Mr & Mrs V L Goaman

Southlands Court Residential Home

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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection on 15 and 17 June 2015.

We last inspected the home in June 2013 and found no breaches in the regulations we looked at.

Southlands Court provides accommodation and personal care for up to 25 people. Any nursing needs are met through community nursing services. There were 23 people resident at the time of the inspection.

The service has 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.

Summary of findings

Safety was not fully promoted because the arrangements for assessing, monitoring and mitigating risks were not effective. Monitoring and auditing arrangements did not inform the registered manager or provider where action needed to be taken.

The arrangements for staff training did not ensure staff were fully aware of current good practice, such as moving people safely; some staff had not received some training for many years. Actions following environmental risk assessments were not always followed up within the specified timescales and fire doors were propped open and staff did nothing about it.

Medicines were stored securely and people received their medicines as prescribed but records were not always completed and some medicine in stock was out of date.

The registered provider and registered manager were not up to date with their regulatory responsibilities. Whilst people were involved in decisions about their care the staff did not understand how to ensure people's rights were protected. This had led to at least two people who may be unlawfully deprived of their liberty, one because their movements were being closely monitored and one because a strap was used to restrain them in their wheelchair.

Records were not always accurate and complete. This included positioning and dietary monitoring records.

We have made a recommendation about environmental adaptation to promote the independence of people living with dementia.

Recruitment procedures were in place but one person started working at the home before the checks of their suitability to work in a care home environment was confirmed.

Risks to people's individual safety were assessed and followed up although not always recorded. People's care plans provided enough information for staff to understand what person centred care the person required but plans were not always in place within a reasonable timescale. This meant staff might not understand what support one person required, whose behaviour was a challenge.

Staff had sufficient understanding of abuse and how to report any concerns to protect people from abuse. The registered manager understood her responsibilities and how to alert any concerns identified.

Health care professionals had no concerns about the service and felt the standard of care delivered met people's needs and preferences. They said they were always contacted appropriately and they had a lot of confidence in the registered manager and staff at Southlands Court.

Staff were caring, kind and treated people with respect and dignity, taking their views into account. All interactions between staff and people using the service were unhurried and put the person as the priority. There was friendly banter and gestures of affection.

People liked the food and people's dietary intake was monitored and followed up as required for their well-being. Activities were organised but there was no evidence that they took into account people's personal interests or hobbies. However, no person mentioned a lack of activities and the homely atmosphere and friendly interactions with staff gave people lots of opportunity for social interaction.

People said when they called for assistance it arrived quickly. There were sufficient staff to meet people's needs in a timely way.

We found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 always safe.

Action in response to environmental risk assessments was not always followed through.

Some medicines were passed their expiry date and some medicine records were inaccurate. People did receive their medicines as prescribed.

People were protected from abuse and staff were prepared to whistle blow concerns if they felt this was needed.

There were sufficient staff to meet people's needs

Requires improvement

Is the service effective?
The service was not effective.

Staff did not understand or meet their responsibilities under the Mental Capacity Act and deprivation of liberty safeguards. This meant people were not always consenting to the care they received and some were being unlawfully deprived of their liberty.

Staff did not receive a complete induction, training or supervision of their work. Staff did feel supported.

The independence of people living at the home with dementia was not promoted through adaptation to the environment in which they lived.

People liked the food and their dietary needs were well met. People had access to health care support to promote their wellbeing.

Requires improvement

Is the service caring?
The service was caring.

People received care from staff who treated them with respect, dignity and kindness. Relationships were made which provided people with the knowledge they were valued.

People's privacy was upheld and information about them was kept in confidence.

Health care professionals were very satisfied with the standard of end of life care delivered.

Good

Is the service responsive?
The service was responsive.

Staff responded promptly when people needed care and support and they understood individual's likes and dislikes.

Good

Summary of findings

Staff were responsive to people's health care needs and sought prompt advice and support from health care professionals.

