Mrs Jackie Mitchell

The Coppice

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 18 June 2015 and was unannounced. The service was last inspected in November 2014. During that inspection the provider said that she aimed to run the service as a small family home and as such, considered the regulations did not fully apply to the service. As a result, a number of breaches in many of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 were found.

The service provides residential care for up to three older people. People are cared for in the provider's home, which is a bungalow and there is an adjoining annexe flat which can provide accommodation for one person. At the time of our visit the annexe was not occupied.

The registered provider manages the service. 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.

The provider told us that the home had been sold and that the two people living there would be moving to other care providers. The provider told us that they had not taken action to meet with any of the breaches identified during our last inspection other than obtaining a Disclosure and Barring Scheme (DBS) disclosure for her husband who also lives on the premises and therefore comes into contact with the people who live there.

Summary of findings

People were not safeguarded from abuse and avoidable harm and there were no comprehensive individual risk assessments in place to ensure people's safety. Accidents were not reported appropriately.

We did not see that the provider demonstrated kindness or compassion when providing care to people and there was no evidence of caring relationships.

People did not receive effective care and their quality of life was compromised because their individual needs, including social and leisure needs were not assessed or planned for. We did not find evidence to support that the provider sought people's consent for the care and support they received and there was no evidence people contributed to decisions about their care.

Staffing levels were not sufficient to manage people's needs. For example, two physically dependant people needed two staff to assist them safely, however, we saw only the provider on duty and evidence of times when only the volunteer staff member was available to people who used the service. Daily routines of people who used the service were subject to staff availability.

There were no systems in place to assess and monitor the quality of the provision. We found the provider did not demonstrate an understanding of their responsibilities as a registered care provider and had failed to take action to meet with the requirements for improvement set at the last inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

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 supported to make choices or safeguarded against harm and risks were not appropriately managed.

Accidents were not reported appropriately.

Staffing levels were not sufficient to enable people to receive appropriate support.

Medicines prescribed for people were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

People were not given choices in the way they lived their lives and their consent was not sought in line with legislation and guidance. The provider lacked understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff lacked the support and training they needed to provide safe and effective care.

Is the service caring?

Inadequate

The service was not caring.

Interaction between the provider and the people who lived in The Coppice was not caring and people were not treated with dignity or respect.

People's right to privacy was not observed.

People were not involved in their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive the care, they needed and there were no care plans in place that reflected how people would like to be supported. Assessments were not carried out and people's needs were not regularly reviewed.

Care was not centred on each person as an individual and there was a lack of meaningful activity and social care.

Is the service well-led?

Inadequate

The service was not well led.

The management of the service was not open and transparent.

The provider did not demonstrate an understanding of the principles of delivery of high quality; care or of their responsibilities as a registered care provider.

The Coppice

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 took place on 18 June 2015 and was unannounced. The service was last inspected in November 2014. During that inspection the provider said that she aimed to run the service as a small family home and as such, considered the regulations did not fully apply to the service. As a result, a number of breaches in many of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 were found.

This inspection was carried out by two inspectors. We reviewed information we held about the service before the inspection. Prior to this inspection we had sent the provider a 'Provider Information Return' (PIR) form. This form enables the provider to submit in advance information about their service to inform the inspection. The provider had not returned this form.

We met and spoke with both of the people who used the service. We spoke with the provider and the only member of staff who works at the home on a voluntary basis. We observed how people were cared for and reviewed people's care records. We inspected the premises and looked at documentation in relation to the management of the service.

Inadequate

Is the service safe?

Our findings

During our inspection we looked for policies and procedures the provider had in place for making sure that people who lived at the home were safe. The provider was not able to provide us with any policies and procedures in relation to ensuring that people were adequately protected from abuse.

At the last inspection in November 2014 we found that staff had not received training in safeguarding people and we told the provider this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 11 Safeguarding people who use services from abuse.

During this inspection the provider confirmed to us that neither she nor her volunteer staff member had received any training in area since the last inspection. This demonstrated a continued breach of regulations in relation to safeguarding people. Since the last inspection the regulations have been updated and this breach is now demonstrated under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment.

