Grove Lodge Care Home Limited

Marple Lodge Care Home

Inspection report

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Marple
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Cheshire
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Tel: 01614277248

Date of inspection visit:
16 February 2016
23 February 2016

Date of publication:
16 May 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 16 and 23 February 2016. During the previous inspection in October 2014, we found required improvements had been made. However, during this inspection we found those improvements had not been sustained.

Marple Lodge is registered to provide accommodation and personal care for up to 19 adults. On the two days of our inspection there were 16 people resident at Marple Lodge. Care was provided in either single or double rooms some with en-suite and there are communal bathrooms on both floors of the home.

The home had a registered manager and a manager who was intending to register. 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.
We identified 10 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 this report.

There had been no routine checks of the building. There were no water temperature checks, fire tests had not been regularly carried out and emergency lighting checks had not been done since September 2015. The window restrictor in a first floor bedroom was broken and the window could be fully opened. There was equipment left by fire doors and in some areas the carpet was frayed. This meant the provider could not be sure the service was safe.

People's risk assessments were either missing or not fully completed. Medication records had some missing signatures. Some MAR's and care records did not contain a photograph of the person. This would make it difficult for new staff and agency staff to identify the person they were administering medication to. Some people's medication was not being administered as prescribed. One person had allergies to certain medication, which staff had not documented on their MAR's, which meant they could be administered medication, which could cause them harm.

There were enough members of staff to keep people safe, although staff said an extra member of staff would enable them to spend more time with people. Staff training, supervisions and appraisals had not been completed for over a year.

There were two incidents recorded which should have been referred to the local authority under safeguarding which had not been done.

Mental capacity assessments had not been carried out. The provider had applied for Deprivation of Liberty Safeguards authorisations, which the local authority had granted. However, we found three we looked at had expired. This meant the provider was depriving people of their liberty illegally.

The records in the handover book showed that people had good access to physical healthcare; however, staff had not recorded this in people's care files. This meant it would be difficult to see people's healthcare history.

We saw good interaction between staff and people who used the service. It was clear from our observations that staff knew people well. Relatives told us staff were kind and they were happy with the care their loved one received. Staff maintained people's privacy and dignity. However, we found care records were kept in an unlocked cabinet in an unlocked office in the reception area of the home.

People's care records contained conflicting information. The new manager told us they were reviewing care plans as they had identified they were lacking in detail. We looked at the care plans of five people and found only one had been reviewed and updated. Staff told us there was no on-going assessment of peoples care. Staff had not consistently monitored people's weights. We could not see referrals had been made to the GP or dietician where people had lost weight.

There were very few organised activities; the new manager was in the process of introducing a programme of activities.

The provider did not have a system in place to assess the quality of the service. There were no audits carried out. Monthly staff meetings took place; however, actions identified during the meetings were not followed up.

The provider had not complied with their duty to notify us of two safeguarding and one police incidents and deprivation of liberty safeguards authorisations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Routine checks of the premises had not been made. We found some areas of the building were not safe. There were no risk assessments of the building.

People's risk assessments had either not been carried out or not fully completed. Medication was not always administered as prescribed.

Safeguarding referrals to the local authority had not been made.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up to date. Staff had not had supervision or an appraisal for over a year. Although staff told us they felt supported in their role.

Mental capacity assessments had not been carried out. Deprivation of Liberty Safeguards had been authorised but subsequently expired. People were being deprived of their liberty illegally.

Food was plentiful and people appeared to enjoy their meals. People were offered drinks throughout the day.

Is the service caring?

Good

The service was caring.

Staff knew people well. Staff were kind and patient with people.

People's privacy and dignity was considered during personal care. However, we found people's care records were stored in an unlocked cabinet in an unlocked room.

People's relatives told us they thought their loved ones were well cared for.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care records contained conflicting information. People's weight was not regularly monitored, and weight loss was not referred to within the provider's policy.

People's care was not reviewed or updated when there were changes in their needs. However, good information was shared about people during twice daily handover.

There was very little planned activity.

Is the service well-led?

Inadequate

The service was not well led.

The systems for checking the safety and quality of the service were ineffective or not in place, which placed people at risk.

The registered manager has a duty to notify us of certain incidents this had not been done.

Monthly staff meetings were held, however, actions identified during meetings had not been followed up.

Marple Lodge 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.

