Yorkvalley Limited

Haven Lea Residential Care 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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection, carried out on 19 and 24 June 2015.

Haven Lea Residential Care Home is registered to provide accommodation and personal care for up to 26 adults. The service is located in the Whiston area of Merseyside and is close to local public transport routes. Accommodation is provided over two floors. These floors can be accessed via a stair case or passenger lift.

The service does not have 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. A manager had been appointed by the registered

Summary of findings

provider to manage the service, however they were absent from work and the registered provider had appointed a temporary manager to oversee the management of the service.

The last inspection of Haven Lea Residential Care Home was carried out in May 2014 and we found that the service was meeting the regulations we reviewed.

At this inspection we found a number of breaches 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.

People who used the service were protected from potential abuse. Staff had received safeguarding training and they had access to relevant safeguarding policies and procedures. Staff had a good understanding about how to respond to allegations of abuse.

Equipment people used to help with their mobility such as wheel chairs, walking frames and stand aids were dirty with dust and food debris and they were not cleaned in-between use, increasing the risk of cross infection. People's bedrooms and communal areas of the service were kept clean.

Improvements were required to the environment to make it more homely and suitable to meet people's needs. The décor and furniture in people's rooms and communal areas showed signs of wear and tear and there was a lack of orientation signs and environmental stimulation for people living with dementia. We have made a recommendation about the environment.

Medication was stored securely and checked when received into the home. Medication administration records for some people had not been completed which meant there was no guarantee that people had received their prescribed medication. There was a lack of information about the use of medication which people were prescribed 'as required' (PRN). The use of PRN medication was not reviewed to ensure it was being used appropriately and was effective.

We have made a recommendation about the management of some medicines.

Staff were provided with training in mandatory topics, however, they had limited knowledge due to a lack of training in relation to the specific needs of people who used the service. This included care of people living with diabetes and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The principles of the law were not followed when making decisions for people who lacked capacity and needed their liberty restricting for their safety.

People's care records were not complete and some people did not have a care plan for their assessed needs. There was no evidence to show that care plans were developed and reviewed with the involvement of the person they were for, and significant others, such as family members and health and social care professionals.

There was a lack of stimulation for people. There were no organised activities and most people spent their time asleep or watching TV in the lounge. People told us they were often bored and they said they would like more activities. Opportunities for people to access the local community were limited to when their family members visited.

Appropriate referrals had not been made to external services for people who needed help with their mobility. For example, The same wheelchair was used to help people to move around the service.

The registered provider did not notify CQC about the deaths of people who used the service and there was a lack of information held at the service about the circumstances of people's deaths. Systems were not in place to check on the quality of the service and ensure improvements were made. Staff did not feel empowered to contribute to the development of the service.

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.

People told us they felt safe. Staff knew how to respond to allegations of abuse.

Equipment people used for their mobility had not been regularly cleaned to minimise the spread of infection.

Records relating to the administration of medicines were incomplete and lacked information about the use of PRN medicines. These are medicines which people require when needed.

Requires improvement

Is the service effective?
The service was not always effective.

Staff lacked knowledge of and they failed to apply the law when making decisions for people who lacked capacity.

People's records were not complete and kept up to date to reflect their current and changing needs.

The environment lacked stimulation for people living with dementia. The décor and items of furniture were dull and in poor condition.

Requires improvement

Is the service caring?
The service was caring.

People and their family members told us that the staff were kind and caring.

Staff spoke about people in a caring way and they were patient and caring in their approach when providing people with care and support.

People made everyday choices and their independence was promoted.

Good

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

People's care needs were not always appropriately assessed and planned for. Some people did not have a care plan for their assessed needs.

People were bored and lacked stimulation because of the lack of activities available to them.

People's complaints were not responded to in a timely way.

Requires improvement

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

The service did not have a registered manager.

Inadequate

Summary of findings

The registered provider failed to notify CQC following the deaths of people who used the service.

There was a lack of effective quality assurance systems to ensure improvements were made to the service people received.

Haven Lea Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was unannounced and took place on 15 and 18 May 2015. The inspection team consisted of two adult social care inspectors.

During our visit to the service we spoke with eight people who used the service, two family members and eight staff. We also spoke with the temporary manager and three visiting healthcare professionals. We looked at five people's care records and observed how people were cared for. We toured the inside and outside of the premises including people's bedrooms. We looked at staff records and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection and information we received from members of the public and local commissioners.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe at the service, their comments included; "I feel safe and secure here", "I'm not worried about anything at all" and "I'd let them know if I was worried".