We looked to see how accidents and incidents were recorded and reported. We saw an entry in one person's daily records that said they had fallen out of her chair trying to take their slipper off. Records stated "No harm only a slight graze to the forehead." We asked the provider about any other known incidents. She told us about a fall involving a person who was no longer living at the service. The provider said the person "didn't actually fall" but went down on their hip which they had "broken three times before and it fractured again." The provider confirmed that the incident relating to the fracture had not been notified to the Care Quality Commission as she was not aware that this was necessary. We saw that neither of these accidents had been separately logged or reviewed to ensure that preventative action could be taken where necessary.

The provider told us that they had not made any notifications to the Care Quality Commission since the last inspection and was not aware that they should have made notification where the person fell and sustained a fracture.

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

Risk to individuals was not adequately assessed or understood by the provider. Care plans contained little detail about risks to people and how these were managed, and plans showed no evidence of being reviewed to ensure that risk management was always relevant to people's needs. For example, when we asked to see the care plan around safe use of a hoist recently installed for one of the people, the provider told us they did not have one.

During our last inspection in November 2014 we found that staffing arrangements did not meet with the needs of the people living at the home. We told the provider this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 22 Staffing.

On this visit we found there had not been any systems put in place to ensure that there were always sufficient numbers of suitably skilled staff present in the home to safely meet the needs of the people who lived there. The provider told us they had assistance from one part-time member of volunteer staff but there were regular periods throughout the day when there was only one person present. The provider was the only person present to provide care for people overnight.

We saw in people's care plans that they needed two staff to assist with transfers, meaning that there were regular times where the service was unable to meet this need safely. On the day of the inspection the provider initially told us that she planned to be out for the afternoon, meaning that only the staff member would have been present. We asked the provider how people would have their needs met safely with only one member of staff if, for example, the person had been sick or ill and needed to bathe and change their clothing. The provider said that the people who lived at the home were never sick and therefore this was not a problem. We asked the provider how the person who needed the hoist would be assisted safely at times when only one member of staff was present. The provider said this did not happen as the volunteer was always there when the person was assisted out of, or into, bed. We did not see that any consideration or planning had been given to staff availability for any deviation to what was considered people's usual routines. When the volunteer staff member arrived at the home we asked how they would safely manage to support people to move. They told

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Is the service safe?

us "Both stand up. It's not hard to do it by yourself." The volunteer staff member also told us that the provider only planned to be out of the home for an hour that day. This was not what the provider had already told us.

We found there was no plan in place to ensure that suitable staff could be deployed if the provider or volunteer staff member were absent for any length of time, for example for sickness or holidays. This is a continued breach of regulation which, under the new regulations demonstrates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing.

At the last inspection we found that the provider's husband, who came into regular contact with the people who lived at the home, had no current Disclosure and Barring Service (DBS) check. We found this had been obtained since that time.

At the last inspection we found that medicines were not managed safely at the home. This demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation13, Management of medicines.

On this occasion we asked the provider what medicines people had in the home. The provider told us they had only one medicine for one of the people living at the home. We found that medicines were stored in the cupboard of the kitchen dresser. The door to the cupboard did not close properly and could not be locked. When we looked in the cupboard we found several boxes of medicine. Five boxes, one bottle, a partially full dosette box of medicines and a number of boxes of dressings were in the name of a person we did not recognise. The provider told us they had previously been resident at the home. We also found boxes of medicines for another person whose name we did not recognise. The provider told us this person had lived at the home "years ago." We also found a bottle of tablets which the provider told us was for their dog.

This meant that medicines were not stored safely and the provider had not given us the correct information in relation to what medicines were in the home.

We looked at the medication administration record (MAR) chart for the person who the provider had told us received regular medicine. The chart was not correctly dated and there were no signatures of administration to identify who had administered the medicine. We also noted that the chart only included one medicine. However we had seen a box of another type of medicine in the cupboard prescribed for this person with the instruction for the medicine to be taken three times each day.

This demonstrated a continued breach of regulation which under the new regulations demonstrates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(g) Safe Care and Treatment because medicines were not managed safely.