This inspection took place on 16 February and 23 February and was unannounced.

One inspector carried out the inspection. Before the inspection, we reviewed the information we held about the service. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, six medication administration records and two staff files and various maintenance records.

We spoke with three members of staff, the registered manager, the new manager, two relatives and chatted to three people who lived at Marple Lodge and spent time observing throughout the day. On this occasion, the provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we gave the provider the opportunity at the inspection to provide us with any relevant information.

Inadequate

Is the service safe?

Our findings

We reviewed eight care plans and found staff had not fully completed or dated risk assessments in most cases. The risk assessments had tick boxes. The moving and handling assessment required staff to tick boxes which said, 'Can be left alone safely, can be left alone but needs a reminder about risk, needs occasional supervision and encouragement to be aware of risks, has no concept of danger and places themselves at risk, has no concept of danger and places themselves at risk frequently and this may affect others'. Staff had ticked the relevant boxes but without any detailed risk assessment to go with it, to identify actions to be taken to mitigate risk(s) and maintain the safety of the person. This meant people who used the service were at risk of unsafe care.

One person who used the service had an allergy to certain medication. Staff had written this in the person's care records but not on their medication administration record. This meant they were at risk of being prescribed and administered medication, which may cause them harm. We asked care staff to check this with the person's GP and pharmacist.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the safety of the building and found a UPVC window in one bedroom on the first floor of the home had a broken window restrictor, which meant the window could be fully opened. We found other sash windows that had restrictors which were set too high which meant the window could be opened wide enough for people to either fall our climb out. This did not comply with health and safety regulations. We asked the provider to assess all the windows in the home and provide us with assurances they were all safe. On the second day of our inspection the provider arranged for the restrictors on the sash windows to be made safe. A new restrictor had been ordered to replace the broken one on the UPVC window.

In places the carpet was frayed which was a trip hazard. There were ladders left propped up against a wall on the first floor corridor near people's bedrooms, there was also a vacuum, mops and buckets left in a corridor. This not only presented a risk to people who used the service because of the possibility of tripping but in some cases, staff had stored the equipment by fire doors. There were also items stored at the top of some steps behind a fire door. The downstairs reception office door had a stained glass window, which had broken leaving a hole in the glass. A chest of drawers on the first floor corridor had a handle missing which had left the sharp end of a screw protruding. Staff and people who used the service were at risk of injury, should they have brushed or fallen against the screw. On the second day of our inspection we found some of these issues had been resolved. We asked to see the provider's safety checks and risk assessment of the building and we were told this was not done.

In three of the six bedrooms we looked at the nurse call system cord was missing and in one case the person's bed was at the opposite end of the room to where the cord would have been. We spoke to the manager about this who told us they thought the cords had been removed to enable the rooms to be decorated. This meant people would not be able to call for assistance should they need it.

Fire alarm testing records we saw showed staff had not carried out weekly tests as required by the provider's policy. The tests were sporadic, we saw there had been one test in July 2015, four in August 2015, one in September 2015, none in October and November 2015 with one in December 2015 and the last one was completed in January 2016. Monthly emergency lighting checks had not been completed since September 2015. We were told that water temperature checks had been carried out but we were not provided with written evidence of this. We checked the water temperatures and found them to be reasonable. We were provided with an up to date legionella certificate, however, the provider did not flush out infrequently used outlets for example showerheads and taps.

We asked to see personal emergency evacuation plans for people who used the service and were told these had not been completed. Staff we spoke with told us all the doors in the home were fire doors and that people would be safe behind those doors for 30 minutes. Staff said they would move people away from where the fire had started and wait for the fire brigade to come. On the second day of our inspection the new manager gave us a copy of fire procedures which stated the building should be evacuated. The mobility of people who used the service would make this difficult particularly during the night. The only way to evacuate the first floor was either down the main stairs in the building or through the fire exit down two sets of stone steps as the lift could not be used in the event of a fire.

We shared all our concerns about the safety of the premises with the homes manager.

This was a breach of Regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Marple Lodge living areas were spacious and there were several areas for people to sit in comfort. There were two conservatories and two living rooms with televisions. One of the living rooms was open plan to the dining room. People's bedrooms were generally pleasantly decorated and people had added personalised items. Gardens were well maintained and there were pleasant views out of all of the home's windows. Throughout our inspection the home was maintained at a comfortable temperature.

