Trustees of Honeywood House

Honeywood House Nursing Home

Inspection report

Honeywood House
Rowhook
Horsham
West Sussex
RH12 3QD
Tel: 01306 627389
Website:

Date of inspection visit: 8 & 16 January 2015
Date of publication: 20/04/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Overall summary

This unannounced inspection took place on the 8 and 16 January 2015. Honeywood House Nursing home is a care home situated outside the village of Rowhook. The home is a large converted and adapted 18th century mansion house standing in 10 acres of park and woodland. It offers personal and nursing care to 28 older people, some of whom live with dementia.

When we inspected the home on 24 June 2013 we found a breach of regulations which related to care and welfare and consent to care and treatment. The provider sent us an action plan and told us how they would address these concerns. With the breach regarding consent by they told us they would be compliant by 18 by 11 July 2013 and care and welfare by 14 August 2013.

Summary of findings

When we inspected on 15 July 2014 we found continued breaches with regards to care and welfare and consent to care and treatment. We also found a breach in relation to assessing and monitoring the quality of service provision. We received an action plan from the provider stating how they would address these issues.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had an understanding of abuse and had access to safeguarding policies and procedures; however these were not always put into practice. Risk assessments relating to people were not consistently completed and did not identify ways of reducing the risk. Staffing levels were not planned and organised to meet the needs of people. Staff received training but not in all subjects to ensure they could meet people's needs living in the home. For example there was no training in the area of dementia. Staff did not receive formal supervision. Staffing recruitment records were incomplete and did not ensure all necessary checks had been undertaken to ensure people were safe. The administration of Medicines practices in the home were not safe.

Staff had awareness but lacked an understanding of the Mental Capacity Act 2005 and the principles of this had not been applied in full. Assessments had not taken place to see if people had the capacity to make specific decisions and there was no evidence of any 'best interests' decision processes being followed. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do deprive people of their liberty following formal assessment. No applications for DoLS had been made but we were not assured that the provider followed or was ready to follow the requirements in the DoLS.

People had involvement in the choices of what meals were put on the menu. However there was always only one choice available on the menu at lunch time.

Staff were kind, respectful and caring. However, people were not provided with opportunities to be actively involved in decisions about their care and the home. Care plans did not provide detailed information to guide staff about the support a person needed. They were not personalised and did not provide sufficient guidance for staff to know how to meet people's individual needs. People had no concerns or complaints about the home and would speak to the manager if they did.

No external auditing took place, the manager or staff carried out all audits. There was no formal way of identifying any learning was taking place as a result of the audits taking place.

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 this 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.

Information was available on the differing types of abuse and staff had access to the local authority safeguarding policy and procedure. Staff had been trained in the safeguarding of vulnerable adults. Staff had access to the necessary safeguarding procedures but these had not always been followed in practice.

Risk assessments were not always individualised and did not detail how the risk should be minimised. Risk assessments for the environment had been completed.

Staffing levels varied and were not organised to meet the needs of people. Staff received training although not in all areas needed to meet the needs of people. Staffing recruitment practices were not thorough and did not ensure the safety of people.

The management of medicines was not safe and people were at risk of not receiving medicines safely.

Is the service effective?

Inadequate 

The service was not always effective.

Staff did not understand the principles of the Mental Capacity Act 2005 and they had not been applied correctly. Consent was sought from people's relatives without evidence they had the legal authority to provide it.

Staff received training but this did not ensure staff had the skills to meet the needs of people. There was no system for formally supporting and supervising staff

People had involvement in the menu planning but there was no choice on the menu at lunchtime.

People's health needs were reviewed regularly.

Is the service caring?

Requires Improvement 

The service was not always caring.

People were not consistently provided with opportunities to be actively involved in decisions about their care.

Staff demonstrated a good understanding of how to treat people with kindness, and respected their privacy and dignity.

We have made a recommendation the service seeks advice about supporting people to express their views and actively involving them in decisions about their care and support.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

Care plans were not always developed to ensure all people's needs could be met. Care plans did not record people's individual needs and show staff how these should be met. Communication about people's day to day changing needs was not consistent or robust

People had no complaints and no complaints were recorded. There was a complaints policy and procedure available.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The service has a registered manager who is also one of the four trustees of the registered charity.

There were no systems in place for external auditing to take place. There was a lack of effective checks to ensure a quality service was provided to ensure people received safe and effective care. Where the manager had gathered useful information through surveys and audits, this information had not always been used to identify improvements

The manager knew people well and there were opportunities for people and daytime staff to raise issues and discuss concerns at regular intervals.

