Mr R M & Mrs P P Duffy

# The Spinney Residential Home

## Inspection report

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## 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? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

We inspected The Spinney Residential Home on 13 October 2014 and on 17 0ctober 2014. The visit was unannounced. Our last inspection took place on April 2014 and, at that time, we found the service was not meeting the regulations relating to consent to care and treatment, care and welfare, safeguarding people and assessing and monitoring the quality of the service. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked and found improvements had not been made.

The Spinney Residential Home is a large detached home in Armley. The home is registered to provide accommodation for up to 30 persons who require

# Summary of findings

personal care. The accommodation for people who lived in the home is arranged over two floors linked by a passenger lift. On the day of inspection 26 people were living in the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found people's safety was being compromised in a number of areas. This included how the home were managing medicines at the home. For example, the temperature was not being recorded in the area of the home used to store medicines. This meant the effectiveness of medicines could not be ensured.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision.

People were not protected from the risk of abuse. The registered manager told us they did not consider the incidents to be safeguarding incidents. The Registered Manager had not followed their safeguarding procedures by reporting incidents to the local safeguarding team.

People enjoyed the food, but choice and independence in accessing food and drink was not promoted. People's nutrition and hydration needs were not always being met. People were not always receiving the health care support they required as their care was not planned or delivered consistently. For example, one person had been refusing meals on a regular basis and their weight record showed they had lost 5lb in two weeks. The staff at the home told us they were not monitoring the nutritional intake of this person. We also saw the person's GP had not been contacted for guidance.

The home displayed activities on offer to people although we saw there were no activities being facilitated on the days of our visit. This led to people sitting in both communal areas and in their rooms for periods of time with no stimulation.

On both days of our visits we saw people looked well cared for. We saw staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

People told us there were enough staff to give them the support they needed and this was confirmed in our observations. While staff told us they had received induction and training, the records did not always reflect this. There were no induction records for some staff and training records did not show clearly the training staff had received. This meant people could not be confident staff had the skills to meet their needs.

Leadership and management of the home was poor and there were no systems in place to effectively monitor the quality of the service or drive forward improvements. There had been a lack of action in addressing shortfalls identified at the previous inspection.

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

Inadequate

The service was not safe. People were not adequately protected from abuse and avoidable harm. We saw that safeguarding arrangements were in place however they were not being followed.

Care was not planned and delivered in a way that ensured people's safety and welfare. We saw people living at the home did not have their mobility needs assessed. Care plans were not in place to provide staff with guidance on how to meet people's mobility needs safely with the correct number of staff and equipment to be used. This meant people were not safe. We have asked the provider to make improvements.

People were cared for in an environment that was clean and hygienic. However, we found people may not be protected from the risk of infection because appropriate hand washing equipment were not in place. We have asked the provider to make improvements.

**Is the service effective?**

Inadequate

The service was not effective. We looked at three people's care records we saw their individual needs had not been assessed. Another person who was at risk because of their behaviour was found to have no assessments or care plans in place to provide staff with guidance on how best to support the person. This meant people were at risk of receiving care which did not meet their needs.

The home had carried out two audits since our last visit in April 2014. The audits were not effective. They had failed to identify issues or failed to follow up on issues when they were identified. This meant that peoples' care needs were not being met. We have asked the provider to make improvements.

There were no suitable arrangements in place with regard to obtaining consent from people. Also where people may not have the capacity to consent, we saw there had been no assessments of people's mental capacity carried out under the Mental Capacity Act 2005. We have asked the provider to make improvements.

**Is the service caring?**

Good

The service was not always caring. Staff who worked at the home were kind and caring. However, the provider had failed to take appropriate action where issues were identified which impacted on peoples' care, safety and welfare.

The staff we spoke with told us they felt they provided people who lived at the home with a good care and they had a good staff team. People living at the home seemed genuinely pleased to see staff members when they came both into their rooms and in the dining room.

When we looked around the home we saw people's bedrooms had been personalised and contained personal items such as family photographs.

# Summary of findings

**Is the service responsive?**

Inadequate 

The service was not responsive to people's needs. Care plans did not always show the most up-to-date information about people's needs, preferences and risks to their care.

Accidents and incidents at the home had not been followed up appropriately to ensure the risk of recurrence was minimised. People who needed additional support with their healthcare needs from external professionals did not always receive their support in a timely manner.

We spoke with the provider about the provision of activities at the home. The provider told us they did not employ a person for the purpose of arranging activities at the home. However, one member of staff was coming in an hour earlier to carry out activities. The provider also confirmed the staff member had not received any additional training for this.