Medication was not always managed safely. We reviewed the medication administration records (MAR) of five people who used the service. In most cases, staff had signed for medication administered, although we did see some gaps in signatures. Not all the MAR's had photographs of the person which may cause a problem for new staff and agency staff.

One person had been prescribed eye drops on 27 January 2016, which needed to be destroyed two weeks after opening. It is good practice to write the date of opening on the box to ensure the drops are not administered after two weeks. Staff had not done this and we could not be sure the drops had been administered within manufacturers' guidelines.

The manager and the registered manager told us the pharmacist regularly delivered medication training to staff; however, this had not been recorded in staff files. The registered manager had not carried out checks to ensure the competency of staff to administer medication.

We spoke with staff about medication, which needed to be administered at least 30 to 60 minutes before food. We were told alendronic acid was administered this way; however, several people had been prescribed lansoprazole, which was not administered before food, as it should have been.

One person had been prescribed medication covertly, this is where medicines are added to food or drink without the person's knowledge. We saw the person's GP and family member had been involved in the

decision to do this.

There was a good system in place for medication to be taken as required (PRN), for example paracetamol, staff signed the MAR and a separate sheet which indicated the dose and time taken. However, we reviewed people's care records and found there was no guidance for staff to enable them to identify what signs to look out for which would mean a person required their medication. A person living with dementia may not always be able to verbalise their need for medication to manage pain, or their need for medication at times of heightened distress.

Staff told us there was no problem obtaining medication and there was a good system in place for medication to be checked and signed in when delivered. Medication was stored in a locked cabinet which was secured to the wall in the homes dining room.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us staffing levels were sufficient for the number of people living at the home. Staff told us an extra member of staff would be helpful particularly on a morning. Staff rotas showed there were three members of staff who worked between 8 am and 8 pm and there were two members of staff who worked 8pm and 8am. Staff arrived 15 minutes before their shift started to conduct a handover. The home were using some agency staff as there were vacancies. Staff we spoke with said they were happy with the agency staff used.

We reviewed two staff files and five agency staff records and saw the provider had completed all the relevant checks. These included identity checks, references and checks with the disclosure and barring service prior to a person commencing employment at Marple Lodge.

Staff we spoke with had a reasonable understanding of safeguarding and the whistleblowing process. We were told they would report any concerns to the manager of the service and would have no hesitation in contacting adult social care or the Care Quality Commission. Staff said they had no doubt the manager would take any concerns seriously and they would be fully investigated. One member of staff said, "People are safe here." We spoke with a relative of person using the service who said they had absolutely no concerns about the safety of their relative.

We saw two incidents recorded which would require the registered manager to make a referral to the local authority under safeguarding protocols. The registered manager had not done this. We advised the new manager of this who said that referrals would be made.

This was a breach of Regulation 13 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff we spoke with told us they had not had any training in the last 12 months, which meant all their mandatory training was out of date. Records we saw confirmed this. Staff supervisions and appraisals had not taken place. Staff files we reviewed confirmed this. The new manager had completed a matrix of training that staff required. We were told a series of training DVD's had been purchased to assist in staff training.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From our observations and information in people's care records most people who used the service would be unable to give consent to their care. Staff told us where people refused for example their medication they would leave them for a while and then offer it to them again. If this continued for more than a day they would contact the person's GP. Staff had a basic understanding of the Mental Capacity Act 2005 and how consent impacted on how they delivered care; however, there were no mental capacity assessments in peoples care records. A mental capacity assessment is required to determine whether a person may be subject to a deprivation of their liberty.

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

The manager told us most people living at Marple Lodge were subject to Deprivation of Liberty Safeguards (DoLS) authorisations. We reviewed the files of three people with a DoLS authority in place and found they had recently expired. The authority stated that an application should be made at least 14 days prior to the expiry of the authorisation if the person was still having their liberty restricted. This had not been done. There was no central system to monitor the expiry of applications. The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards and to report on what we find. The Deprivation of Liberty Safeguards provides a legal framework to protect people who need to be deprived of their liberty in their own best interests.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were unable to tell from people's care records whether people had good access to other health and social care professionals. Staff told us the local GP surgery visited the home once a week. If a person needed to see a GP they were added to the list for the GP to see. Staff said the GP would see most people at the home very regularly. A chiropodist and optician visited people at Marple Lodge. The only evidence of these visits in care records were from optician visits. We did see details in the staff handover book where appointments had been requested. The handover book was then updated with details of the professionals visit. This meant people's care records did not have a complete record of their health.