Honeywood House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 and 16 January 2015 and was unannounced. The inspection team was made up of one inspector and a specialist advisor who had specialist knowledge in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection, we examined previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law. At this inspection we followed up information of concern, with regard to staffing levels at night, people not being given choices and poor communication within the home.

Following the inspection we requested information from health and social care professionals.

During the inspection we spent time talking to ten people, three nurses, four health care assistants, the deputy manager and the registered manager. We looked at the staffing records of six members of staff and records of service quality audits, three residents' meetings and three staff meetings. We looked at survey questionnaires people had completed regarding the home. Nine people's care records were also reviewed.

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

Inadequate

Is the service safe?

Our findings

People felt safe at Honeywood House and if they had any concerns they would speak to the manager. People knew the manager and looked to her for reassurance.

Information on abuse, including the different types of abuse, and the local authority safeguarding policy and procedures were available to staff. Staff had an awareness of safeguarding procedures, and the training matrix identified all nurses and health care assistants had completed a course on SOVA (safeguarding of vulnerable adults). The manager knew what actions to take in the event that any safeguarding concerns were brought to their attention. They said there had been no instances that required reporting.

However, in the records of one person we saw a record of a physical incident between two people, which had resulted in both people being upset. We could see from this person's records they had been given reassurance and support. However there was nothing in the other person's records to identify the incident or that they had received reassurance or support. The event had not been recorded as an incident, which questioned whether staff had understood the need to record this and see it as a possible safeguarding incident. The nurse in charge was unable to give us any further information and there was no records to evidence any action had been taken.

Risk assessments were kept in people's plans of care, which were kept in their room. These had not always been completed fully. Where risks had been described, clear actions were not identified to minimise these. For example, a risk assessment identified a person as 'High risk of falls'. It did not then detail how the risk could be minimised for the person. A 'Fracture risk assessment' for another person identified the fall risk as 'High'; however there was no information on how this risk could be reduced. Care plans identified risks to people, staff and other residents by the behaviour of some people. However no supporting risk assessments had been completed to ensure the safety of people and staff. These behaviours included shouting, spitting and hitting. People did not have individual Personal Evacuation Plans (PEPS) in their records to ensure there was adequate information on how to evacuate them safely in case of a fire.

The lack of risk assessments in place to ensure the safety and welfare of people meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010)

The home had a fire risk assessment for the building and there were contingency plans in place should the home be uninhabitable due to an unforeseen emergency such as flooding. Copies of contracts demonstrated and ensured the equipment in the home was serviced, by appropriate bodies, and deemed safe.

It was difficult to establish how staffing levels were assessed to ensure there was enough staff to meet the needs of people. The manager did not use any analysis or risk assessment to determine people's needs to inform staffing levels. Staff told us the numbers of people do not increase but the needs of people do increase. Evidence showed a varied picture with regards to the level of staff on duty, which did not relate to meeting the needs of people. Over a two week period one nurse was on shift for 11 consecutive days in the morning and on three days there were two nurses on shift in the mornings. For the following two weeks two nurses were on shift in the mornings for ten days, and for four days which were weekends there was one nurse on duty. It was not clear how this related to the changing needs of people. The hours covered by health care assistants were varied and it was again difficult to determine how these had been planned to meet the needs of people. Over a two week period it varied from having seven health care assistants on duty to five health care assistants on duty on a morning shift. The afternoon shift rota also showed there were variations on some days from there being five health care assistants on duty to other days where there were three health care assistants on duty. During the lunch time on the second day of our visit people who ate lunch in their room had to wait for support. One person was served lunch in their room but could not reach their food. Eight minutes later a health care worker went to support the person to eat. They had just served four people with their lunch. On almost all shifts over a two week period there was at least one agency staff member on duty. Staff told us the number of staff on duty at night did have an impact on how busy they were and if there was enough staff to meet people's needs.

Appropriate steps had not been taken to ensure there was always sufficient numbers of staff with the relevant skills to meet the needs of people. This was a breach of Regulation

Inadequate

Is the service safe?

22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures in the home were not sufficient to ensure all the necessary checks were being undertaken before staff worked in the home. It was not possible to establish the qualifications and experience of all staff, The application form the home used had a very small space for recording the qualifications of applicants. We were shown a new form which the home is going to use which had a bigger space for recording qualifications. Two references had not been undertaken for three staff members. The provider had not completed the necessary checks with the Disclosure and Barring Service (DBS) to ensure all staff were suitable to work with the people in the home. These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. For one person the necessary check had been made but this was several months after they had started working in the home. The manager did not have any evidence of the qualifications or experience of the agency staff. They advised they had been reassured by the agency supplying the staff, but there was no record of this.