**Is the service well-led?**

Inadequate 

The service was not well-led. The registered manager said care plans were discussed with people however; we found no evidence of this in the care records we reviewed. People we spoke with said they had not been involved in their care planning.

People were not protected against the risks of inappropriate or unsafe care because the provider did not have effective systems to assess and monitor the quality of the service people received.

There were few opportunities for people and staff to be involved in or consulted about decisions which affected their daily lives. Action we had asked the provider to take at the last inspection remained outstanding.

We asked people if they had been involved in decisions made about the service, if they had completed questionnaires or attended any meetings held. We saw that people had been asked for their opinions about changes to meals however, there was no evidence to show if action had been taken in response to this.

# The Spinney 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 checked 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.

We inspected the home on 13 and 17 October 2014. The inspection was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience with expertise in caring for older adults. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We also spoke with the local authority. We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 10 people who were living in the home, three care staff, the deputy manager, the registered manager and the provider. 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 spent time with people in the communal areas observing daily life including the care and support being delivered. We looked at four people's care records, four recruitment files and four staff training records, as well as records relating to the management of the service. We looked round the building and saw some people's bedrooms (with their permission), bathrooms and communal areas.

The Registered Manager had no arrangements in place for checking hot water temperatures. When we checked the temperature in people's en-suite areas, bathrooms and toilets we found the temperature was 50 degrees centigrade. This meant people were at risk of being scalded.

There were areas of the home which did not have adequate equipment in place for hand washing. This meant people were at risk of infection.

Inadequate

# Is the service safe?

## Our findings

At our inspection in April 2014 we were concerned that people who used the service were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider sent us an action plan outlining the improvements they would make which they said would be in place by July 2014.

We found the service was not safe. Some of the staff we spoke with had a good understanding of what constituted abuse and knew the correct action to take if abuse was suspected. However, other staff members were not clear. Staff told us they reported safeguarding issues to the registered manager who would respond appropriately to any concerns raised. Staff knew about whistleblowing and who to contact if they felt concerns were not dealt with properly. Staff we spoke with said they had received safeguarding training; however records we looked at were not clear in showing if staff were up to date with the training. The registered manager told us safeguarding training was updated every three years. However, there were no records in place to show staff had attended the required training on this basis. This meant people were at risk. Although people we spoke with told us they felt safe in the home, we saw incidents had occurred which meant people were not safeguarded from abuse. Incidents had occurred where people who lived at the home had assaulted each other. The manager had not reported the incidents to the local safeguarding team. We saw there were no care plans or risk assessments for the people involved to guide staff or help prevent repeat events. This meant staff did not manage the risks appropriately and keep people safe. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Assessments of people's mobility needs had not been carried out. This meant there was no guidance in place for staff who were providing assistance to people. For example, one person who was receiving respite care required the use of a walking frame for support. They also needed one staff member to support them. This information was included on a referral document but the home had not carried out an assessment of the person's mobility needs. There was no care plan or risk assessment in place to provide staff with guidance on how to support the person. We spoke with two staff members and we asked how they knew what level of support people needed. They told us they would look in care plans. We gave one person as an example and asked staff about the level of support the person needed. They did not know. We told staff there were no care plans in place for the person. They told us they had been providing support for the person and would just show each other. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed there were enough staff to meet people's needs. People we spoke with told us they felt there were enough staff available to give them the support they needed and no concerns were raised about the staffing levels. One person said, "I am very well looked after, I feel very safe." Staff we spoke with also told us there were enough staff on duty to meet people's needs. We looked at four staff personnel records which showed the home had not followed safe recruitment practices. For example, we found evidence of induction in only one of the records. We saw another record did not contain details of the person's references. In another record only one reference had been sought from the two required as stated on the application form.