Activities were arranged and there was opportunity for social interaction.

People said they had no reason to complain. There had been no complaints for many years.

Is the service well-led?

Requires improvement

The service was not always well led.

There was not sufficient monitoring to ensure the service was as safe and efficient as it could be. Records were not always fully completed .

The registered provider and registered manager were very visible at the home, ready to listen to people's views and people had confidence in the way the service was run.

Southlands Court Residential 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 15 and 17 June 2015 and was unannounced. The inspection team consisted of one inspector.

We reviewed information we had about the service such as previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not talk with us.

We spoke to eight people who lived in Southlands Court, two people's family, six staff members and the registered provider and manager. We looked in detail at the care provided to five people, which included looking at their care records. We looked at three staff recruitment records and at staff training records. We also looked at a range of quality monitoring information such as minutes from meetings. We asked a member of the community nursing team their opinion of the care provided and had previously received information from a GP with knowledge of the home.

Requires improvement

Is the service safe?

Our findings

People received their medicines as prescribed. One person said theirs always arrived at the time they expected them. No people using the service were managing their own medicines at the time of the inspection. Medicines were kept securely in a locked room plus cupboard or trolleys. The temperature of the medicines fridge was monitored. However, there were no records of the temperature of the medicines storage room, so staff could not be sure medicines were being stored within the manufacture's guidelines. There were also some medicines in stock past their expiry date, although not currently being administered to people.

Medicines were recorded into the home as part of the audit system of their use. Any unused medicines were logged for their return to the pharmacy. Codes were used for unused medicines and a code and explanation was used when one person was administered their medicine earlier than the routine time for this.

Staff used a monitored dosage system in which they had been trained. They registered manager said that checking the medicines into and out of the home was the audit method used for medicines management.

For safety, a GP made a record for the home of any change in medicines. Staff said that this was very useful. All hand written medicine entries were checked and signed by two staff members so the accuracy of the record was confirmed. However, records of medicine usage were not always accurate. For example, a record on a medicine register did not correspond to the amount of medicine stored. The deputy manager found the medicine had been given but the register had not been signed as it should. Also, a senior staff had signed to say a medicine had been given before it was administered. This had the potential to cause confusion and mistakes.

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

The premises looked well maintained and staff had a list of contacts should a fault need immediate remedy. However, staff practice was not always safe. The laundry and linen room doors had a notice that they should be kept shut but both doors were seen propped open with no staff were in the area. The deputy manager said she was not surprised and staff kept doing this although they had been told not to. We also saw a bedroom door with a wedge which would to stop the door shutting device working should the fire alarm sound and therefore put people at risk in the event of a fire.

Records of maintenance and servicing included equipment such as hoists and a chair lift and those checks were in date. Risks were assessed but the actions identified through those assessments was not always followed up and so risk was not always mitigated. For example, thermostatic valves were to be checked annually, but this but had not happened. Small electrical equipment was to be checked annually; this check was due March 2015 but had not happened and was not yet arranged. All water tanks were to be cleaned annually but had not been cleaned since 2008.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were recruitment and selection processes in place. Staff files for the most recently recruited staff included completed application forms and a record that interviews had been undertaken. In addition, checks were done, which included references from previous employers and health screening. Disclosure and Barring Service (DBS) checks were done, but not always before the staff member started working in the home. The registered manager was unable to provide the date when one DBS check had been requested and the staff member said it was after they had started working at the home. The DBS is to help employers make safer recruitment decisions and should help prevent unsuitable people from working with people who use care and support services. This therefore needs to be completed before the person is employed. The registered manager said the staff member had worked under close supervision during the period before the DBS was returned.

There were varying levels of staff confidence in their knowledge of the types of abuse and how to respond to any concerns. The registered manager said "Safety of everybody is my responsibility including staff who are aware of what to inform me about." However, there was no care plan in place for one person. This meant staff did not have a plan to follow to protect the person and themselves although the person had threatened them and spent time screaming and distressed.

