Jeesal Residential Care Services Limited

Vicarage Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Vicarage Road is registered to provide; Accommodation for persons who require nursing or personal care up to six people. At the time of our inspection there were five people using the service, two people had moved in the day before from another Jeesal Residential Care Services Limited which had recently closed. The service provided single accommodation over three floors, some of which were self- contained. There were a number of shared facilities over two floors.

People's experience of using this service and what we found
The inspection was carried out due to concerns about Jeesal Residential Care Services Limited ability to ensure people were safe and well cared for. This included concerns from the Local Authority. People using the service had experienced a lot of change. Two people who had moved in the day before our inspection had the opportunity to visit several times before moving but their care records were not fully transferred or complete. They were supported by redeployed staff from their previous home who knew them well. The existing staff team did not have much knowledge of the people moving in. No transitional plans were in place. We were unable to see how the service had considered the compatibility of each persons' needs and the skills and training needs of staff to meet their needs. Prior to admission staff had not received behavioural strategy training and core staff teams were not in place. For everyone using the service there was a need for people to have clear routines, boundaries and planned activity schedules to help them feel safe and ensure predictability.

We were not assured that accurate records were maintained. The electronic recording system had good capability if used to its full advantage, but we found many sections of the care and support plans were blank. Some information was out of date and risk assessments were generic rather than specific to the health needs and behaviours of people using the service. Poor planning, recording, reviewing and accessibility of information meant we could not clearly see how people's needs were being met or that staff had all the information required to safely meet people's needs.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. Based on our review of the key questions: Safe, Effective and Well led we found the provider was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
•The model of care and setting did not maximise people's choice, control and independence. Restricted social activity was noted due to COVID-19 pandemic. However, we noted creative solutions had not been found to enable people to continue to access things they enjoyed. Goals were not dynamic, and people did

not have the same opportunities as others in the community. There was limited involvement of people in clubs, societies, memberships or access to both community facilities and community transport. People had little choice about where they lived or who they lived with.

Right care:
•The Care and support was not person centred as people were not supported and encouraged to develop their life skills and live purposeful, meaningful lives. Activities were often repetitive and short lived based around staff shift patterns and availability of shared transport.

Right culture:
• Staff spoken with felt disempowered with little direction, leadership and support from the senior management teams. Staff felt supported by the current acting manager but there was no registered manager to implement and sustain change. Staff felt their hard work was not acknowledged, and they felt undervalued. Staff training did not reflect the needs of people using the service. Governance and oversight had been poor resulting in both a fall of care standards and people's living conditions.

The provider had not been proactive in ensuring the property was safe and routinely maintained. Ongoing maintenance work was underway but more as a result of concerns expressed by other agencies including the CQC and the local authority. Radiators and pipework were uncovered which could pose a risk of scalding. Risk assessments had been put in place and the acting manager ensured us their long-term improvement plan was to cover the radiators to eliminate any risk. Environmental risks had not been considered in line with people's known behaviours particularly the risk from destroying property and breaking glass, electrical sockets and other items. This exposed people to the risk of avoidable harm and the environment had not been sufficiently adapted.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Deprivation of liberty safeguards, (DoLS) were in place for some people, but for at least one person their DoLS status was not known and for another person staff restricted their access to the community due to associated risks but these had not been considered in terms of the persons rights and wishes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The last rating for this service was good (published 26 June 2019)

Why we inspected
The inspection was prompted in part due to concerns about the provider and their locations and in part by information of concern received about this location. A decision was made to carry out of focused inspection to look at the key questions Safe and Well led, which we extended further to cover Effective.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well led sections of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to: consent, safe care and treatment, staffing, and good governance and there being no registered manager.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Vicarage Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector over one day.

Service and service type
Vicarage Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with the manager, the acting manager, a senior and two other care staff. We observed the care and support being provided to people and spoke with three people. We spoke with a visiting health care professional. We reviewed one support plan and checked medication for one person. We requested some initial records including rotas and cleaning schedules.

