Care Quality Commission

Mrs Lalitha Samuel

Friars Hall Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced inspection on 27 and 28 November 2014. Friars Hall Nursing Home provides nursing care for older people and those with physical disabilities and dementia. The service can accommodate a maximum of 54 people. At the time of our visit 48 people were living at the service.

At our previous inspection in January 2014 we identified that people's capacity to consent to their care and treatment had not been assessed. The Mental Capacity Act (MCA) 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. Following this inspection the provider sent us an action plan detailing the improvements they intended to make. At this inspection we found that although some improvements had been made, there were occasions where the provider had failed to ensure that people's consent had been appropriately sought. Staff continued to lack knowledge about the MCA, and when this applied.

Summary of findings

The manager in post was not a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

In the last 12 months, the service has had three managers. The current manager informed us they had recently resigned. The failure to retain a manager has led to inconsistent governance and leadership of the service. This has resulted in risks to people's health, safety and welfare not always being identified and managed.

The provider did not have suitable arrangements in place to safeguard people against the risk of abuse. As a result the staff could not demonstrate they had the knowledge to ensure that concerns were identified and reported in a timely and appropriate manner. People did not have their care needs met by staff who had the right skills to meet their complex needs.

There were not enough staff to meet the needs of people. Staff were constantly busy, spending little quality time with people. People were not protected from the risk of isolation because staff did not have time to sit, talk and reassure them. Lack of staff meant some risks and incidents were not identified and so had not been addressed.

People's medicines were not always managed safely. This placed people at risk of receiving medication they did not always need rather than being supported to manage their anxieties in other ways.

There was no clinical lead at the service; nursing staff relied heavily on other health care professionals to manage people's health needs. The service was failing to effectively address reoccurring areas of risk to people's health, safety and welfare. Care plans of people had insufficient information to ensure staff knew how people's complex health and social care needs should be met.

The environment had not been adapted to suit everyone's needs. There was no signage for people with dementia or a sensory impairment to find their way round the service. This contributed to people becoming confused and disorientated.

The provider and manager were unable to demonstrate an understanding of the importance of quality assurance systems and consequently there were none in place. There was no analysis of incidents, accidents, falls, complaints and safeguarding concerns to help develop strategies to reduce risks for people. The provider was failing to ensure appropriate action was taken so that the service was operating safely and effectively.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?
The service was not safe.

The provider did not have suitable arrangements in place to manage risks, including medication and pressure area care.

Staff did not all understand their responsibilities to report concerns and safeguard people against the risk of abuse.

There were not enough staff to ensure people's needs were consistently met.

Medication was not always given as prescribed.

Inadequate

Is the service effective?
The service was not effective.

People's capacity to make decisions about their care and treatment was not always being assessed.

Staff had not been provided with training that gave them the skills and knowledge to ensure people's needs were being met.

People had mixed views about the meals and mealtime experiences. People did not always have access to food and fluids.

The adaptation, design and decoration of the service did not meet people's individual needs.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Although staff treated people with kindness and spoke with them in a caring way, the care and support provided focussed on the completion of tasks, rather than spending any meaningful time to sit and talk, to promote people's wellbeing.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Care plans were often out of date and not reflective of people's current needs. They contained insufficient information about conditions, such as dementia to guide staff to ensure people got the care they needed.

There was no information available to people with information on how to make a complaint. For people without family or friends information on advocacy services was also unavailable.

Requires Improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

Failure to retain a permanent manager had led to inconsistent governance and leadership of the service.

The provider did not have systems in place to assess the quality of the service and to ensure the service was operating safely and effectively.

The service is registered to provide nursing care for older people and those with dementia. The provider did not have plans in place to demonstrate how they kept up to date, with developments in these areas, to ensure the care provided was appropriate and keeping up with best practice.

Friars Hall Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 November 2014 and was unannounced. The inspection team consisted of an inspection manager, an inspector, a pharmacist inspector, a specialist professional advisor, whose specialism was in nursing care and an Expert by Experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. The Expert by Experience had experience of supporting people with dementia and mental health needs.