This was a breach of Regulation 17 (c) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014

We observed the lunchtime meal and found it to be a sociable pleasant experience. There were no menus on display and people were not given a choice, although we did hear staff explaining what the meal was and whether they would like gravy. One person needed assistance with their meal; the member of staff assisting the person did so gently and assisted at the pace of the person. People seemed to enjoy their food and it looked appetising. The cook told us if someone did not want the food on offer she would make something else for the person. Jacket potatoes, sandwiches and salads were always available. One person preferred to a have a large breakfast and have their lunch later, we saw staff enabled this to happen.

The cook told us the manager wanted to introduce some new menus to include some international dishes. They said they made most food from fresh ingredients, including cakes and deserts. The cook said most people preferred cereal and toast for breakfast and people could have an egg if they wished. We were told a cooked breakfast was not available. Staff said there was no one who required a special diet. Throughout the day we saw drinks hot and cold drinks being offered to people. A relative we spoke with said "The food looks good and there's plenty of it."

Good

Is the service caring?

Our findings

Throughout our inspection, we observed staff interaction with people. On the first day of our inspection staff were kind and patient. However, on the second day of our inspection we heard one member of staff speak sharply to a person. We spoke with the manager about this who said they would speak with the member of staff.

It was clear from our observations staff knew people well and knew the best way to communicate with them. People were able to move around the home freely, others appeared to be happy sitting and watching television. Staff sat with people and chatted with them. One person liked to sing and staff joined in and sang with the person. Relatives of people who used the service told us the staff were 'lovely, very kind'.

People were well-groomed and dressed age appropriately. Staff told us that sometimes people did not want personal care. When this happened, they would leave the person for a while then go back and ask them again and this usually worked.

We saw in some care files staff had asked family members for information about the person's history. This included information about their family, where they had worked, and what hobbies and activities they had enjoyed. A member of staff told us that one person had always loved art and was very good at it. Staff had supplied the person with art equipment. We saw another person walking around with a newspaper and whilst the person did not read the newspaper, staff used it as a topic of conversation to engage person.

Staff told us how they preserved a person's dignity. They gave examples of ensuring people were covered with a towel when assisting them with personal care. Staff ensured bathroom doors were locked when they were assisting people with their shower. We observed staff knocking on people's bedroom doors even when they knew people were not in their room.

Relatives told us staff had kept them informed about their loved ones care. One relative told us staff would often call them to update them. They said, "The home is always ringing to tell me what my relative (person's name) is up to."

People's care files were kept in an unlocked cabinet in an unlocked room just off the reception area of the home. During our inspection, we found that staff very rarely occupied this office. This meant that people who used the service, their visitors and visiting professionals could easily access people's confidential information.

Requires Improvement

Is the service responsive?

Our findings

Care files we reviewed contained conflicting information. For example in one person's care plan it stated the person was 'fully mobile', in another section of the care plan it stated 'walks with supervision'. The person's care plan said in two places 'prefers her own company' and 'does not like to join in with activities' and in another section it said, 'likes socialising with others'.

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

There were two different types of care plans in place. We found it difficult to find any detailed information in either type of plan. Plans contained 'tick boxes', these had not been dated when completed and information to back up the tick boxes was either missing or minimal. In one person's care plan we saw in the continence section the person had 'occasional accidents', the detailed assessment said, 'to show where the toilet is'. We were concerned that new staff and agency staff would not have the essential information they would need to care for people.

We reviewed people's weight monitoring charts, and saw that staff had not regularly weighed everyone. Staff had weighed one person in, June, July. August, September, and then November 2015, and over that period this person had lost 20lbs. There was no record staff had weighed the person since then. Staff had not referred the person to the manager as per the provider's policy when a person lost weight on two consecutive weeks. We saw another two people had lost weight without referrals being made. We noted that staff had not weighed most people in January 2016. We checked people's care files and could find no record of referrals to people's GP or dietician. There was a note on each of the records stating 'scales not accurate' and they had reported it to the manager. Information at the front of the 'weights book' said the scales were weighing a pound heavy.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not have time to read people's care plans; they said they found out any new information about people from the daily handover. We reviewed the handover book and found it contained good information about for example, how people had slept, if they had eaten well, if they were feeling unwell and if they had any appointments or visits.