A lack of appropriate recruitment checks before people stated work in the home meant people were at risk of receiving care from people who were not suitable to work at the home. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were errors in the security, storage, reconciliation, disposal, ordering and recording keeping of medicines at the home. This included the management of controlled medicines. Each medicines administration record (MAR) contained an error, which meant medicines were not being administered in a safe way. There were differences between people's MAR and the medicines recorded on the dispensing blister dosset boxes which held the medicines. Staff frequently changed entries on the MAR. We saw errors in the recording of medication which was not in line with the homes policy on 'Administration of All Medicines'

Special conditions associated with administering certain medicines were not being followed For example one medicine had to be given on an empty stomach and the person should not eat or drink for 30 minutes afterwards. The person should also sit or stand in an upright position for 30 minutes after the medicine was administered. These details were not included in the record and staff could not assure us this happened. There was no evidence in people's records that medicine reviews had ever taken place. There were a large amount of pharmaceutical products in the medicines cupboard, which were not accounted for in stock.

Three people had been prescribed a medication for anxiety to be given "as required" (PRN). There were no care plans for the safe administration of PRN medicines which meant there was a lack of clarity about when the medicines should be given, how the effects were monitored and the circumstances under which a second dose could be given. This placed people at risk of inconsistency and of receiving the medicine when it was not indicated, and not receiving it when it was in their best interests to do so.

The disposal of medication was not safe. The practice did not comply with any guidance available on the safe disposal of medicines because of its implications for security and the safety of people living at the home.

The poor practice in the administration, recording and storage of medicines was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Staff had received training on the Mental Capacity 2005 (MCA). The MCA is related to testing people's capacity to make certain decisions at a specific time. When people are deemed not to have capacity to make a decision, a best interests decision should be made with the people who know the person including professionals. Staff lacked knowledge to know how to apply the training when working with people. Staff had little knowledge about the MCA 2005 and its principles. There was no information regarding assessing and detailing people's capacity to make decisions.

The home had a comprehensive policy on the Mental Capacity Act (MCA) 2005; however this was not being adhered to. It stated, "Decisions made about the assessment of mental capacity and the determination of best interest will be recorded accurately in the resident's care plan". There was no evidence this practice had occurred. People's records included a one page document regarding consent. There was no indication an assessment of the person's capacity to make this decision had been made. Where it had been recorded the person did not have capacity to make decisions and the next of kin could, we found the legal documents were not always in place to ensure the next of kin had the legal authority to make these decisions. We saw no evidence of any best interest's decisions.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010.

Staff received some training. The training matrix listed seven key areas which the provider had identified as required for staff's role. This included mental capacity, fire, infection control, manual handling, food hygiene, safeguarding of vulnerable adults and first aid. The training calendar for the year 2015 had been displayed and staff had to record when they could attend. Topics included manual handling, risk assessment, nutrition, food safety, safeguarding, first aid, infection control and care of dying. We were told each training session lasted two hours and had a suggested start time of 2:00pm. This gave little flexibility for people working shifts and was a short time period for some areas of training. The training certificates, which were kept in staff folders, did not reflect the training listed on the training matrix. The certificates did not include the content of the training session and this was not recorded elsewhere. The lack of assessment of staff knowledge after training meant the provider could not be assured staff had understood the training. Staff had not received training on dementia or on how to support people with behaviour which challenges. One person was restless and wandering and was having conversations with people who were not there and at times became agitated and aggressive. The person was not being supported in a meaningful way by the staff and it was not clear that staff knew how best to support the person. They used terms with the person of a rational nature such as "You don't want to go in there, there is nothing there". When there clearly was something of interest to the person.

Nurses did not have regular competency assessments as they should do according to the relevant and applicable guidelines of their professional bodies. Medication training was not on the list of annual training. Staff did not have the training to ensure they could care for people effectively.

There were no systems in place to support staff development through the use of supervision such as 1:1 time with the manager. This meant the provider was unable to confirm staff were working to an appropriate standard. Staff did not receive any formal supervision meetings.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had an induction which included written and practical work which lasted several months and covered aspects of caring for people in a nursing home. The staff member signed as each module in the induction had been covered and the senior member of staff who had deemed them competent signed the record. Staff received an annual appraisal.

Meals and food choices were often discussed in residents meetings and it was clear people were involved in the decision of which meals were on the menu. A four week menu was displayed in the dining room. The main meal was at lunchtime, there was no recorded choice at this time but a choice at breakfast and tea time. We were told by a health care assistant, "If people do not like something, we can always get them something else". This did not

Inadequate

Is the service effective?

recognise a person's right to have choice. A member of staff, who was on duty during the afternoon of our visit said, "We do give a choice at breakfast and tea but most people don't remember what they have ordered anyway" indicating a lack of respect and assumption of lack of capacity. Given that a number of people lived with dementia at the home, there was no pictorial means of assisting people to choose the foods they preferred.