We looked at notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at information we held about the service and safeguarding concerns reported to CQC. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

We spoke with 10 people who used the service and two relatives. We spent time observing care used the Short Observational Framework for Inspectors. This is a specific way of observing care to help us understand the experiences of people who were unable to talk with us, due to their complex health needs.

We looked at records in relation to nine people's care. We spoke with nine staff including care, nursing, catering and activities staff and the manager. We looked at records relating to the management of the service, staff recruitment and training records, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Before our inspection safeguarding concerns had been raised about the safety and welfare of people who used the service. These included the support provided to people who, because of their health sometimes behaved in a way that upset others. We saw a number of incidents that confirmed that the service was not managing this well enough to ensure people are kept safe and protected.

Care plans did not provide any guidance to staff on how to support people who may, due to their dementia, may be at times angry, frustrated or confused. Staff were unable to tell us the signs they recognised in people which were indicators that their moods might be changing or of particular situations that they found difficult, which might change their behaviours. Incident records identified three occasions where a person had been upset by the behaviours of other people; this included them sustaining a physical injury. Providers are required to report such incidents to the local authority so that decisions can be made about how to investigate and protect people. These incidents had not been reported and investigated which meant that no action had been taken to protect the individual or minimise the risks of such incidents reoccurring. We were so concerned about this that we shared our concerns about these incidents with the local authority safeguarding team.

The provider had a safeguarding policy and procedure in place to manage concerns about people's safety, however staff said they had not read these, and were not sure where they were located. Only, one out of the nine staff spoken with was aware of how to report concerns to the local authority. Staff did not have safeguarding training in the last two years and had a limited understanding of their responsibilities for keeping people safe and reporting concerns. People who used the service were at risk of avoidable harm due to the lack of staff's knowledge of the provider's policy, the absence of training to support this policy and a general confusion as to what made a safeguarding concern and how it should be responded to. This is a breach of regulation 11 of the Health and social care Act 2008 (Regulated Activities) Regulations.

Staff told us the workload was very heavy, they were kept going all the time and there was little time to speak to people or to give them any quality of care. A relative commented "I've noticed that they could do with some more staff here because they are rushed off their feet." Staff described some people who used the service as getting angry because nobody had time to stop, talk and help them. The provider was unable to demonstrate how staffing levels were reviewed to ensure there was sufficient staff available. Staffing numbers had been calculated according to the number of people using the service rather than against individual needs which varied. On the day of the inspection there were 48 people living in the service. The providers calculations of how many staff were needed did not match the rota. There was a deficit of one member of staff each day which they could not explain.

We observed that staff were constantly busy carrying out tasks and spent little time with people who needed more support or monitoring to keep them safe. For example, two people in the lounge were overheard arguing loudly. Other people were upset by this and said, "Oh help me" and "I'm still hungry, I am not well." There were no staff present and no call bell visible or accessible to people in the lounge to call for staff assistance. This was a breach of regulation 22 of the Health and social care Act 2008 (Regulated Activities) Regulations.

The provider had not learned from a previous incident at the service where someone had been injured. There was no risk assessment undertaken following the initial incident and measures had not been taken to minimise or prevent the risks for anyone else in the future. This left people at continued risk of harm. We saw that a similar incident had occurred which, could have been avoided. The manager told us they would take action to ensure that this was now addressed.

A significant proportion of people using the service had mobility issues which required the use of manual handling equipment to support them. Concerns had been raised by a visiting professional about the inappropriate use of moving and handling equipment. Manual handling assessments had been completed by a senior member of staff who had not received the appropriate training to do this. They did not identify the model of hoist and type of sling to be used and changes in people's weight had not resulted in reassessments to ensure the slings being used were the correct size. We observed several people sitting on their slings in their wheelchairs or armchairs. None of the risk assessments identified if the slings, in use were safe to remain in situ, when the person was seated. The risk of this causing or contributing to developing pressure areas had

Inadequate

Is the service safe?

also not been considered. All of this had the potential to place people at risk of receiving care that was unsafe or inappropriate to meet their needs. This was a breach of regulation 9 of the Health and social care Act 2008 (Regulated Activities) Regulations.