Staff told us there was no ongoing assessment of people's care. We reviewed five people's care files and could only find updates in one person's file. We spoke with the manager about this who told us they had identified several areas for improvement with care files and was in the process of updating everyone's care files.

Staff told us there was not a schedule of activities and due to staff vacancies, they were unable to spend as much time with people as they would like. The manager told us activities were limited but the previous week

there had been a visit from 'Charleston Charlie' which everyone had enjoyed. The manager told us they were looking at another form of entertainment for the following week.

This was a breach of Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the results of the April 2015 relative satisfaction survey and saw the results were mainly positive. There were no complaints recorded and staff told us there had not been any complaints about the service. Staff said they would try to help if someone made a complaint and would ensure they told the manager. We did not see the complaints policy displayed anywhere in the home.

Staff told us the provider had never carried out a staff survey. Staff surveys demonstrate to employees that the provider is taking a genuine interest in them, their views and ideas.

Inadequate

Is the service well-led?

Our findings

The provider did not have a robust quality assurance system in place. There were no audits of the service carried out. The provider had appointed a new manager and they were in the process of implementing new systems. The registered manager who was also the provider and the registered manager of another service did not carry out any checks of the service. The manager told us the registered manager spent half the day Monday to Friday at Marple Lodge.

There was a system in place for recording accidents and incidents. However, we found in some cases staff had filled in an incident form but not an accident form. There was not a system in place to monitor themes and trends.

The provider had an extensive set of policies and procedures; however, we could not see how the provider had implemented them at Marple Lodge.

The manager held regular monthly staff meetings and topics covered were varied and meetings were well attended. Minutes we saw documented discussions around staff appearance and grooming and the importance of short nails. There was a reminder to ensure people who used the service had plenty of drinks, 'residents nails to be cleaned every day' and to ensure that a GP was spoken with when either people refused their medication or were usually asleep at the time they should be administered.

One meeting documented a discussion with regard to staff updating care plans. Minutes stated that 'everyone was to take on a resident to a full care plan'. Minutes also stated that 'staff were to confirm weekly weights are being done'. Our observations were that staff had not updated care plans and weekly weights were not done. The provider did not have a system in place to ensure actions identified during staff meetings were completed.

There was a comprehensive statement of purpose, however, several areas of the statement of purpose were not being adhered to, which included that all staff would have up to date training.

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

Part of a registered manager's responsibility under their registration with the Care Quality Commission is to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered managers responsibility to notify us of certain events or information. There had been two incidents within the home that would be considered as safeguarding. There had also been an incident involving the police. The registered manager had not notified us of this. By not notifying us of incidents such as these, we are unable to assess if the appropriate action has been taken and the relevant people alerted. The provider has a duty to notify us when DoLS authorities have been granted, this had not been done.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff we spoke with told us they thought the new manager would be very good and that she had already made a difference. Staff were happy working at Marple Lodge, they thought they worked very well as a team. One member of staff said, "I have never worked anywhere where everyone gets on so well." Another member of staff said, "There's a good set of girls here." Staff told us the manager listened to what they had to say and considered their opinions.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1) (b) People were not offered activities to meet their needs. The provider did not ensure care plans were designed to ensure services users needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent (1)(3) The provider did not ensure that care was provided with the consent of service users. The provider did not ensure they acted in accordance with the Mental Capacity Act (2005)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)(2)(g) The provider did not ensure the proper and safe management of medicines.

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 (1)(3) The provider did not ensure there were effective systems in place to investigate any allegation or evidence of abuse. (1)(5) The provider did not ensure there were effective systems in place to ensure service users were not deprived of their liberty

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs (1) The provider did not ensure the nutritional and hydration needs of services users was met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (2)(a) The provider did not ensure staff received training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not read, and consider guidance in relation to the regulated activities they provide, they did not notify us of certain events or information.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)(2)(b)(d) The provider did not do all that was possible to mitigate risk. The provider did not ensure the premises were safe to use for their intended purpose in a safe way.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) The quality assurance processes in place were not effective. (1)(2) (b)(c) The provider did not assess, monitor or mitigate the risks relating to the health, safety and welfare of services users. The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each

service user.

The enforcement action we took:

Warning Notice