During our visit we looked at how the home was cleaned and how the prevention and control of infection was managed. We looked in the communal areas for people who lived at the home and in the bedrooms of the two people living there. Before doing this we sought the permission of the people who lived at the home, and were accompanied by staff when we entered their rooms. We saw evidence of dried food and food spillage on the walls and furniture in one person's bedroom and asked the member of staff whose responsibility it was to ensure that people's rooms were kept clean. They were unable to tell us. We saw that the frame of the commode stored in the bathroom was not clean and showed evidence of rust, meaning that it could not be cleaned properly. The seat pad was stained and the cover was cracked on the underside, meaning that it could not be kept adequately clean. Beds in both rooms were made with clean over-bedding; however we found what the provider confirmed to be faeces on pillow cases and sheets. The pillowcases and protectors in both rooms were stained.

There was a lack of suitable hand washing facilities for staff and we did not see any evidence of staff having received training in infection control.

This demonstrated a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(h) Safe care and treatment because poor management of infection control could put people at risk.

When we inspected the service in November 2014 we found there were no risk assessments for the premises or comprehensive risk assessments for individual people's care. Accessibility to the home was restrictive for people with limited mobility due to a gravelled surface. The steps to right side of the bungalow were in disrepair; the main steps up to the front door were steep and unsuitable for people who used a wheel chair or a walking aid. The door

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Is the service safe?

steps were steep and the main kitchen floor uneven. We said this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 15 Safety and suitability of premises.

On this inspection we found there had not been any improvement with regard to the safe accessibility of the premises, or risk assessments for people's safety. This demonstrated a continued breach of regulation which under the new regulations demonstrates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment.

Inadequate

Is the service effective?

Our findings

When we inspected this service in November 2014 we found that staff were not trained or supported adequately to enable them to deliver safe and effective care to people who lived at the home. We said this was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 23 Supporting workers.

We asked the provider what improvements they had made since the last inspection. The provider told us that neither themselves not the volunteer member of staff had undertaken any training since our last inspection.

We saw that the training policy in place consisted of one sentence, was undated and contained no detail. It stated "Because The Coppice is only a small home staff is (sic) not engaged on a regular basis, however if this were to change training would be undertaken." There was a handwritten, undated addition to this which stated "However if this changes supervision would be undertaken." There was no detail as to what training was required, when it needed to be repeated or how any training would be undertaken.

We looked at the personnel file for the volunteer member of staff. We saw they held a current emergency first aid certificate and a level 2 award in food safety. We also saw record that a moving and handling update had been undertaken since our last inspection. There were no details about this update and no information about what the update had included.

We did not see any evidence of either the provider or the member of staff having undertaken any recent training other than the provider having attended a briefing in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

This meant that staff had not received training appropriate to their role and demonstrated a continued breach of regulation which under the new regulations demonstrates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18(2) Staffing.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

When we inspected this service in November 2014 we found there was no evidence of people's mental capacity having been assessed and people's consent or preferences were not sought. We said this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2010, regulation 18, Consent to care and treatment.

On this visit we found that the provider lacked understanding about the need to include people in making decisions or the appropriate means by which decisions were made when a person lacked capacity to do so for themselves. For example, the provider told us that one person's relative had expressed a wish for their family member not to be hoisted when transferred, however she could not tell us when asked, whether that person had an appropriate Lasting Power of Attorney for care, stating "It's nothing to do with me." We did not see any evidence of the person themselves being consulted about use of the hoist.

When we were speaking with one of the people who lived at the home the provider interjected, in front of the person, saying "(name) can't answer you, (person) doesn't understand." However, we found that the person was able to understand what we were saying and was able to answer our questions.

There was no information in the care plans that as to how the provider assisted people to make decisions about their care or whether appropriate reference had been made to the Mental Capacity Act 2005 and associated code of practice in establishing people's capacity or ability to make decisions for themselves.

We were concerned that one person's care file included the information that the person's relative, who was a medical professional, preferred to "check" with their relation "than have the local doctor." We did not see any evidence of the person being asked for their preferences in this matter or any agreement or best interest's decision process around this.

Another example of people not being given choice was when we witnessed both the provider and the member of

Is the service effective?

staff place sweets directly into a person's mouth with their fingers, despite the person being able to eat independently. The person was not asked if they would like a sweet or which one they would like.