The environment was generally clean and hygienic, however items of equipment people used to help with their comfort, independence and mobility including; walking frames, stand aids and wheelchairs were unclean with dust and food debris. The same wheelchair which was used to transfer three people at different intervals throughout the day was not wiped over in between use. This increased the risk of the spread of infection. We raised this with the temporary manager and she made arrangements for equipment to be cleaned immediately. Staff had completed infection control training and they had access to information and guidance in relation to prevention and control of the spread of infection. Personal protective equipment (PPE) including disposable gloves and aprons were located around the service and readily available to staff. Staff used PPE as required, for example when they assisted people with personal care and when handling soiled laundry.

Medication was checked when it was received into the service and it was stored safety. There was a system in place for the disposal and return of medication to the pharmacist. Staff who administered medication had received appropriate training and had had their competency checked at regular intervals. Staff had access to policies, procedures and good practice guidance in relation to managing people's medication. Each person who required medication had a medication administration record (MAR) which detailed each item of prescribed medication and the times they were to be administered. There were gaps in some people's MARs where they had not been signed or coded for medication they should have received. A member of staff told us the gaps were probably because staff had forgotten to sign them. This meant there was no guarantee that people had received their prescribed medication. Two people were prescribed PRN medication; this is medication which is to be taken when required. However, there was no information or guidance for staff detailing the circumstances for administering the medication. MARs showed that one person had been administered the maximum amount of PRN medication each day since it was prescribed in October 2014. There was no evidence to show a review had taken place with the persons GP to discuss the continuous use of PRN medication and the possible effects.

We recommend that the service consider current guidance on giving 'PRN medication' to people alongside their prescribed medication and take action to update their practice accordingly.

Risk assessments had been carried out for the environment including the lounge, entrance hall, kitchen and conservatory. They identified potential risks to people's safety and detailed the measures required to reduce the risk of harm to people. For example, daily checks were required to ensure; all walkways and fire exits were kept clear and that areas were adequately lite and free from trailing wires. However, there was a wheelchair and a stand aid stored in front of two external fire doors, despite there being a notice displayed on the doors requesting that the doors be kept clear from obstructions. This posed a risk to people's safety in the event of an evacuation. We raised this with the temporary manager and she immediately arranged the removal of the equipment and addressed the concern with the staff team. Prior to our inspection we received concerns about the safety of people when using a patio area directly outside the dining room. There was a set of stone steps leading off the area onto a garden, however there were no measures in place to ensure the safety of people who were at risk of falls. Following our inspection the temporary manager advised us that a safety gate had been installed to minimise the risk of harm to people who were at risk.

Staff knew where emergency equipment was located, such as first aid boxes and firefighting equipment. The equipment was easily accessible to staff and had been regularly checked to ensure it was effective and safe to use. Staff had received training in topics of health and safety including; first aid and fire awareness. They were confident about dealing with emergency situations such as if a person suddenly became ill or if there was a breakdown of essential equipment at the service.

People were protected from abuse or the risk of abuse. Staff had completed safeguarding training and they had access to the procedures they needed to follow if they witnessed or suspected abuse. Staff described the different

Requires improvement

Is the service safe?

types of abuse and signs which indicate abuse may have taken place. Staff also explained the actions they would take if they suspected or witnessed abuse this was in line with the relevant local authority's safeguarding procedures.

The number of staff on duty was appropriate to keep people safe and meet their individual needs. Staff told us they felt the staffing levels were safe and that they had time to provide people with the care and support they needed. People received assistance from more than one staff when they needed it, for example when being transferred by the use of a hoist and standing aid and when they received personal care. Staff rosters for the previous month showed that there had been a consistent number of staff on duty over this period.

Requires improvement

Is the service effective?

Our findings

People told us they had enough to eat and drink. They said they liked the staff and that they were good at their job. People's comments included; "The staff know me well and do whatever I ask" and "We get good old homemade food".

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff had not received any training in relation to the MCA and DoLS and they had limited understanding about it. Care records and practices carried out at the service showed decisions were made on behalf of people; however there was no evidence to show that the principles of the Mental Capacity Act 2005 had been followed to assess people's ability to make a particular decision. Also, people's best interests had not been considered as part of a decision making process. For example; one person's care records stated that their family members deal with all their decisions and another person's care records stated that their family dealt with their finances. People's mail was left in a rack with a sign on it stating "Post for family members. Please check regularly". A member of staff confirmed that people's post was put in the rack for their relatives to collect.