After the inspection
We spoke to a further three staff and deputy manager. We spoke with two relatives. We continued to request information including access to the electronic monitoring system and policies and procedures. Some information was not provided including evidence of staff development and additional role specific training. We were not provided any information about how the service supported people to move to the service from another service and how took into account the views of the people moving.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

● Processes for managing individual risks to people were poor. People's care and support plans included generic statements and did not clarify the level of risk or actions necessary to mitigate risk. For example, one person's record stated, 'may choke, staff are with me and may need food cut up if easier.' There was no separate choking risk assessment or nutritional care plan. This meant we could not see why the person was at risk, or what food might be acceptable or unacceptable in terms of consistency and size. Staff familiar with people's needs were aware of potential risks but there were staff recently deployed to the service who did not have adequate oversight of risk.

●Some people had high risk and, or antisocial behaviours which if not managed effectively, could put them or others at risk. Behavioural support plans varied in detail and did not cover all behaviours described in the support plan. They did not clearly state what actions staff should take to protect themselves or others. Staff were not adequately trained and care plans, behavioural support plan and risk assessments were not always reviewed following an incident.

●One person had 19 recorded incidents in 18 months, ten of these had occurred in one month. There had been no analysis as to why there had been a spike in incidents or how the care and support could be adjusted. One incident had led the person to throw objects and break glass, the risk of injury to them or others had not been considered or what actions could be taken to prevent a reoccurrence. The environment in which the incident occurred had not been considered or steps taken to make it safer.

● During our inspection ongoing maintenance was taking place to rectify some outstanding issues. Radiators and pipework were uncovered. There was no immediate risk as the heating was off and we were advised that these would be covered as part of ongoing service improvements. Environmental risk assessments were not in place, but consideration had been given to the risk from uncovered radiators.

●We requested some information following the inspection and found remedial actions had been identified with electrical wiring, and fire safety and the Development Director assured us these were being addressed and provided us with their action/improvement plans.

Preventing and controlling infection

● Cleaning schedules were in place, but these contained gaps and there was no overarching cleaning audit being completed within this service which was contrary to the infection control policy. Staff prioritised supporting people with their daily routines which at times compromised the cleaning of the service.

● We were mostly assured that staff were using personal protective equipment (PPE) effectively and safely. We observed a lapse in mask wearing by one member of staff. There were no spot checks being carried out which might have helped ensure staff were wearing the correct PPE.

● We were not fully assured that the provider could prevent and manage outbreaks in relation to COVID-19 as they were not auditing their service to ensure staff were following good infection control practice. We also

had concern last year that staff were not adhering to infection control procedures or taking appropriate measures against the virus or using the necessary PPE.
● The provider's infection prevention and control policy had not been reviewed in 2019, or 2020. The first case of COVID-19 nationally was recorded in January 2020. We therefore would have expected the infection control procedure to be reviewed in light of changing guidance.

People were not fully protected from the risk of avoidable harm because risks had not been assessed or mitigated.
Infection control procedures did not adequately protect people and staff from the risk of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors to the service had been kept to a minimum in line with guidance. Checks and information were in place for visitors coming onto site including rapid lateral flow tests, guidance on hygiene, wearing a face covering and washing hands. Temperatures were also taken.
● We were assured that the provider was meeting shielding and social distancing rules. Isolation rules for anyone contracting COVID-19 were in place and to date there had been minimal exposure with only one member of staff being required to isolate. Social distancing was hard to achieve within the service, but people had someone to one staffing and their own accommodation. However, some were sharing facilities such as the second-floor bathroom.
● We were assured that the provider was admitting people safely to the service. People moving to and away from the service into other setting were subject to regular testing and everyone had received their first and second COVID-19 vaccination.
● We were assured that the provider was accessing testing for people using the service and staff for the presence of COVID-19.
●Hand sanitiser and PPE were readily available, and we observed staff wearing masks when supporting and interacting with people. Staff had access to training and information about COVID-19.