We did not see people leave their rooms during the inspection and were not aware of them being offered the opportunity to do so. When we asked about access to the toilet the staff member told us that they had taken the commode to people's rooms on more than one occasion, but did not refer to people having chosen or preferring this. We saw that both people took their midday meal in their bedroom but did not see or hear staff asking if this was their preference. Daily records did not give any evidence of people being offered the opportunity to leave their rooms or to engage with each other on a daily basis.

Due to the need for two people to assist with transfers the rising and retiring times for people were defined by the hours worked by the volunteer staff member, meaning that people's choice in this was restricted.

This demonstrated a continued breach of regulation which under the new regulations demonstrates a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for Consent.

The provider did not keep records which enabled her to demonstrate that people's well-being was supported by meeting their nutritional and hydration needs. There were no nutrition or hydration assessments contained within people's care plans and no evidence that people had been offered the opportunity to make choices.

People's weights were not monitored or recorded. The provider told us "They can't stand on scales." There was no provision of alternative means of measuring body weight such as weighing scales with seats. This meant that that people who lived at the home could be at risk of unintentional weight loss which may go unnoticed.

People did not have independent access to fluids. In one person's room we saw a drink in a plastic cup had been positioned on a chest of drawers out of the person's reach. The provider confirmed that the person was able to eat and drink independently. When we asked why the drink had been placed out of the person's reach she told us "Everything goes in (person) mouth, so it has to be out of reach." When we asked why a drink could not go into their mouth the provider said "(Person) might chew the cup." This meant that the person was denied the opportunity to drink independently and was reliant on the presence of the provider or member of staff in order to have a drink.

Whilst we saw that people were not offered choice or independent access to fluids, we did not see any evidence of people's physical wellbeing being adversely affected with regard to their nutritional and hydration needs.

We saw evidence within people's care records that the provider did not work collaboratively with other health care professionals to make sure that people's needs were assessed and met as appropriate. For example, in one person's daily record we saw the provider had written "Nurses doing full assessment on (name) poor woman most upset." A further entry relating to this assessment said "So annoyed (name) needs hoist, don't think so!" Another person's daily records contained an entry which read "Another visit from SW (social worker). What for!"

We also saw a record in one person's file which said that although the person was registered with a doctor, the person's relative would prefer they were contacted if anything was wrong. Whilst this person was a suitably qualified medical practitioner, this practice could result in the person being denied access to the GP they were registered with and any other services provided by the GP practice.

When we inspected the service in November 2014 we said that people may not have their day to day health needs or access to healthcare services when needed and said this was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. The evidence found on this inspection demonstrated a continued breach which under the new regulations is captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (3)(f) Person Centred Care.

Inadequate

Is the service caring?

Our findings

People living at The Coppice were not always treated with respect. When we spoke with people the provider or staff member replied for them without waiting for the person to respond themselves. We spoke with one person who was listening to music in their room. We asked them if they also liked to watch television. The provider did not wait for the person to answer the question and told us "No, (Person) doesn't like loud noises," although the person was seated next to a radio and could hear all ambient noise in the home as their door was kept open. The person to whom we were speaking smiled and told us that they did like to watch television. The provider did not acknowledge or respond to the person when they told us this. We spoke with the person again and asked if they had liked to dance. The staff member replied immediately saying "(Name) doesn't like to dance."

We saw that one person had a bowl of sweets placed out of their reach. We saw both the provider and the member of staff place sweets directly into the person's mouth with their fingers, despite the person being able to eat independently. Neither offered the person the bowl, giving them the chance to select their own sweet. As the bowl was placed out of reach the person was unable to have a sweet when they wished, despite daily records showing that eating them was something they liked to do.

When we saw the soiled bedding on one person's bed the provider responded by saying to the person "I don't know when you've done that, (Name)."

We saw very dirty tissues stuffed in one person's drawer. When we asked the provider about this they said "Well we use it to wipe (Person) face, (person) gets food all over."

We saw inappropriate remarks in care records that showed lack of respect for the person or their care. One record was "(Name) are a whole packet of sweets today. I hope it doesn't give (them) the runs." An entry in one person's care plan said "(Name) is unable to do anything for (them)self apart from eat" and "(person) screams at anything."

