us they could speak to the manager when they wanted to.

The registered manager was not in day to day charge and had a manager to oversee the running of the service. The registered manager said they visited the service 'most days, to check on the maintenance and general environment and to make sure that there was enough food'. The registered manager told us they did not get involved in the 'day to day' running of the service. We asked how they checked and supervised the quality of the care; they said they 'left this to the manager'. There was a number of quality assurance audits carried out by the manager. These included infection control, health and safety, medicines, and care plans. Some of the audits had not picked up the shortfalls including the gaps and lack of updates in the care plans. The audits were not checked by the registered manager.

The registered manager was not aware of updates to legislation including the Health and Social Care Act (HASC Act) 2008 (Regulated Activities) Regulations 2014. The registered manager and the manager overseeing the service were not aware of guidance published by the Care Quality Commission (CQC) on how providers should meet regulations. We showed them a copy of the provider handbook which the HASC Act requires providers to 'give regard to' and they told us they had not seen it.

The registered manager had not returned the action plan requested at our last inspection within the stated timescales. They told us they had not received the final inspection report. We sent it to them again and they then sent us an action plan. The action plan was not clear. The action plan stated what the provider 'will do' by July / August 2015 but did not show how this would be achieved, who would be implementing each action and how it would be monitored to ensure each action was completed. Information and evidence we requested following our inspection was either not sent or not sent within the requested timescales.

Staff meetings were not held on a regular basis. The last staff meeting took place on 30 January 2015. A number of issues had been raised including completing records, giving people choices, night staff duties and making inappropriate comments in front of people. These areas were evident at our inspection and had not been addressed.

Systems and processes were not operated effectively to assess and monitor the service and take action to improve and communicate effectively with people. This is a breach of regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was not aware of their responsibilities and obligations with regard to legislation. The manager had not notified CQC of important events that effect people as legislation requires. We discussed this with the manager at the last inspection. There had been a death that needed to be reported to CQC, but the registered manager had not sent in the appropriate notification to CQC.

The provider had not notified the Care Quality Commission of reportable incidents that occurred at the service. This was a breach of Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.

There was not an open and transparent culture where people, their relatives and staff were actively involved in contributing and having their say about the service. People and their relatives were not invited to meetings. Quality assurance surveys had not been sent out. During our visit staff only asked people if they wanted a drink or what they wanted for lunch and recorded this, staff did not ask people about the service.

We asked the registered manager and the manager about the visions and values for the service. The manager said it was to ensure that that they provided 'safe, good quality care'. Staff talked about a family atmosphere and felt that as 'a small service' they 'knew people very well'. Not all staff understood about promoting choices and taking people's preferences into account.

Staff were not clear about the aims and objectives of the service. They were not clear about their role and responsibilities and what they were accountable for. The night staff's understanding of their duties varied. Staff made decisions about how the night duty was managed and when people should get up in the morning without consulting people. One member of staff told us they had a set list of duties that they carried out during the night and that they were allowed two half hour breaks. Another

member of staff told us that night staff 'split' the shift and they could each take a three hour sleeping break and be woken up if they were needed. The registered manager and the manager in charge told us that this was not the process, but there were no systems in place to check what happened during the night shift.

People and their relatives were not involved in the day to day running of the service. Although people and their relatives felt they could talk to the manager. They had not been consulted about activities, meals and where they would like to spend their day. People had not been asked for their views about the service they received or for suggestions about how the service could be improved. There had been no meetings with people or their relatives and there were no systems in place to obtain the views of people and their relatives. People were not always given opportunities to make decisions about their care and people were not involved in their care plans. Feedback was not obtained from stakeholders such as the local authority or health care professionals.

The provider did not have systems in place to seek and act on feedback from relevant persons and other persons on the services provided. This was a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were not completed correctly. The rotas were not up to date. The copies of the rotas for April and May 2015 were not fully completed. When changes were made to cover sickness or annual leave, the changes were not updated to the rotas. Two weeks of the rotas were not filled in, so no one knew who had worked. Staff did not sign in when they came on duty, so there was no way of checking actual staff working hours. Night care records did not show what times staff actually checked on people. A member of staff told us it took them about 15 minutes to check everyone at night, but the night check records showed that everyone was checked on the hour.