Another person's care records stated that they had memory loss and 'may try to get out the fire doors'. There was no evidence that a DoLS had been applied for in respect of this person despite them being restricted from leaving the building. Staff did not consider people's rights and understand that restrictions were being placed upon people unlawfully. This meant that the rights of people, who were not able to make or communicate their own decisions, were not protected and people were being deprived of their liberty unlawfully.

The temporary manager had a good awareness about the MCA and how and when to apply for a DoLS. We were informed since our inspection that a DoLS application had been submitted to the relevant agency in respect of a number of people who used the service.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from inappropriate deprivation of their liberty.

Care records including need assessments, care plans and monitoring charts were not complete or kept up to date. One person's next of kin details had changed, however their records had not been updated to reflect the change. Nutritional assessments for three people were incomplete and weight monitoring charts were not consistently kept up to date. For example, one person's care plan stated 'weigh weekly', however the last entry made onto their weight chart was on 06 June 2015. Falls risk assessments for two people and a moving and handling risk assessment for another person were incomplete. The assessments identified a risk but they did not detail the action staff needed to take to manage the risk of harm to the people and others. The majority of care records held in people's files had not been dated and signed on completion and sections of records were incomplete. This included records detailing the support people needed with taking medication, moving around, managing finances and communication. Each person's file contained a form titled 'About me'. The forms were a way of gathering information specific to the individual for example, previous life history, preferred method of communication, religion and spiritual needs, however they were incomplete. This meant people were at risk of receiving ineffective care and support.

People were supported to attend general healthcare appointments with their optician, chiropodist and dentist and a record of the visits including outcomes was kept. A number of people had received input from visiting health care professionals including nutritionists, dieticians and speech and language therapists (SALT). Records showed that the visiting professionals had provided staff with advice and guidance about the support people needed with eating, drinking and managing a healthy diet. Care plans had not been updated to include this information. Staff told us they knew the care and support people needed and whilst the lack of accurate record keeping did not impact on people's care, people were at risk of receiving inappropriate care and support.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people the needs of people who use the service were not planned for.

Improvements were required to the environment to ensure it is properly maintained and suitable to people's needs. Although people's rooms were personalised with photographs, ornaments and other personal items, the

Requires improvement

Is the service effective?

decoration and furnishing in some rooms was showing signs of wear and tear. For example, bedroom furniture and paintwork were chipped and stained. The decoration in communal areas including bathrooms and the main lounge was dull and uninviting. Easy chairs and side tables in the lounge were stained and damaged and the carpet was heavily stained in parts. Curtains in the lounge were ill fitting and some of them were torn. Minutes taken from a recent 'relatives' meeting showed that family members commented about the poor state of the furniture and curtains in the lounge and they had put forward ideas for improvements.

There were a number of people who used the service living with dementia, however the environment did not promote people's orientation and it lacked stimulation. For example, corridors and communal areas were painted in plain dull colours and there were no sensory facilities for people to look at or touch. There were no period items to stimulate people's memories and generate conversations from the past. Doors throughout the service, including people's bedrooms, toilets and bathrooms were the same colour. This had the potential to cause confusion for people living with dementia as different coloured doors can help people recognise where they are.

We recommend that the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'.

Recruitment records for staff that had commenced work at the service in the last year showed appropriate checks were obtained in respect of them, prior to them commencing work. Training records evidenced induction training for new staff. Two staff who had commenced work at the service since our last inspection told us they completed training in key topics including safeguarding, moving and handling and health and safety. They also told us they spent a two week period shadowing more experienced staff.

Although staff had been provided with a range of training they had not completed some training relevant to the needs of people who used the service. For example, caring for people living with diabetes and the MCA 2005 and DoLS. Staff lacked knowledge and understanding about these topics which meant people were at risk of receiving inappropriate care and support.

Good

Is the service caring?

Our findings

People told us that they were well cared for. People's comments included "They care a lot", "They do whatever I ask them and they are always very nice", "Nothing bad to say about any of the, they are all great and look after us very well" and "Very caring". Family members told us; "The staff are kind and they care a lot about my mum" and "They always listen and take their time, they are so good".

Visiting healthcare professionals told us that they thought the staff were very caring and did their best for the people who used the service. They said they had always observed staff to be kind and patient towards people and they said had spoken about people in a caring way.