Systems for ensuring medication was provided for people safely were not robust or safe. There were discrepancies between the number of medicines in stock and the amount signed as having been administered. Additionally, there were gaps in Medication Administration Records (MAR) which failed to explain if medication had been taken or if not, why not. For example, in the MAR for one person's insulin for the management of their diabetes, there were several incidents of no signature or other explanation. Therefore we could not be assured they received treatment as prescribed by their GP. We brought this to the attention of the manager who told us they would address this to ensure the person received their medication appropriately.

There was no protocol in place for providing medication on an as and when required basis. For example, one person's medication for the management of their anxiety was being administered most days and not on an occasional basis, as prescribed. No further assessment or review had taken place to ensure this was safe or appropriate. This medication should have only been administered as a last resort and when all other attempts to reduce the person's anxiety have been tried. A professional had raised this as a concern because the service had not identified it themselves as a concern.

Controlled drugs were not being stored in line with the Misuse of Drugs Safe Custody Regulations. Secure storage of controlled drugs is necessary to ensure that they are appropriately administered and not mistakenly or deliberately misused. Although the management carried out monthly audits of medication, these had failed to identify the issues identified during this inspection. This was a breach of regulation 13 of the Health and social care Act 2008 (Regulated Activities) Regulations.

Staff had the checks completed prior to starting work at the service. However, although staff had completed an application form, these contained basic details and gaps in their previous employment history had not been fully explored. Criminal records checks were completed, however two staff recruited through an overseas agency indicated 'references were available on request'. There was no evidence that these references had been requested to explore the person's suitability for the role or establish if they were of good character and were suitable for the role they were to perform.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in January 2014 identified a breach of regulation because people's capacity to consent to their care and treatment had not been assessed. We found that whilst some improvements had been made there were still areas where the provider could not be assured that people's rights were being protected. In line with the providers action plan Mental Capacity Act (MCA) 2005 assessments had been completed for existing people who used the service. However, the care plan of one person stated that they required their medication administered disguised in food and drink (covertly). There was not a specific assessment relating to their capacity to consent to taking their medication. Neither was there evidence of a subsequent best interest decision to receive their medication covertly. Without this it was not possible to tell that the care was being provided in way that protected their rights.

Staff had a limited knowledge of the MCA because they said this was dealt with by the qualified nurses. As care staff had the majority of the contact with people, this lack of understanding meant that issues relating to consent were potentially overlooked. This could include the failure to appropriately seek consent, follow agreed best interest decisions and be unaware of how to respond to apparent changes in people's capacity. This was a continued breach of regulation 18 of the Health and social care Act 2008 (Regulated Activities) Regulations 2010.

We looked to see how the Deprivation of Liberty Safeguards (DoLS) were applied in the service. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. Documentation in people's care plans showed that where people's liberty was being restricted to protect them from harm or the risk of harm, appropriate requests had been made and authorised by the local authority, to ensure that this was done in accordance with the law.

Nutritional risk assessments had been completed, where people were identified as being at risk. Referrals had been made to dietetic and the speech and language therapists. However, there were inconsistencies in documentation that made it unclear what care was needed or had been provided. For example one person's care plan for nutrition stated they were 'at risk', however a further risk assessment stated there was 'no risk'. Another person's records were inaccurate because we saw that drinks had been placed outside of their reach, but records stated they had been consumed.

People referred to a lack of choice around food. The provider had recently introduced a four week menu rotation; however they were unable to tell us if or how people were involved in choosing and developing the menu. People told us, "I'm on a special diet; I think there isn't much of a choice, with pudding there is no choice." Other comments included, "I do love to eat fish, but it's hard to get (here) and "I do like yogurt, but they don't always have them."

Biscuits were offered with a hot drink mid-morning and mid-afternoon; however there was no choice because they were all the same type of biscuits. There were no finger foods, such as crisps, cakes or fresh fruit readily available in communal areas. One person was frequently calling out; "I am hungry" becoming very vocal and shouting. People could request snacks from the kitchen, however not everyone was mobile or able to communicate they wanted a snack. The manager informed us they were unable to have snacks in communal areas because of a person who was a diet controlled diabetic. They had failed to explore other ways of managing this.