Staff knew where the policy for whistle blowing could be found and this included types of abuse and the contact

Requires improvement

Is the service safe?

details for the local authority safeguarding team. Most staff had not received recent training in the protection of people from abuse. The registered manager said that this information was included in staff induction but this was not evident from induction records. However, staff had contacted the Care Quality Commission in the autumn of 2014 and so had taken steps to report their concerns outside of the service. This showed that they took the steps they felt necessary to protect people from abuse.

The registered manager demonstrated a good understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis for the protection of people.

When call bells activated staff responded quickly. People and their family members felt there were enough staff to meet people's needs in a safe way. One person said, "I feel safe because there is somebody here to help me" and call bell response times were "very, very good." One person's family member said, "She feels secure here."

Staff said there were enough staff. Staffing arrangements had been discussed at staff meetings. The registered manager said staffing was arranged according to people's needs and she would adjust staffing numbers if people's needs warranted this. Staff said, "Everybody works together; they help each other." A district nurse confirmed that people's needs were met although she said that when people's needs were higher the staff were obviously much busier.

People were protected through the arrangements to promote their health. For example, staffing routines prevented people from pressure damage and falls were recorded and increased risk identified and followed up. One person had been referred to a "falls team" for investigation. Hand over of information between staff, both written and verbal, helped to ensure staff were aware of any risks.

Requires improvement

Is the service effective?

Our findings

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known. People's individual wishes were acted upon, such as how they wanted to spend their time and whether they wanted help with personal care.

Staff had limited understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. They had not received training in the subjects. MCA and DoLS were not being appropriately followed when complex decisions needed to be made, such as whether a person should have their movements monitored as the least restrictive option. For example, there were no decision-specific, time-specific capacity assessments completed by staff at the home. The registered manager said she would ask health care professionals to do this. One capacity assessment had been completed by a community psychiatric nurse (CPN), the decision being whether a person understood the risk when they stood from a wheelchair. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The CPN capacity assessment had led to a best interest decision to use a lap belt to stop the person standing when in the wheelchair. The registered manager believed this was authorisation to restrict the person's liberty, but this was not a legal authorisation under the deprivation of liberty safeguards.

People had Lasting Power of Attorneys or Court of Protection deputyships, which can be for property and financial affairs or care and welfare. A Lasting Power of Attorney (LPA) is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if they are unable to at some time in the future. This is similar for the Court of Protection, when someone becomes a 'deputy' to act on a person's behalf. However, the registered manager did not have copies of those LPA's and could not confirm they were in place for people or what they were for. This meant she might be acting outside of the legal authority to consult a family member who says they hold LPA and are authorised to act on their family's behalf. This meant that consent was not being sought in line with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not observe any person actively trying to leave the home. The provider had not assessed people who may be at risk of being deprived of their liberty. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The Supreme Court judgement of 19 March 2014 confirmed that if a person lacking capacity to consent to the arrangements required to give necessary care or treatment is subject to continuous or complete supervision and control and not free to leave, they are deprived of their liberty. The registered manager said that people were free to leave but added that staff might accompany them for their safety. One person had a pressure call mat positioned between their chair and their bedroom door for use at nights; when they moved onto the mat it would activate the call bell system and staff would know the person was standing and may be leaving their room. This was continuous supervision and control when in use. There had been no mental capacity assessments to consider whether they were being deprived of their liberty in any way. Staff had not realised they were depriving the person of their liberty and had not taken advice or applied for a DoLS authorisation to meet their statutory responsibilities.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff induction is the start of the process of understanding the necessary skills to perform their role appropriately and to meet the needs of the people living in the home. Staff confirmed that they worked along side a senior member of staff when new to the home, were not expected to undertaken tasks they did not understand and always had the opportunity to asks questions.