We also found there was a lack of evidence to show appropriate checks were undertaken before staff began work. For example, one staff member had not had a criminal record bureau check (CRB) carried out since 2007. We spoke with the provider who was not sure when they needed to reapply for a CRB (now known as Disclosure Barring Services (DBS). . We saw the provider had not requested information regarding checking of the 'Adults barred list' for one staff member. We spoke with the provider about this and they told us they had been advised to do this as the person was not in direct contact with people. The staff member was a member of cleaning staff who we observed to have contact with all of the people living at the home. This is a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager confirmed there were no room temperature recordings being carried out by staff of the area of the home where medicines were stored. Medication administration records (MAR) were looked at and we found people were not receiving their medicines as prescribed. For example, one MAR showed a person prescribed twice daily asthma medication had refused this medicine at

Inadequate

# Is the service safe?

'bedtime' on 39 occasions since the 8 September 2014. This meant they were only having the medicine once daily at 'breakfast'. We spoke with the deputy manager who told us they person had not refused the medicine but were asleep at the time staff attempted to administer the medicine. This meant staff had not accurately recorded why the person had not received their medication. We also saw no contact had been made with the person's GP in order for them to review the medication and see what the impact was of the person missing the medication. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

# Is the service effective?

## Our findings

At our inspection in April 2014 we were concerned that where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. The provider sent us an action plan outlining the improvements they would make which they said would be in place by July 2014.

At this inspection we found although the manager and deputy manager were aware of the Mental Capacity Act (MCA) 2005 and DoLS, mental capacity assessments had not been completed to meet the requirements of the MCA 2005. For example, in one person's care records we saw there was a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) document in place which stated the person 'lacked capacity'. We saw the staff were making daily decisions relating to administration of medicines and personal care on the person's behalf. We found no evidence to show a 'best interest' meeting having been held to show the decisions made were in the person's best interests. The registered manager confirmed there were no DoLS currently in place for people living at the home. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found staff had not received the induction and training they required to meet people's needs. The manager told us all new staff received induction before starting work. However this was not confirmed in the records we saw, which showed no evidence of induction training. Staff we spoke with said they had shadowed experienced staff when they first started working at the home but had not received formal induction training.

We discussed staff training with the registered manager. They were not able to tell us which training they considered to be mandatory for staff and when refresher training was required. We asked to see how they recorded the training staff had attended and they told us they kept people's certificates in staff records. However, the records in place did not show staff were up to date with the training they required for their role. There were also no records to show if refresher training was required or booked. There was no training and development plan for staff. This meant people were at risk of receiving support from staff who did not have the required skills and training to meet their needs. We saw the lack of training impacted on moving and handling practices when people were being assisted to stand or transfer. We observed one person supported by staff using a 'drag lift' which placed both staff and the person they were moving at risk of injury. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the registered manager if staff received supervision and appraisals. They gave us a document with dates showing appraisals were planned however; the document showed dates earlier in the year and those appraisals had not been completed. The manager showed us records of supervision for six staff which had taken place over the previous three months.

Staff did not always ensure that people were eating and drinking enough to keep them healthy. Staff told us one person had been refusing meals on a regular basis. We looked at the person's weight chart and saw they had not been weighed since 29 August 2014. Prior to this they had lost 5lb in two weeks. We saw there was no nutritional needs assessment in place for the person. There was a 'care plan/risk assessment' in place which stated they were 'high risk'. It also stated a 'food/fluid chart' should be kept by staff however, we saw there was none in place. The care plan also stated the dietician had been involved and stated the person was to have high calorie foods and fortified milk shakes. We spoke with staff who told us the person did not like the milkshakes so they were not having them. We spoke with the kitchen staff about what information they had about people's dietary needs and how they fortified food. They told us they had no information about people's diet other than people with diabetes.

We were told by staff another person had been refusing meals. When we looked in the person's daily records we saw their refusal of meals recorded by staff. We saw a 'care plan/risk assessment' for the person which stated the person was a 'low risk'. We looked at the person's weight chart and saw they had been losing weight since April 2014 gaining weight on two occasions. We were told by staff they were not monitoring the nutritional intake of this person. They also told us they had not contacted the GP of the person or the dietician who had previously been involved with the person. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people told us the food was good. One person said, "The food is lovely, I really enjoy the meals. I put weight on in my first week here." The cook said there was always a

Inadequate

# Is the service effective?

choice and alternatives were available. The menu was displayed in the home and we heard people discussing what they were having for lunch. We spoke with one person in the dining room who was given a pudding but did not eat it. When the staff came to remove the dish the person said, “I couldn’t eat it because I don't like jam.” The care worker asked if anyone had asked if they wanted it with jam. The person said no they'd just brought it. The person was offered an alternative but refused. The food looked appetising although we saw meals were brought to people already plated which meant people had no choice in the components of the meal or portion size. We saw drinks were brought round by staff at specified times throughout the day and people were offered a choice.