Records of people's preferences were held in the kitchen. Records showed people had been referred to a speech and language therapist (SALT) as necessary and the guidance from them had been clearly documented in care plans. The cook was aware of some of the special diets people required. However, they were unaware some people required foods suitable for those with diabetes. There was no specific guidance for staff about the volume of fluids people should have which meant effective monitoring was not possible. This meant that people were at risk of not receiving appropriate nutrition and hydration. People were weighed monthly and from the records we reviewed we did not see any significant .weight losses. MUST's (Malnutrition Universal Screening Tool) which is a screening **tool** to identify adults who are malnourished or at risk of malnutrition had been undertaken and recorded each month.

The home had good links with the local GP practice and a doctor called every week, and over a two week basis saw each person. If needed, the doctor would visit between these times. People had access to a chiropodist, optician, and community psychiatric nurse.

Requires Improvement

Is the service caring?

Our findings

People were complimentary about the staff in the home. Staff treated people with kindness and talked to people in a respectful and polite manner. We heard a lot of banter between some staff and people, which people enjoyed. We did not hear call bells ringing for long periods.

Staff were unanimous that the care was "Brilliant". One staff member told us, "All the staff here care about people, they would do anything for them, we are all the same, and that is why it is so good working here". The manager told us, "We are brilliant at what matters, that is caring, we all really care about residents and that will always come first, way in front of paperwork".

Throughout the day people had unrestricted access to their bedrooms and some people chose to spend part of the day in their room. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. Bedroom doors were always kept closed when people were being supported with personal care. This meant people's privacy and dignity was respected. Staff knocked on people's doors and waited for a response before entering. People were addressed by their preferred name by permanent staff members. However agency staff referred to people as "Darling" and "Love". People's choices were not always promoted. One person was up at 7:20am told us they were cold. They were assisted to put on a cardigan and when asked by us if they wanted to go back to bed, they told us yes. If we had not been shown around the person would have remained in their chair, feeling cold.

People's care plans did not record or demonstrate people had been involved with the development of these. They did not record the person's view point. Life story books were in people's rooms, but these had not completed consistently The manager had contact with people when on duty. The manager and permanent staff had a good relationship with people. Agency staff did not always have sufficient knowledge of people to ensure they treated people with dignity. One person asked an agency staff member the name of a person they were assisting in a wheel chair. The agency worker just shrugged their shoulders. The person asked a permanent staff member and was told the person's name. Staff when around intervened and offered reassurance to people who were wandering in the large hallway. Residents meetings were held and minuted. Those not wishing to attend were asked if they would like to raise any issues. When comments were made these were recorded and the action taken to respond to these comments was recorded.

We recommend the service seeks advice and guidance from a reputable source, about supporting people with dementia to express their views and actively involving them in decisions about their care and support.

Inadequate

Is the service responsive?

Our findings

Care plans did not identify people's individual needs and ensure the welfare and safety of people. People had care plans, but these recorded basic information and did not give a clear and accurate picture of people's individual needs. Care records followed the same format and had the same risk assessments for each person. They were not individualised and lacked detail. They did not include all the areas relating to the person's care and treatment needs.

The 'care plan' used by the provider did not facilitate the full assessment of people's risks or needs. This meant people were potentially at risk from a range of conditions which were not detailed adequately in care plans. There were no care plans relating to identified needs in people's assessments. For example, where a care plan identified a person needed support with continence care there were was no detailed assessment and no clear guidance for staff about the steps they should take to ensure a person's independence and their safety and dignity. When a person was identified to being prone to recurrent urinary tract infections, there was no care plan or guidance about what staff should do to help reduce the risk of reoccurrence. We saw three people had episodes of agitated behaviour. There were no support plans to help reduce the incidence of these and ensure their safety or that of others and improve the quality of people's lives.

Care plans detailed no information on people's care preferences and so staff were not always aware of people's individual preferences. For example, when we arrived on one morning we found seven people asleep with their lights on, seven more people asleep, and five people were up. We were told by the night staff this reflected people's choices. However this information was not recorded in people's care plans. One person was still in bed. We were told they would ring their bell regularly and ask to get up. When we visited they were still in bed and they did not have their call bell in reach. They asked a member of staff to pass them their call bell. When asked by staff if they wanted to get up they replied "yes".