Systems and processes to safeguard people from the risk of abuse
● We were not assured that safeguarding training was effective in helping staff understand their role in identifying and protecting people from abuse.
●There was limited evidence of regular staff support, training and development to ensure staff practice was up to date and in line with the organisation's values and behaviours.
● We had not received any safeguarding concerns or notifications from this service since the last inspection and a review of incidents did not provide evidence that incidents were escalated and effectively reported.
● We raised concerns with the local authority about the management of people's money. Although robust processes were in place to account for personal spending, however monies for some people were paid into an account held by the provider. Monies were made available to a person via a house account rather than into an individual's account. We did not receive assurance about this from the provider when requested. We also did not receive specific information about how people paid for mileage when using vehicles and if these house vehicles were owned by individuals or the company.

People were not fully protected from the risk of harm or abuse. This is a breach of regulation 13. (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

●Staffing levels were appropriate to the needs of the people using the service. There was currently a blended team which included staff from a previously registered Jeesal service and staff traditionally employed at Vicarage Road. Staff spoken with did not raise concerns about staffing however, on the day of inspection the service was initially one staff member short.

● Follow up information requested from the provider highlighted a number of staffing vacancies coming up and an unsuccessful recruitment drive. The provider was advertising for a registered manager, night staff and were soon to have multiple vacant day hours. A lack of applicants would have an impact on the service, and this had not been discussed with the Local Authority to come up with a plan to ensure all the 1-1 hours could be covered.

● Staff recruitment records were managed centrally. A recruitment checklist showed a robust process was in place, but we were unable to verify this from the records we inspected. We were advised that all recruitment records were uplifted on to an electronic system, but we found this not to be the case. For example, disclosure and barring disclosure records provide a unique reference number which should be recorded and was not on the electronic record.

Using medicines safely.

●Medicines were mostly managed well and administered by staff who were trained to do so.

●During the inspection we viewed one person's medicines. Medicines were stored in people's rooms and we did not have anyone else's permission to check their medicines.

● Daily medicines checks were carried out to help ensure no errors were made and if they were these could be identified quickly and rectified. Monthly medicine checks were carried out, but these did not provide detail of the evidence viewed to make a judgement and were therefore not sufficiently robust.

● Medicines were stored safely, and keys kept securely.

● Staff administering medicines received training and their competencies assessed at least annually. Should a medication error occur medicine competencies would be revisited.

● Medicine records included guidance for administration, including medicines for occasional use, a description of the medicines, its purpose and potential side effects.

● Medicine reviews had led to a reduction in medicines for some people due to the long- term implications of regular prescribed medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.
At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
●Staff training was variable, and we were not assured staff had the necessary training and competencies for their role.
●Training records ranged from 100% compliance to 57 %. All were based on eLearning rather than face to face training. The provider attributed this to COVID-19 where online training was the safest way to provide training. Staff had not had an annual appraisal and one to one supervision had not been occurring regularly following the absence and then resignation of the manager. This meant staff's practices had not been monitored to ensure they understood their training and were able to implement it in practice.
●Gaps in staff's knowledge were identified and included their understanding of the individual needs of service users including their complex behaviours associated with learning disability and mental health.
● Some people had behaviours which could put themselves and others at risk and staff had not been adequately trained to deescalate behaviour in line with the positive support plans. The organisation provided non abusive psychological and physical intervention (NAPPI) level 1 training for its staff. At Vicarage Road only 57% of staff had up to date training. This put them and others at risk should an incident occur. Prior to the inspection an incident had occurred, and staff had called for backup from another service to help manage the incident.
● Some people had specific health care needs and the training records provided no evidence of localised training around the needs of people using the service. For example, continence, skin care, and risks associated with dysphagia. Not all staff had up to date first aid training.
● Evidence requested was not provided about additional training staff received when holding senior or management positions. We were therefore not assured of the competencies of staff for their specific roles. Care staff within the workplace did not have designated 'champion roles' which would help them develop their skills in line with their strengths and interests.