We found limited information to show people’s health care needs were being met. Some care records did not contain risk assessments for mobility, pressure areas, nutrition and falls. We saw one person had received input from a psychologist regarding behaviours they displayed. Records showed this person required staff to use ‘distraction techniques’ at times. However, care records did not contain a care plan or risk assessment regarding this. This meant staff did not have the information how to provide care for this person. A person who was receiving respite care at the home had exhibited some difficulties when eating. Daily records showed they had choked on one occasion. However, there was no guidance in place to manage the risk of choking. We also saw this person did not have a GP. The registered manager told us they did not know how long the person would be at the home for so they had not registered the person with a local GP. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good

# Is the service caring?

## Our findings

At our inspection in April 2014 we were concerned that care was not always planned and delivered in a way that was intended to ensure people's safety and welfare. The provider sent us an action plan outlining the improvements they would make which they said would be in place by July 2014.

We received positive feedback from people who used the service; most people we spoke with said staff were 'very good' and described them as kind and caring. People said staff treated them with respect. One person said "If anyone says they're not happy then they're just grumbling. This is the nicest place I've been in." Another person said, "I didn't want to come here at first but it's much better than when I had the carers. I'm not on my own so much now and I used to have falls. My daughter isn't so worried about me. It's much better." A further person said, "The manager is fab. She comes in now and again and if I had any concerns then I know I could tell her." Our discussions with staff showed they knew how to maintain people's privacy and dignity and we saw this was put into practice. Staff knocked on the doors of people's rooms before entering. We also saw how staff gave people time and explained what they were doing when they were assisting people with lifting equipment.

We saw some staff interacted with people well and had developed good relationships. For example, one person had wanted to buy a new bed and was assisted to do this by care staff. The person told us "The staff are really good and will always help in any way they can. I'm happy here, especially having my new bed." One person we spoke with was very upset. They told us they had wanted to go to a funeral that day but had been told by staff they could not because of our visit. We spoke with the manager and the provider about this and they told us a relative had let the person down at short notice.

Inadequate

# Is the service responsive?

## Our findings

The registered manager told us no complaints had been received in the last 12 months. We asked the deputy manager how people were informed about the complaints procedure. They said the complaints procedure was displayed in the home and if people wanted to know about the procedure they could ask staff for a copy.

The registered manager said care plans were discussed with people however; we found no evidence of this in the care records we reviewed. People we spoke with said they had not been involved in their care planning. One person who lived in the home said they felt people were not listened to. The provider and the manager told us they had advertised relatives meetings but no one had attended. We were shown minutes from one resident's meeting in June 2014 however, we saw no action had been taken from the issues raised. The registered manager told us satisfaction surveys were used and we saw two had been completed by relatives and a further by a person living at the home. One of the issues raised were the lack of activities at the home for people. We saw a relative had said "It would be nice if people had more to do." We saw no evidence to show how the issues raised had been addressed. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the care plans we looked at required updating. People's choices and views were not reflected and there was no evidence to show how people had been involved in decisions about their care. For example, there were spaces on documents for people to sign to say they agreed with the care plan. However, we saw no one had signed in the space. Care plans contained basic information which focused mainly on people's health care needs and provided little information about people's preferences, likes and dislikes or life history. For example, we saw one of the activities planned was carpet bowls. We spoke with one person at length about their interests and they told us they had loved playing bowls. They had their own set in their room. The person was not aware the home had this as part of their activities. They told us "I've never been told that they played bowls here." We looked at the person's care records and saw it did not mention activities they enjoyed.

In another care record we saw staff had completed a 'life preferences' document in which we saw the term 'wandersome' had been used to describe the person. The document also stated the person 'dislikes staff disagreeing with them about what day it is. Sometimes it upsets them.' We saw there were no care plans in place which provided staff with guidance on how best to support the person.

Review dates in care records showed care plans were planned to be reviewed monthly and we saw this had been done however, the evidence of review was an overview copied from daily records and did not review the care given to show whether the care plan in place was effective. For example, one person's care records showed they had a lump in their breast which required monitoring for changes. If changes occurred the breast care nurse was to be notified. There was no assessment or care plan in place to guide staff on how to provide the necessary care.

We found a document which had not been completed in one person's care records which had it been completed would have provided staff with a better understanding of the person concerned. The document was titled 'At a glance' and allowed for areas of risk to be identified, 'what to do to keep me safe, how dementia has affected my thinking and doing, what I can still do and what I find difficult.' In the same person's care records we found further documents which would have ensured personalised care was given had not been completed. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw people were sat in communal areas of the home and their own rooms for periods of time with no stimulation. Planned activities for the day were not taking place on either of the two days we visited. The registered manager told us a staff member had been appointed to coordinate activities but this is in addition to their usual duties. We asked if they were being offered specific training in this area of work and were told, "No, not being sent on a course or anything like that. They're just coming in an hour earlier than the start of their shift to do the activities." On both days of our visit the staff member was on leave. The registered manager had not ensured staff were in place to facilitate activities.