Staff gave us examples of how they ensured people's equality and diversity. One member of staff said "Everybody is different and need different things" and another staff member said; "People are entitled to live their lives as they want, we are not here to judge".

People's privacy and dignity was respected. People were consulted regarding their preferred gender of staff that provided them with personal care and people told us that this was always respected. People received personal care in the privacy of their own rooms and bathrooms and staff knocked on doors before entering. People's care records included their preferred title and staff knew what people preferred to be called.

People told us that staff were kind and compassionate and took time to speak with them. Staff sat close to people and spent time talking with them. Conversations which took place showed staff knew people well. When speaking with people staff maintained eye contact and showed interest in what people had to say. Staff engaged in banter with people and we saw people laughing and joking with staff. One person told us, "The girls know I like to smile and I enjoy a laugh and a joke".

Staff were patient in their approach and they reassured people who were upset and anxious. For example, one person was very nervous and became upset when being assisted with their mobility. Staff spent time reassuring the person and the person soon became less anxious.

Staff were respectful when using hoists to transfer people. They ensured people's dignity throughout and explained what they were doing.

People were encouraged to make choices and their independence was promoted. People were given choices about what they wanted to eat and drink and where they preferred to spend their time. Care records included information about people's ability and level of independence and the tasks which people preferred to carry out for themselves. One person's records stated that they like to brush their own hair and put make up on. Staff encouraged people to do as much as they could for themselves. Staff told us they encouraged people to carry out small tasks such as setting tables at meal times and tidying their bedrooms to maintain their independence.

Information about advocacy services was made available to people. The temporary manager told us no one who used the service was currently receiving support from advocacy services; however she was aware of how to access the service should people require it. Staff understood the circumstances when a person may need support from an independent advocate.

Requires improvement

Is the service responsive?

Our findings

People told us they had not seen their care plans and had not been involved in the development of them. Their comments included: "No I haven't seen it and nobody has talked to me about it" and "I've not seen it but I'm sure I've got one".

People's needs were assessed and planned for on admission to the service. However, people did not have a care plan for all of their assessed needs and, changes in people's needs were not always planned for. For example, two people who were living with diabetes did not have a care plan for this. Staff were unsure about the effects the condition had on a person's health and wellbeing and they were unsure about how to manage the symptoms of diabetes. For example; one member of staff said, "If someone appeared unwell I think I would need to give them sugar". Over a period of three months staff had reported in a staff communication book that a person had a rash and that they had applied cream to it. One member of staff told us that the person had had the rash on and off for some time and that they had been instructed by the manager to apply cream to the affected area. There was no information in the person's individual notes about this and there was no care plan in place, despite this being an re occurring condition which needed treatment.

Risks people faced were not always planned for. One person's care records identified that they were at risk of falls and that they required equipment to alert staff should they get up out of bed. However, the person did not have a risk assessment in place for this and the equipment they required was not in place. Staff confirmed that they knew the person was at risk of falls and that they had never seen a pressure mat in their bedroom. Another person had bedside rails in place because they were at risk of falling out of bed but no risk assessment had been carried out for the use of bedrails. The lack of planning people's care put them at risk of not receiving care and support to meet their needs.

Appropriate referrals had not been made for people who needed equipment to help with their mobility. Three people whose needs differed significantly were, at different intervals throughout the day, transferred around the service by the use of the same wheelchair. Staff told us that the wheelchair belonged to a person who no longer used the service. There was no evidence to show that the people had been referred for a wheelchair assessment, despite their care plans stating that they required the use of a wheelchair at all times for transferring and staff confirmed this. This practice was not person centred and people did not receive appropriate care and support to meet their individual needs.

There were limited opportunities for people to take part in activities at the service. People's care records included information about their likes and dislikes and preferred hobbies and interests. Each person had a document in their individual file for staff to record their involvement in activities, however these were incomplete. There was no activities co coordinator at the service and staff told us there hadn't been one for some time. Minutes taken from residents and relatives meetings showed people had commented about the lack of activities at the service. Throughout the two days of our inspection most people who used the service were sat in the lounge either asleep or watching TV and they were not offered any alternative stimulation. There was a sideboard in the lounge which contained a variety of board games and there was a book shelf in the conservatory, however none of the facilities were used or offered to people. There were newspapers and magazines available for people, but they were all out of date, some were over three months old. People told us they often got bored and would like to do more. One person said, "We have a mini bus but we don't go out in it and I know some people would like that" and another person said, "I fall asleep because I'm bored". One member of staff told us that the only opportunity people get to access the community is when they were taken out by family members.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people the needs of people who use the service were not planned for.