Staff had not been provided with training that gave them the skills, knowledge and qualifications to ensure people's needs were being met. For example, staff told us they had not received training in dementia, diabetes and managing behaviours that challenged others. As a result the staff could not demonstrate a consistent and planned approach to support people in managing these conditions. For example, we found there had been a significant increase in incidents of behaviour that was challenging. The lack of staff training, along with the absence of guidance, was demonstrated during the inspection by two incidents of aggressive behaviour between people who used the service which was not appropriately dealt with.

The manager had contracted an external training company to provide training in the future. Staff told us they had recently attended dignity and equality training to help them support increasing variety of the needs of the people using the service. Dementia and challenging behaviour training had been scheduled December 2014. There was no structure in place to ensure that new employees understood their role. Two new staff told us their induction

Requires Improvement

Is the service effective?

consisted of an orientation of the service and an introduction to policies and procedures. They confirmed they had not completed a formal induction that gave them the knowledge, skills and confidence needed to carry out their roles.

We found that the environment had not been adapted to suit everyone's needs. There was no signage to help for people with dementia or a sensory impairment to find their way round the home. People were observed walking about confused and entering other people's rooms. Some people's rooms had names, or a number, some had neither. There were no memory boxes to help people distinguish their own room. The purpose of the memory box is to contain personal; items that stimulate a person's memory. Corridors were bland, with no distinguishable features, such as different coloured door frames to help people identify toilets and bathrooms. This lack of signage had resulted in people becoming confused, urinating in communal areas and other people's rooms. Strong odours were identified in particular areas of the service, which were being masked with overpowering air fresheners. Equipment, such as hoists were being stored in bathrooms, which not only cluttered the bathrooms but restricted people's access. A store room on the first floor next to the lift contained wheelchairs, walking aids, boxes of clothing and two vacuum cleaners. There was no door to the room which may prove to be a potential hazard to people and would not have contained a fire should it occur.

We recommend that the service seek advice and guidance from a reputable source about how to support people in meeting their individual nutritional needs, particularly those with specialist needs including dementia and diabetes.

Requires Improvement

Is the service caring?

Our findings

Staff responded quickly to people but the support provided was focussed on completing a specific task and little time was available for staff to spend quality time with individuals. This resulted in care which was not delivered in a compassionate manner or in a way that encouraged conversation, sharing or choice. For example, staff were observed going from room to room, attending to people's care needs. Conversations were limited to asking or responding to questions about their care. One relative told us, "Staff are very focused on getting the job done and do not always tell my [person] what they are doing." They commented, "It's like, I've got a job to do and I'm going to do it."

The midday mealtime was not a sociable experience for people. Support provided by staff was focused on providing people with their meals, with little or no interaction. People were brought into the dining room in wheelchairs and positioned at tables; no offer was made to transfer to an ordinary dining chair. People were not encouraged in conversation or to use it as an opportunity to encourage people to move. For example, in upstairs dining room, four people had been sitting in armchairs all morning, and had tables placed in front of them to eat their meal. They were not offered the choice to sit at the table.

We asked people if they preferred to sit at the table, one person told us, "Sometimes we do." On the second day of the visit all four people were seated at the dining table. It was not clear from talking with these people or the staff if this arrangement was as a result of choice. We asked a further six people observed sitting in wheelchairs if they would prefer to sit in an arm chair; three said they would prefer this. A further person told us they would prefer to sit in an armchair, but staff were too busy. Staff said they did sit people in armchairs, but they had been busy and had not had time. This indicated that staff had not fully considered people's preferences, or their comfort.

There were occasions where we observed staff provide support which was done with kindness and tenderness. For example, a member of staff was observed supporting a person who appeared quite poorly, to drink, this was nicely done and plenty of encouragement was provided. We also saw one member of staff engaged with a person having a conversation about music. This conversation spontaneously turned into a singing session with much banter and laughter.