Staff were not adequately trained and supported to meet peoples assessed needs. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA

application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We requested some additional information from the provider about how decisions were made to move people and who was involved in the decision. No additional information was provided and from the records we viewed we could not see how staff supported people to make day to day decisions.

●People's communication plans were not robust, and information was not in an accessible format for people's assessed needs.

● Three people had a DoLs in place, one person did not and for a fifth person their DoLs status was unknown. This meant we were not assured there were necessary safeguards in place for this person. For the person without a DoLs their care and support plan contained language which was not conducive to the least restrictive practice.

The service was not acting in accordance with the MCA and the code of practice. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care and support plans were not up to date or fully accessible on admission to the service. Gaps in staff's knowledge and training meant we were not fully assured people's needs could be met.

●A transition plan was not in place before two people moved to the service. They had both had multiple previous moves and the service had not considered how the transition could be managed successfully. On the day of inspection one person was pleased with their flat but did not have all their belongings or working WIFI and television signal. Both people chose to be supported by male staff, but this was not initially possible and on the morning of inspection the home was short of staff.

Supporting people to eat and drink enough to maintain a balanced diet

●People had involvement in their dietary intake, but the risks associated with their diet and health had not been considered.

●The diet and nutrition policy included dining room audits, and menu audits. The acting manager confirmed neither were carried out within the service. People were involved in choosing their main meal and there was a menu plan in place. Choices were provided but we saw limited information about people's dietary needs or preferences.

● We did not get a clear picture of risks associated with dysphagia. Several staff identified people who needed support and food cut up. However other staff said no one needed assistance. Electronic care plans identified some people needing support and food to be cut up but there were no separate dietary care plans, or risk assessments. Staff were not adequately trained, and the risks not clearly established.

Staff working with other agencies to provide consistent, effective, timely care

●Limited evidence was provided of the service working closely with other health and social care professionals to ensure best practice was observed.

● A health care professional told us advice was only sought when a situation escalated, and the deputy manager told us they were not currently working with the learning disability team or any other health care professional regularly.

Adapting service, design, decoration to meet people's needs

● The property was a good size and people had adequate space and both shared and private facilities. The property was undergoing some renovation and maintenance in readiness for the people being admitted. We saw from governance and staff meetings that environmental concerns had existed for some time and the

provider had not been proactive in maintaining the environment.

Supporting people to live healthier lives, access healthcare services and support

●People were supported to access health appointments including the psychiatrist and the GP. Concerns were raised last year about staff understanding of mental health and how to promote people's well- being. We found gaps in staff knowledge and a lack of specific training.

● People had a separate health record and a one- page profile which documented any specific needs. We found information was generic and did not always provide a useful overview for staff. For example, one person had issues with continence and constipation. The plan of care did not include information about exercise and diet, or details of how to promote good skin care.

●People had guidance in place about teeth and gum care, but there were no oral assessments and we could not see when people last went to the dentist. The acting manager told us this had not happened during the pandemic.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●Systems and processes were not in place to monitor the service effectively and take timely actions when shortfalls were identified. The service was not complying with best practice guidance or meeting all the regulatory requirements.

●The provider's mission statement 2021 states: 'Jeesal Community Services commits to providing support for people with learning disabilities to lead fulfilling lives as part of the community. We do this by investing in our environment, technological advancements and more importantly, our people. We pride ourselves in employing caring professionals and invest in their continuous training and development.' We found these statements were not upheld in the care and support of people using this service.

● We saw limited evidence of a person-centred culture. People had minimal choice in daily activities and how they were supported and by whom. Staff appeared caring and committed but did not receive adequate training to support people effectively and safely.

●Records were both electronic and paper based making it difficult for staff to find all the required information necessary. This placed people at risk as staff, especially new staff, might not be clear about important information about people's care.