People who used the service and relevant others were not involved in the development of care plans and they had not been given the opportunity to agree with the content of them. People who used the service told us they had not seen their care plans, agreed to them or had taken part in reviewing them. Staff told us that they had not contributed to care plans and that the manager and a senior carer had always dealt with them. People's care plans and associated

Requires improvement

Is the service responsive?

care records were not signed or dated on completion. This was not person centred and meant people's care was planned without taking account of their individual preferences about how their needs are met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not involved in decisions about their care.

The registered provider had a complaints procedure which included information about the process people needed to follow for complaining and the timescales for the service to respond to complaints. The procedure was displayed near to the entrance of the service. Prior to our inspection we were made aware of a complaint made to the registered provider about the service. We were told that the complainant had not received a response to their complaint. We asked to view the details of the complaint, however the temporary manager was unaware of the complaint and other senior staff were unable to locate the records. A representative for the provider was aware of the complaint and told us they had responded to the complainant; however they also were unable to locate the complaints records. People told us they would complain if they needed to and that they felt their complaints would be listened to and acted upon.

People told us they had been invited to attend 'residents meetings' and we saw minutes of meetings which had taken place this year. People were given the opportunity to discuss aspects of the service such as meals, activities and the environment.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. The manager for the service was absent from work and the registered provider had appointed a temporary manager who took up post two weeks prior to our inspection.

People were unsure about the management arrangements at the service. One person said, "I'm not sure who the manager is" and another person said, "I think I know".

Staff, family members and visiting professionals were complimentary about the temporary manager and the way she managed the service. They said she was approachable and had made a number of positive changes to the service since she took up post. Staff said, "You can talk to her and she listens" "She had done so much good in such a short time" and "She held a meeting and introduced herself and was very reassuring". A family member said, "I've noticed a lot of positive changes have been made already".

The registered provider had failed to notify us about the deaths of people who used the service. Records held by CQC showed we had not been notified of any deaths which had occurred at the service since 31st March 2014. Senior staff did not know about the requirement to notify CQC about the deaths of people who used the service. The registered provider is required by law to notify CQC of the death of a person who used the service so that we can decide if we need to take any action.

This is a breach of Regulation 16 Care Quality Commission (Registration) Regulations 2009, as the registered provider failed to notify CQC about the death of a service user.

Accidents and incidents were recorded, however there was no system in place for analysing them to identify any patterns and trends or for feeding back to staff as a way of learning from them.

There was no clear system in place to audit the quality of care provided and to identify risks. The temporary manager and staff found it difficult to locate records of checks and audits carried out across the service. This was because the office was disorganised and there was no structured filing system in place. Some records stored in the filing cabinet which were amongst recent records, dated back to 1993. Senior staff who were often left in charge had no idea where to find records we requested, they said they had never been shown where the records were kept and had had no involvement in maintaining them. They said the only records they to accessed were care records.

The registered provider visited the service regularly and on occasions had attended staff meetings. A representative for the provider told us that the registered provider had completed a report following checks they had carried out around the service, however the reports could not be found.

When records were eventually located we found a number of required monitoring checks had not taken place for some time. This included checks on care records, fire safety and infection control. Monthly checks were carried out on the inside and outside of the building and a record of the findings was made. The checks took account of decorating and the general condition of furniture and fittings. Records for February, March, April, May and June 2015, repeatedly highlighted the same required improvements and during our inspection we found that the work remained outstanding. For example, the decoration of communal areas and some bedrooms was identified as being dull and requiring re decoration and some floor coverings were noted as being tired and in poor condition. This along with the examples cited within the other sections of this report demonstrated the lack of action taken to improve the service people received.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.

Staff told us they had not felt involved in promoting improvements across the service, they said although staff meetings had taken place to discuss their work and the running of the service, they felt the meetings were an opportunity for the manager to get at them. One staff member said they felt the meetings were always negative and used as an opportunity for staff to have a good moan. Minutes from staff meetings showed staff were often criticised and blamed rather than being given the opportunity to learn and move forward.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People using the service were not protected from inappropriate deprivation of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The needs of people who use the service were not planned for.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not involved in decisions about their care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The registered provider failed to notify CQC about the death of a service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.

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.