Staff told us they had recently attended a training workshop where they had discussed promoting people's dignity, privacy and rights. People and their relatives told us that staff respected their privacy and dignity. One person said, "I'm pleased they respect my privacy and treat my room as my home." Other people commented, "The staff wake me up in the morning with a cup of tea and I have a choice of when to get up," and "I'm always asked if I want a bath or a wash." One relative told us, "They [staff] are always respectful and knock on the door and ask if they can do something for my [person]. They seem to respect their privacy and dignity."

People were complimentary about the staff and told us they were caring and kind. Comments included, "The staff here are 100 per cent," "There is a good happy atmosphere here; the staff are talkative and kind," "I've been here five years and find the home not too bad," and "Very happy here." People also told us that they were happy with the support they received. One person told us, "Living here is brilliant; I enjoy everything. I'm finding here quite good." Other comments included, "I've been here five weeks and finding it better than expected, and "I've been here about five months now and I'm happy."

Leaflets relating to the Alzheimer's Society, Nursing Midwifery Council, NHS Suffolk and having flu were on display in the front entrance hall. However, there was no information around the service that provided people with information on how to make a complaint or access an advocate, should they need one. There were no notice boards detailing developments in the service, however the manager had recently published the first of what will be a monthly newsletter people, their relatives and staff.

Requires Improvement

Is the service responsive?

Our findings

People's day to day health needs were addressed through their care plan. Inconsistencies and inaccuracies in these plans relating to pressure ulcer management, dietary needs and dementia, amongst others, had resulted in poor outcomes for people and concerns being raised by health and social care professionals. People using the service and their relatives told us they were involved in initial assessments but did not have access to their care plans or participate in regular reviews. One person told us, "I don't recall a care plan being mentioned by anyone to me." A relative told us, "When my [person] first came here I was asked for input into their care, I was asked about their past, things they liked, for example, their favourite programmes. No one has gone through the care plan with me since."

Care plans and risk assessments had not been updated and therefore staff were not working to the most up to date information. For example, one person had recently been prescribed antibiotics but their care records did not reflect this. Further care plans for two people with diabetes did not contain sufficient information to guide staff. There were no instructions as to the frequency of blood sugar level these checks or guidance for staff on what diabetic symptoms to look out for and report. As a result people with diabetes were at risk of not receiving appropriate care and treatment, when they needed it.

People and their relatives told us although there were some activities in the service these were not consistent and there was a lack of stimulation. One person told us, "The worst thing about the care home is repetition. Most days are exactly the same." Other comments included, "I don't take part in many activities; sometimes I'm asked to take part, but sometimes I'm not." One relative told us "There is not a lot of stimulation; my [person] is left in their room, there is little in the way of activities and entertainment."

In order to maintain hobbies and interests people's preferences and personal histories were to be recorded in a care plan section called, 'My living story'. However, these were incomplete and provided minimal details about people's preference for staff to be able to encourage them to maintain hobbies or interests. People in various areas of the home were sleeping in chairs and disengaged. One member of staff, contracted to work 26 hours a week, had the role of arranging and providing activities in the service. However, they described their task as impossible for one person. They reported that care staff did not have time to participate in activities, so they were now trying to get volunteers to help. One volunteer visited the service every week and brought their dog for pet therapy. A newsletter showed that recent events had included an outing to a stately home, musical entertainment, a harvest festival and the opening of a sensory garden. However, the overall the lack of appropriate stimulation or interesting things for people to do meant that people's social needs were not being fully assessed or met.

We found people were not being protected from the social isolation and loneliness. A significant number of people spent the majority of their time in their rooms. Staff did not support people with individual interests or hobbies and there was no system to ensure that people who spent time alone had this explored through individual care planning to ensure their needs were met. We saw that although staff attended to someone who was alone in their room and distressed there was no guidance for staff about how they could help to reduce the person's anxiety. As soon as the staff member left the person immediately became distressed again. Their care plan contained no information about how this could be managed more effectively. In addition staff were unable to demonstrate to us how they could support the person. All of the above was a breach of regulation 9 of the Health and social care Act 2008 (Regulated Activities) Regulations.