●People had little influence over their care and support or access to the resources they needed for a full life. People did not have sufficient voice in determining how they would like to live and what they would like to achieve as there was no forward planning and goals were poorly developed.

●Overarching governance systems were poor and did not demonstrate how the provider was acting within the appropriate guidance: Right support, right care, right culture.

●The provider had not ensured people lived in a way which promoted their safety because the premises had not been adequately maintained. This resulted in a fall in people's living standards. Remedial actions were being taken to bring the property up to scratch.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The service has not had a registered manager since March 2020 and prior to this the registered manager was working from home and not on site so there was no daily management oversight. The acting manager had insufficient support for their role both in terms of training and time to do administrative tasks as they were often working shifts.

● Remedial building works were being carried out at Vicarage Road and contractors had been on site for a number of weeks. Environmental concerns have been identified by CQC and Norfolk County Council across

a number of Jeesal services rather than by the provider. This meant the provider did not have a robust or effective governance system. Their lack of actions had meant people living in substandard accommodation with unidentified risks to people's health and safety and a fall in their living standards.

●The managing director stated in a meeting in August 2021 that: 'They were aware that there has been a lack of investment over the years within all of the services, and they were now investing in the homes to bring them up to scratch.'

● Care and support plans were not fully up to date or reviewed in line with changing or unmet need. Care plans were not fully accessible to people using the service and information about the service was not in a user-friendly format.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong: Working in partnership with others

●The provider did not have a robust system in place to ensure that all notifications: safeguarding and incidents were reported and acted upon.

●No incidents or safeguarding concerns had been reported to CQC since the last inspection. The acting manager said there had been no safeguarding concerns in the last year. Incidents were not being signed off in a timely way and not routinely referred or discussed with the safeguarding team. The incident reporting process was not followed fully and delays in sign off meant. actions were not always agreed which could help reduce the likelihood of further incidents. We were not assured all staff had the necessary competencies and understanding of what constituted a safeguarding concern and provider oversight of this was poor.

●Oversight of risk was poor, and lessons were not learnt from one incident to another, or from one service to another. However, some improvement in this were noted as managers' meetings were now taking place.

●There was limited evidence of joint working or accessing support and advice from other agencies to ensure people's needs were met holistically. We spoke with several families who maintained regular contact and staff supported people to maintain the contact. However, they were unaware of recent changes within the service and there was no newsletter or contact from the provider.

● Two people had advocates and there was a therapist who visited regularly but there was no recent contact with other social care professionals or advice sought about peoples behaviours and how it could be effectively managed

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Continuous learning and Improving care.

●Feedback about the service was not routinely sought to help ensure improvements were identified based on peoples experiences.

●Governance meetings were held quarterly and showed no recent engagement or involvement from people who used the service. Surveys had not been issued in the last few years to gauge the views of relatives, people using the service and health care professionals. Feedback would help the provider to identify areas where they were performing well and what required improvement.

●A recent governance meeting stated that staff surveys would be rolled out later in the year. We sought staff views on the organisation, and some felt training and development was poor and some staff felt unvalued in their role with little support from the provider.

●A complaints/ compliments log was being maintained by the service, but no complaints were recorded, and people were not routinely asked if they were happy with the service and how it could be improved upon.

There were not adequate systems in place to assess, monitor and improve the quality and safety of the service which includes the quality of the experience of service users in receiving those services. This was a

breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The deputy manager was providing management support to the staff and staff spoken with felt well supported by them and felt they were doing a good job and the workload was organised to ensure people's needs were being met and routines were in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the MCA and the code of practice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been identified or fully mitigated

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have adequate systems, processes or training in place to help ensure people were fully protected from abuse and ill treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We were not assured staff had the necessary competencies, skills and training to meet peoples assessed needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Overall governance and oversight at the service was weak which meant improvements to the service were not identified in a timely way and to ensure the regulated activity was carried out effectively and safely.

The enforcement action we took:

Positive conditions- Regulation 17