Neither the provider nor the volunteer member of staff demonstrated any kindness or warmth toward the people living at the home and spoke of them in a less than respectful manner. For example whilst we were speaking with the volunteer member of staff they said "I have to go and check the ressies (meaning residents of the home) now."

On the day of the inspection we saw both people's doors were open whenever we were present in the corridor. In the afternoon there were visitors to The Coppice who appeared to be visiting the provider in a private capacity. These people left the building using the corridor off which people were living. We asked the provider if they kept a visitors book – she told us that she did not.

When we inspected this service in November 2014 we said that people were not respected or treated with dignity, kindness or compassion and said this was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services.

Our evidence from this inspection demonstrates a continued breach of regulation which, under the new regulations is captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 Dignity and Respect.

Inadequate

Is the service responsive?

Our findings

When we inspected this service in November 2014 we found that people's care needs had not been adequately assessed or care planned and delivered in accordance with their individual needs. We said this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 9, Care and welfare.

On this inspection we did not see evidence of improvement to demonstrate a person centred approach to the care of people living at the home.

The care plan policy we were provided with consisted of one sentence which was inadequate in supporting a robust and responsive provision of care. It stated "The Coppice has a care plan for each resident which will be updated as and when." Information in the care plans was not dated or reviewed, meaning that the service did not have up to date information relating to the changing care needs of the people living in the service.

The care plans we saw were minimal, consisting only of a short list. For example. One person's entire care plan listed the details as follows: "My aim for (Name)" followed by numbered comments as listed here"

1. To make sure she is warm and comfortable
2. To keep her clean
3. To maintain her dignity at all times
4. To ensure she eats well."

There was no indication of the person or relevant others being involved in the care plan and no explanation of how care should be delivered to make sure the person's needs were met safely in the way they preferred. A second untitled page within the care file gave a list of what the person did not like with only one indication of what they did like. This was recorded simply as "(Person) prefers their own company." Wording used did not demonstrate a caring approach. For example the list included "(Person) does not like having anything done to her, washing, getting dressed."

The provider demonstrated poor understanding of capacity and consent and the lawful means by which decisions about care and treatment may be made by appropriate third parties. There was no evidence that the provider had designed care and treatment provision in a way which met individual needs and preferences.

Daily records were not detailed and did not contain sufficient information to demonstrate what care had been delivered. For example, one person's care plan referred to them requiring pressure relief to be provided a minimum of six times per day, but no records had been made as to what this consisted of, when this had been done or by whom.

We saw that one person's daily records contained no entries for 20 May 2015 to 24 May 2015 inclusive, and the provider was unable to explain why the records were incomplete.

We saw that the home had a single sentence 'hobbies and interests' policy (undated) which read "The Coppice aims to assist all residents with their hobbies and interests whether in the home or outside interests". This policy made a statement of intent but contained no information as to how the provider would capture and use information relating to people's interests and use this to provide a stimulus and engagement.

Care plans contained little information as to how people liked to spend their time or how staff could support them to meet their social and emotional needs. On the day of the inspection we saw that both people remained in their rooms at all times. There was a lounge provided for the people who lived in the service but the provider told us that they did not use it. Both people ate and were supported to use the toilet in their rooms, and there was no change in the stimulus available to them – one remained seated in front of the television with their back to their door, the other seated facing the door listening to music. Daily records captured some visits from family but other than a birthday party for one person, there was no evidence of any meaningful activity or people being supported to leave their rooms.

This demonstrated a continued breach which, under the new regulations is captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9(1)(b) Person Centred Care.

The home had a complaints procedure (undated) but had no records as to any complaints made or how these had been resolved and outcomes used to inform development of the service. The provider had no formal systems for capturing and analysing feedback to ensure that the service remained responsive to the needs of the people for whom care was being provided. The provider said that no complaints had been received.

Inadequate

Is the service responsive?

The provider told us that the home had been sold and that both people who lived there were moving to new care provision. We asked the provider when this would be and what contact she had made with the new care providers. The provider said she did not know exactly when people would move and she did not know where they were going. We spoke with the provider about her responsibilities to the people who lived at the home to provide information to their new care providers in order to ensure their health, safety and welfare. The provider told us it was none of her business where the people moved to and she had no intention to make contact.

This demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(i) Safe care and treatment.

Inadequate

Is the service well-led?

Our findings

When we inspected this service in November 2014 we said that the provider lacked insight into her roles and responsibilities in providing an adult social care service. We found there were no systems or processes for auditing and monitoring the quality of the service provision and said this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 10.

On this visit we asked the provider what they had done in response to this. The provider told us they had sold the home and that both people who lived there were moving to new care provision. They said they had not done any auditing or monitoring of the quality of the service provision since the last inspection. The provider failed to demonstrate any understanding of, or intention to comply with the requirements of the Health and Social Care Act 2008 (Regulated Activities).

This meant that the provider had failed to take the action they had been told was required and this demonstrated a continued breach which, under the new regulations is captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(1) Good governance.

During the inspection in November 2014 we found that policies and procedures were not comprehensive, contained the briefest of information and were not reviewed or dated. We said this was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 20, Records.

On this inspection we found there had been no review of, or addition made to, policies and procedures. In addition we found that records relating to the care of people living at the home were insufficient to protect them against the risks of unsafe or inappropriate care.

This meant that the provider had failed to take the action they had been told was required and this demonstrated a continued breach which, under the new regulations is captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2)(a)(b)(c) Good governance.

The failure of the provider to take action to meet with the requirements of the Health and Social Care Act 2008 in relation to person's carrying on or managing a regulated activity, demonstrates a further breach captured under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 4 (3)(a), (4)(b), (5) Requirements where the service provider is an individual or partnership.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(h) Safe care and treatment. There were poor effective infection control and standards of hygiene.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment. There was a lack of effective policies and processes to ensure that people are protected from risk of abuse by means of taking reasonable steps to identify the possibility of abuse before it arises and responding effectively to any allegations of abuse

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Care Quality Commission (Registration) Regulations 2009: Regulation 18 (2)(a)(ii): Notification of other incidents. The provider had failed to make appropriate notification of serious injury to a service user.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18(1) and (2) Staffing. There were insufficient numbers of staff to safeguard the health safety and welfare of service users in the home. There was a lack of suitably skilled and qualified staff to provide care and support to people living in the home.

This section is primarily information for the provider

Enforcement actions

There was a lack of training to enable staff to carry out their role effectively and safely.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(g) Safe Care and Treatment. There were no systems and processes in place to ensure that people who use the service are protected from the risks associated with unsafe storage, recording and administration of medicines.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment. There was no assurance that appropriate measures were taken to maintain the premises to ensure people's safety in relation to easy access to the premises and surrounding grounds.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for Consent.

There were no systems or processes in place to address issues in relation to obtaining consent from residents for the care and treatment received and acting in accordance with the resident's wishes. In particular the service has no awareness of its legal duty to comply with the Mental Capacity Act 2005.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (3)(f) Person Centred Care.

People were at risk of not receiving the care they needed due to a failure to work collaboratively with other health care professionals to make sure that people's needs were assessed and met as appropriate.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 Dignity and Respect.

The provider failed to ensure the dignity, privacy and independence of service users.

The provider failed to treat service users with dignity and respect.

The enforcement action we took:
Notice of proposal to cancel registration.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9(1)(b) Person Centred Care. People living at the home did not receive the care and support they needed to meet with their needs in relation to their health and wellbeing.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(i) Safe care and treatment. People were at risk of not having their care and welfare needs met when the responsibility for their care and treatment was transferred to other persons.

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2)(a)(b)(c) Good governance. People were not protected against the risks of unsafe or inappropriate care and treatment because there was a lack of proper information recorded about them by means of maintenance of an accurate record documented for each person in relation to their care and treatment provided.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA (RA) Regulations 2014 Requirements where the service providers is an individual or partnership Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 4 (3)(a), (4)(b), (5) Requirements where the service provider is an individual or partnership. The provider had failed take action to meet with the requirements of the Health and Social Care Act 2008 in relation to person's carrying on or managing a regulated activity.

The enforcement action we took:
Notice of proposal to cancel registration.