Most of the information about people's care was kept on a computerised care programme. Staff also completed handwritten daily record sheets. There was no consistency to where this information was recorded, so staff found information difficult to locate. Information that should be a care plan was recorded in daily notes for example; the advice from the nutritionist had been recorded in the daily notes and was not in the care plan to give staff the correct guidance. We asked the manager to show us where this information was and she had difficulty in locating the entry. Food and fluid intake charts were not consistently completed so it was not clear how much people had to eat and drink. Some people were diabetic and the handover sheet stated that one person needed to have a cup of tea and a sandwich in bed due to their diabetes. Over the course of three days, it was only recorded that this person had a sandwich on one of these days.

Daily records did not accurately reflect the care provided. The daily records for one person, who had been unwell, reported that this person had been 'unsteady on feet'. There were no other entries about the person. However the person had been asleep most of the day, refused all meals and drinks and been confused. This had not been recorded. Care plans were not kept to date and did not reflect people's care needs accurately. Risk assessments were not completed thoroughly to give staff guidance about how to care for people safely.

People and their relatives were not provided with accurate information about the service. The Statement of Purpose contained inaccurate information. A Statement of Purpose is a document required by legislation to be provided to people to show what the service offers. It referred to 'The Conifers', which is another service, owned by the provider rather the Parsonage Lodge. It stated that more that 50% of staff had a National Vocational Qualification (NVQ), but records provided showed only one out of 12 staff had an NVQ and two members of staff were in the process of doing an NVQ. Other statements including, 'regular review meetings with residents and staff in order to maintain the highest possible standards' were not correct. Policies and procedures were not always followed. For example, references were not obtained in line with the recruitment policy. The quality assurance policy stated that there was an 'annual development plan' and a 'quality audit will be conducted on an annual basis by the proprietor'. There was no annual development plan and the provider had not conducted an annual quality audit.

The provider did not ensure that the systems and processes were operated so they maintained an accurate and complete record in respect of each service user, including of decisions taken in relation to their care. This was a breach of Regulation 17 (2) (c) (d) 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 legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Consistent numbers of suitably qualified, competent, skilled and experienced staff to keep people safe and meet their needs had not been deployed. The provider had failed to ensure that staff received appropriate support, training, professional development, and supervision as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1) (2) (a)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not made sure that staff were recruited safely. Regulation 19(3)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to assess and mitigate risks to people. Risks to people were not always consistent and not all risks had been assessed. The provider had not acted on information shared by other health care providers. 12 (2) (a) (b) (i)

The enforcement action we took:
Cancellation of Registration

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to act in accordance with the Mental Capacity Act 2005. The risk of people being unlawfully deprived of their liberty had not been assessed. Deprivation of Liberty Safeguard authorisations had not been followed up. Regulation 13 (5)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have processes in place to make sure that care was only provided following the principles of the MCA. Regulation 11 (1)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider had failed to ensure that staff spoke with people in a respectful manner. Staff did not always protect people's dignity. People's requests were not always listened to and acted on. Regulation 10 (1)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans had not been kept up to date with any changes in people's needs and did not accurately reflect all assessed risks. People did not always receive their care in the way the care plans described or in accordance with their wishes. People and their relatives were not contributing to their care plans. Regulation 9 3(b)

The enforcement action we took:
Cancellation of Registration

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 operated effectively to assess and monitor the service and take action to improve and communicate effectively with people. The provider did not ensure that the systems and processes were operated so they maintained an accurate and complete record in respect of each service user, including of decisions taken in relation to their care. The provider did not have systems in place to seek and act on feedback from relevant persons and other persons on the services provided. Regulation 17(1) (2) (a) (c) (d) (e)

The enforcement action we took:
Cancellation of Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified the Care Quality Commission of reportable incidents that occurred at the service. Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Cancellation of Registration