Records of newly recruited staff showed they received instruction "on arrival" from other staff at the home but the detail of the instruction was not recorded. Staff told us the instruction included what to do if the fire alarm sounds. It

Is the service effective?

did not include how to prevent a fire from occurring. One staff member added that they had been involved in a fire alarm drill to check their knowledge of how to respond but had not received feedback about how they had performed. Three staff files showed a formalised induction process was used at the home. However, none was completed and one had not been started although the staff member commenced their employment on 6 May 2015. The registered manager was unaware of the Care Certificate, recommended since April 2015 for staff who do not have experience of care work.

Staff were unable to remember when they had training in some subjects and were unsure of the training arrangements. Training records showed that none of the 25 staff had received training in most mandatory subjects in 2015; we found other information showing many had received training in First Aid. Training records for 2014 showed that no staff had received training in moving and handling, four of the 25 had received training in health and safety, five in food hygiene, five in adult protection and six in fire prevention. One senior staff member had received no moving and handling training since 2007. Another staff member said they were not sure when their last fire safety training was and after checking the records told us, "I better get an update then." The registered manager said their last moving and handling training was "a long time ago."

The registered manager said it was difficult to get everybody together and some staff could not get away for the training. One person refused training, although the registered manager said it was mandatory. District nurses had no concerns about the current knowledge and skills of staff providing the care at Southlands Court but the registered manager could not be sure staff were using current good practice or had the relevant knowledge they required. One example was a staff lack of understanding of MCA and DoLS.

The registered manager said, "The door is always open" and "Everybody has a confidential voice" when asked about staff supervision and appraisal. They confirmed there was no programme of supervision and that it was more ad hoc than formalised. She said, "We talk when we can." Supervision provides an opportunity for staff to discuss work and training issues with their manager. It also provides the manager with an opportunity to feedback to staff issues around their performance. Records showed that some staff received supervision of their work sometimes. Staff said they felt supported by the registered manager and were seen discussing care issues throughout the inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many people at Southlands Court were living with dementia. Whilst the premises was very 'homely' and comfortably furnished there was no adaptation to indicate the independence of people with dementia was promoted. For example, one person chose to walk about the home and we were told they kept going into other people's rooms. Their bedroom door was indistinguishable from other bedroom doors along the corridor, other than their name written in small letters.

We recommend that the service finds out more about care home environments, based on current best practice, in relation to the specialist needs of people living with dementia.

People said they liked the food their comments including, "Quite good". One person said, "Lovely meal" to the cook. One person's family said their mother was eating much better than she had been previously. People's food preferences were taken into account; the cook said she was kept informed about this. For example, one person did not like mushrooms and another person did not like fish in batter. We were told there was no alternative menu but changes were made if people wanted this, for example, if they felt unwell. The menu was varied, including prawn salad, egg and bacon pie, poached eggs, meat and cheese dishes. However, a yearly survey of people's opinion, asked people what different meals the service could try, and received responses about rice and pasta dishes. The registered manager said that when these dishes were tried people did not like them and they had not explored this further.

Staff sought people's choices about the tea time menu asking them what they wanted in their sandwiches when sandwiches were the menu option for that meal.

People had hot and cold drinks available to them at all times. Where people were especially vulnerable to poor food and fluid intake, this was monitored. A district nurse said she had no concerns about people's hydration and the way the home monitored people's dietary intake and followed up any concerns.

Requires improvement

Is the service effective?

People were assisted where required with their food and drinks and some people had equipment, such as plate guards, to help them eat independently. Staff were unhurried with their assistance and ensured people ate as much as they wanted.

A district nurse confirmed she visited “a minimum of once a week”. She described the value of a monthly meeting with the home’s management to discuss each person living at the home. She said, “(The registered manager) is pretty much on top of anything. She phones straight away”.

People told us staff were quick to get medical attention where this was needed and we were given examples of advice taken from physiotherapy, chiropody, dental and ophthalmic services to promote people’s health and welfare. For example, relating to one person’s seating needs. Prior to the inspection a GP with knowledge of the home told us they had no concerns about the care delivered at Southlands Court.