The majority of people at the service had relatives, who told us they would be able to raise concerns on their relative's behalf. There was no information available about how they would access advocacy services (to help people who had no one acting on their behalf) make a complaint or when making important decisions. People and their relatives said they would approach the manager if they needed to complain. One person told us, "If I need to make a complaint then I'd ask to see the manager." One relative told us, "I did have an issue about staff not following my [person] care plan. I talked to the manager and this has now improved."

The manager sought people's views about the service through questionnaires. We noted that where people had provided feedback about things that needed to improve the manager had taken action to make changes. For

Requires Improvement

Is the service responsive?

example, where relatives had raised issues about people not being treated with the dignity and respect they deserved on occasion, the manager had arranged for dignity training for staff.

Inadequate

Is the service well-led?

Our findings

There were limited processes in place to assess and monitor the quality of the service and if it was operating safely and effectively. In the last 12 months, the service has had three managers. The failure to retain a manager has led to inconsistent governance and leadership of the service. There has been a failure at the service to address recurring areas of risk to people's health, safety and welfare, and to sustain improvements made.

Whilst nurses were employed there was no clinical lead to take responsibility for this aspect of the service. As a result there was an over reliance on external professionals to support the service and provide care and treatment which the service should have been providing themselves. In addition the lack of nursing leadership and oversight meant that the quality of the nursing was not being monitored to ensure it was appropriate and followed best practice. For example, we were seriously concerned that the provider had not learned from previous incidents of poor management of pressure ulcers. Concerns continued to be raised about how all staff were monitoring and managing people's pressure care. As a result other professionals had raised concerns about people's care.

There were other examples where the service had not learned from experiences or put in measures to reduce risks of people being injured. The provider was unable to explain why these had not been addressed effectively.

The service is registered to provide nursing care for older people and those with dementia. There was no plan about how the service kept up to date with developments in these areas to ensure the care provided was appropriate and kept up with best practice. The provider did not have a clear vision or focus on the service they were providing. None of the staff spoken with were able to tell us what the aims and values of the service were. Recent admissions to the service included people with complex needs including mental health needs. Observation and discussion with staff showed that they had not had the training they needed to give them the skills to support people living in the service. Staff lacked guidance and understanding on how to respond to concerns about people's safety and manage people's behaviours. This did not ensure that people, staff and others were protecting them from the risk of unsafe care or treatment.

Systems that were in place to help identify risks were not robust. For example an infection control audit had been started in September 2014 but not completed; no further audit had been conducted. The medication audit had failed to identify the issues we found at this inspection. There were no other audits to measure and review the quality of the service and care provided. There was no system in place that analysed the outcomes of incidents, accidents, falls, complaints and safeguarding concerns in order to learn from these and improve the service. Where lapses had occurred there were no processes in place to ensure appropriate action was taken to minimise the risks of similar incidents happening again. The provider was failing to continuously assess the quality of the service to drive improvement or identify where lapses had occurred. This was a breach of regulation 10 of the Health and social care Act 2008 (Regulated Activities) Regulations.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: People who use services and others were not protected against the risks associated with insufficient numbers of suitably qualified, skilled and experienced staff employed for the purpose of carrying on the regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services and others were not protected against the risks associated with the unsafe use and management of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: People's capacity to make decisions about their care and treatment were not always being assessed under the requirements of the Mental Capacity Act 2005. The registered provider must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them. Regulation 18 (1) (a) Regulation 18 (1) (b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (a) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People who use the service were not protected against the risks of inappropriate or unsafe care because the registered provider did not have an effective and pro-active quality monitoring and assurance system in place that ensured the service was operating safely and to drive improvement. Neither did not they have effective systems in place to identify, assess and manage risks relating to people's safety and welfare. Regulation 10 (1) (a) Regulation 10 (1) (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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: People who use services and others were not protected against the risks of abuse. This was because the registered provider did not have systems in place to identify the possibility of abuse, prevent it before it occurred and respond appropriately to any allegation of abuse. Regulation 11 (1) (a) (b) Regulation 11 (2) (a) (b) Regulation 11 (3)