People's care plans contained a document entitled 'Life story book'. These had not been completed for all people. When completed they were a useful tool to engage with people. We heard one staff member spending time with one person in their room talking through the person's life story book, which was a meaningful and enjoyable activity for the person. However the lack of a completed document for other people meant they would not benefit from this personal interaction.

There were no pain assessments and no pain care plans for people. A nurse told us, "We do not need them, we all know people so well, and we can tell if they are in pain". We asked how agency nurses would have this knowledge. They replied "The carers would know if something was wrong and there is always one of our staff on when there is agency". Pain can manifest in a number of different and sometimes subtle ways, such as agitation, withdrawal and/or resistance to care which may not be recognised by busy care or agency workers. This meant staff did not have clear guidelines on when and how to support people and how to monitor and control people's pain. This placed people at risk of pain and / or increasing pain

Daily records compiled by staff gave very little detail on the support people had received throughout the day. Care plans had been reviewed every month but these involved very little changes to care plans and usually just had a signature and the date. Changes which had been made involved the crossing out of information and a new sentence added to reflect the change. For example in one plan, 'needs the support of one' was crossed out and 'needs the support of two' added.

Staff received a verbal handover at the start of each shift, The two verbal handovers we observed were basic, and did not include some important information. For example, we had seen a person wandering around the home who later became agitated. The handover did not provide any guidance for staff on how they could best support the person.

The lack of consistency and sufficient detail in care plans, supporting information and staff communication of needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

The home had a complaints policy and a log book. The provider had received no complaints or concerns. There were letters of thanks praising the manager and staff from relatives. People could raise concerns at residents meetings and when raised, issues were acted on.

Requires Improvement

Is the service well-led?

Our findings

Audits were carried out in areas such as medication, accidents, falls, infection control, nutrition and care plans. However these audits were not effectively identifying areas which required improvement. For example, there was no evidence that the errors we had identified with people's medication had been picked up through routine and systematic medicines audits. Infection control audits identified people who had chest infections or urinary tract infections on a monthly basis. There was no analysis of this information recognising patterns where people had recurring infections. None of the information from audits was transferred to people's care plans to ensure their care took this information into account We could not see how the audits were used to make improvements to the service.

There was a lack of external auditing The manager was responsible for carrying out an annual audit. A new audit system was being used this year, but it was still the manager carrying out the audit. The manager who is also a trustee of the provider met with the three other trustees once a month to discuss the home. Minutes of these meetings were not available. Audits were not effective in identifying areas needed to make improvements in, meaning people may not receive a service that meets all their needs.

The lack of a robust quality assurance system was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were informally involved with the development of the service. The manager, when on duty, made a point of seeing each person during their shift; giving people the chance to raise any issues. Residents meetings took place and there had been four in the last 15 months. A shopping trolley had recently been suggested by a person which could go round and give people the opportunity to buy various items. This was going to be implemented. Every three months questionnaires were given to different people to gain their views on the home; ensuring all were included over a twelve month basis. Any issues raised were addressed. There was a suggestion box in the hallway, which we were told was not used by people. Staff meetings were held approximately every three months, at the same time in the day. This meant it was difficult for night staff to attend, which was mentioned to us by staff. The manager informed us they were going to arrange a meeting for night staff. The minutes reflected staff were able to raise issues and we could see that these were responded to.

Staff told us the home was well managed and the registered manager was a visible presence in the home. We were told they were approachable and would always have time to talk to staff. One staff member said, "You can't fault her leadership". People also recognised the manager as being in charge of the home and had confidence the manager would sort out their concerns. They felt she was in charge and would seek her out to express their worries. The manager knew people well and was able to give meaningful reassurance to people. For example they would know the name of a person's relative and when they were next visiting or when they had last visited.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not operate effective recruitment procedures in order to ensure that people employed for the purposes of carrying on a regulated activity were safe to work with people in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure staff received appropriate training and supervision to deliver care and treatment to people safely and an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have adequate quality assurances in place to assess and monitor the quality of the service provided. The provider did not have systems in place to ensure there could be learning from incidents in the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider must protect service users from the unsafe use and management of medicines Regulation 13

The enforcement action we took:
We have served a warning notice.

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 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. This was a breach of Regulation 18.

The enforcement action we took:
We have served a warning notice.

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 Risk assessments had not been completed to ensure the safety of people and staff. Regulation 9 (1) (a) (b)(i) (ii) People did not have care plans to address areas of identified need. Staff did therefore not have guidance on how to meet the needs of people. Regulation 9 (1) (a) (b)(i) (ii)

The enforcement action we took:
We have served a warning notice.