Good

Is the service caring?

Our findings

People felt the staff were very caring, their comments including, “They’re very, very good and very helpful”. Two people said they were very happy at the home. People’s families said staff were caring one saying, “The standards of care are not just high but genuine, warm and staff are a heart felt group”. There were only positive comments about the caring attitude of staff and the registered manager.

All staff interactions with people were sensitive to their needs; kind and respectful. For example, people took varying times to move from the lounge to the dining room and their support with this was unhurried. Jokes were shared, for example, over the choice of a jam sandwich for tea. Staff sat next to people when assisting them to eat.

People were involved in choices, such as where to eat lunch and how to spend their time. Where assistance was given people were informed about what was happening and why. People received individual attention and were helped to feel involved and valued.

A recent questionnaire completed for the service said, “My visitors were welcome what ever time of day, even my little dog.” Visitors said they felt welcomed and they knew the registered manager well and were seen chatting and sharing information. Staff talked about a “ Happy family” atmosphere at the home, and this is what we observed.

People received their care in private and the registered manager was careful to maintain confidentiality when discussing people’s care needs.

People were able to express their views. One person said, “They do all the worrying for you.” The registered manager said that, where possible people’s care needs were discussed with them so their views were taken into account. There was also a yearly feedback questionnaire. The questions included whether people were given enough choices and were they able to express their views? The responses were very positive.

A district nurse confirmed the home took their advice and followed recommendations when providing end of life care. She said, “If you give advice you can guarantee it is acted on.” She described how proactive staff were with regard to preventing pressure damage.

People who were very frail and receiving their care in bed appeared comfortable and received regular attention from staff. The family of one said they had no concerns about the care and were happy they had chosen Southlands Court for their mother.

Good

Is the service responsive?

Our findings

People expressed satisfaction with the service they received. Comments included, “All very friendly here”. One person said staff say when they want to get her up in the morning but she didn’t mind. Staff confirmed they only provided assistance for people to rise and return if the person was happy for them to do so. There were no negative comments about the service. Staff were very attentive to people’s needs and responded immediately when support or information was needed. Health care professionals had no concerns about the care and welfare provided at Southlands Court, one described some aspects of the care as “outstanding”.

Each person received an assessment of their needs including information from any health care professionals who had delivered care, prior to admission to the home. The assessment included ‘Carer and family involvement and other social contacts and relationships.’ The assessment included what abilities people had and where they needed support, for example, to put their shoes on or to apply their make up.

In preparation for, and following admission, staff identified any risks to people’s health and took steps to reduce the risks for people’s safety. For example, one person had a wider than normal bed provided to prevent them from falling and a pressure mat to alert staff if they tried to leave their room without support. However, that assessment and the steps taken to mitigate the risk, had not been recorded as a risk assessment although they had been at the home for one week. Other measures to reduce risks included a mattress on the floor next to the person’s bed to prevent injury should they fall from the bed and raised chairs to help people’s independence when mobilising.

Care plans are a tool used to inform and direct staff about people's health and social care needs. People’s care plans at Southlands Court provided sufficient detail for staff to understand the person’s needs and provide person centred care. For example, one described how a person was able to gargle their mouthwash. The registered manager told us people’s care was discussed with them, or their family representative where at all possible. People’s families felt they were kept informed.

A person who had been at the home for one week did not yet have a care plan in place. The registered manager said they were still getting to know them before a plan was produced. This meant staff did not have access to a plan of how to provide the support that person needed in a thought through, agreed and consistent way.

Staff were able to describe people’s individual interests as they had knowledge of their past lives and what was important to them. For example, previous employment and sporting interests and successes. The registered manager talked of the importance of a “Good, detailed history, crucial for everyone who comes in.”