Inadequate

# Is the service well-led?

## Our findings

At our inspection in April 2014 we were concerned the provider did not have an effective system to either regularly assess and monitor the quality of service or manage risks to the health, safety and welfare of people who use the service and others. The provider sent us an action plan outlining the improvements they would make which they said would be in place by July 2014. They told us they would be completing a quality audit template which would help them to monitor all aspects of care of people living at the home. We saw this had not been done. The provider also told us they would be inviting the people living at the home and their relatives to meetings which would enable them to become more involved in the day to day running of the home. We saw only one meeting had taken place since our last visit in April 2014.

A registered manager was in place. We found notifications of abuse which should have been submitted to the Care Quality Commission (CQC) had not been. We spoke with the registered manager about this and they told us they did not consider the events to be notifiable. For example, where one person had hit another person. The registered manager told us they did not consider this to be abuse. We are currently considering what action to take.

We found the service was not well-led. There were no effective systems in place to monitor the quality of the service or drive forward improvements. We found the home was poorly organised and although staff responded to people's needs as they arose this was reactive rather than proactive and planned.

The registered manager has been in post for many years and was unable to provide us with explanations as to why things had happened or evidence to support the decisions they had made.

We saw accident reports were filed in an accident file. We saw on the documents where it was required for the manager to sign off and record 'actions/findings' this was often left blank. The manager told us there was no system in place to audit and review accident or incident reports. This meant themes and trends were not identified so there was a risk of repeated incidents as actions were not identified or lessons learnt. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us they had audited the care plans earlier in the year and when we asked to see copies of the audits they said there were no records. We found issues in the care records had not been picked up. For example, in one person's daily records we found information about the person's on-going weight loss and refusal of food. The registered manager was unaware of the issues. People's care plans were not personalised and did not reflect their current care. Reviews were recorded monthly but comprised mainly of where staff had repeated recordings made in people's daily records. We asked to see copies of any other audits taken to monitor the quality of the service and the registered manager showed us a 'monthly manager's audit' date July 2014. We saw the audit was incomplete in several areas. The audit required scoring and it had not been scored. The provider told us the local authority had given the home the audit to use but they did not understand how to use it. We also saw a 'medication audit' dated July 2014. The audit was not complete and we saw where an action had been identified this had not been carried out.

The registered manager told us staff meetings were usually carried out every three months. We asked to see minutes from the last meeting. The minutes we were given showed the meeting was held in May 2014. They also told us a meeting had not been a meeting held since.

There were no opportunities for people to be involved in decisions about the home and their daily lives. There were no formal system in place to gain the views of people who used the service, relatives, staff or health care professionals. When we asked the registered manager about this they told us the provider was responsible for satisfaction surveys however, the provider, who was present throughout both days of the inspection, was only able to show us only three completed surveys. The registered manager confirmed there were no other systems in place to gain this information.

We asked the registered manager about any improvements that had been made or were planned to the service. They told us some areas of the home had been refurbished. Also there had been some improvements made to the building following our last visit which had prompted a visit from the Fire Officer.

Inadequate

# Is the service well-led?

We found the management in place at the home lacked understanding of the principles of good quality assurance which meant best practice/guidance was not recognised or utilised to move the service forward and improve outcomes for people.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse<br>Regulation 11 (1)((a)(b)(i)(ii)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding service users from abuse.<br>The registered person did not ensure service users are safeguarded against the risk of abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines<br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br>Regulation 14 (1)(a)c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs. |

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.<br><br>The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br><br>Regulation 21 (a)(i)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Requirements relating to workers<br><br>The registered person did not operate effective recruitment procedures. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff |

This section is primarily information for the provider

# Action we have told the provider to take

Regulation 23 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers.

The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>Regulation 9 (1)(a)(b)(i)(ii)Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services.<br><br>The registered person did not take proper steps to ensure each service user received care that was appropriate and safe. |

**The enforcement action we took:**
Warning notice to be met 1 December 2014.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>Regulation 10 (1)((a)(b)(2)(b)(i)(c)(i)(d)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.<br><br>The registered person did not have effective systems in place to monitor the quality of the service delivery. |

**The enforcement action we took:**
Warning notice to be met by 1 December 2014.