Staff told us there were activities arranged for four hours a week plus two hours to attend to people’s nails. There was a programme of activities which included an exercise class, some entertainment and quizzes. Some people were colouring pictures the second day of our inspection. People had magazines and newspapers and television and Southlands Court was a very homely environment with pleasant gardens. Some people benefitted from the home’s mini bus and were able to take trips away from the home. However, we saw no evidence of person centred activities based on individual preference, such as following hobbies. There were photographs of previous activities including cooking and celebratory events.

A complaints procedure was available to people and described how they could make a complaint and their options if they were not happy with a complaint response. People told us they had nothing to complain about and the registered manager said they had not had any complaints for years. People using the service, their family members and staff confirmed that any day to day grumbles would be dealt with straight away.

Requires improvement

Is the service well-led?

Our findings

The provider and registered manager were not up to date with the current legislation with regard to the way the service must be delivered. For example, they were not prepared for the changes in regulations under the Health and Social Care Act and did not understand their responsibilities under the MCA and DoLS. They were therefore not equipped to meet their regulatory responsibilities.

The registered provider said they visited the home three times a week, knew all the people using the service, the majority of the families and all the staff. They said, "(People) would come to me" if they had any issues or things they wanted to discuss. The registered provider said they had a good rapport with the GP who attended most people at the home. The registered provider described the registered manager as being "Very focused on the home", adding that she would spend any amount of time trying to work out a problem – "wanting to do what people want". They said discussions with the registered manager about the running of the home were not recorded and we found no information with regard to how those discussions had led to improvement.

The registered manager was experienced and had been in post for many years which provided stability and continuity. The quality of the service people received was monitored through discussion with people and a yearly survey but systems were not in place to ensure people's safety. For example, the system for monitoring training was ineffective because some staff did not attend mandatory moving and handling training.

There was an open and inclusive culture at the home. The registered manager relied on an 'open door' policy and relaxed and informal approach to staff supervision and staff sought her advice regularly. However, this approach meant that poor practice might not be identified or responded to in a timely manner. For example, the registered manager was aware of possible unprofessional practice by a care worker but said they had not spoken to that staff member yet. They said that professional boundaries were discussed at induction but there was no record of that discussion. Professional boundaries was not part of the induction process used at the home. The staff member had received supervision from the registered manager but professional boundaries had not been discussed during that meeting.

Arrangements for assessing, monitoring and mitigating risks were not always effective. For example, actions from environmental risk assessments to improve safety had not been done within a reasonable timescale. This meant those risks might have increased. People were being deprived of their liberty unlawfully.

An accurate and complete record was not always available in respect of people's care. For example, the positioning and dietary monitoring for one person had a day missing and the person's name was not recorded. One person had no record of risk assessments or a care plan one week following their admission. An entry in a medicine register was missing and a medicine was signed as given before it was administered.

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

People using the service and their families said the home was well-led. One person said in a survey, "The place is run extremely well from the management, care, kitchen and domestic staff." Staff felt the home was well-led. They said, "The culture is good. We have good team work and it is a happy family." We observed that it was an open culture and a happy family atmosphere and leadership was visible and inspired staff to provide a quality service.

The registered manager notified the Care Quality Commission as she was required to do.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The management of medicines was not robust with regard to record keeping, safe administration and stock control.** Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Consent was not being sought in accordance with the Mental Capacity Act 2005.** Regulation 11

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 **People were being deprived of their liberty without lawful authority.** Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The arrangements for induction, training and supervision of staff do not ensure staff can carry out their role using current best practice.** Regulation 18 (2) (a)

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Actions were not being taken in a timely way to ensure the premises was properly maintained. Regulation 15 (1) (e)

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 17 HSCA (RA) Regulations 2014 Good governance There were not effective systems to assess, monitor and mitigate risks and records were not always accurate and complete. Regulation 17 (1) (2) (b) (c)

The enforcement action we took:
A warning notice was served on 2 July 2015 to be met by 30 September 2015.