Ms Susan Carol Thorne

Maddalane Care Home

Inspection report

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Tel: 01752360253

Date of inspection visit:
05 August 2016

Date of publication:
23 October 2017

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?	**Inadequate**

Summary of findings

Overall summary

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We carried out an unannounced comprehensive inspection of this service on 5 August 2016.

Prior to our inspection we had received information of concern that people were not being treated kindly by the provider and the meals were of a poor standard with little choices. We were also told people were not always able to have a shower when they chose to, the heating was not always turned on, there were poor infection control and medicine practices, and a shortage of staff. The local authority had also informed us that five safeguarding alerts had been raised in relation to people's care.

Maddalane Care Home provides care and accommodation for up to 14 people. On the day of the inspection 12 people were living in the home. Maddalane provides care for older people.

The provider managed the service and was registered with the Care Quality Commission. 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.

People told us there were not always enough staff to meet their needs. People were not always protected from avoidable harm and abuse because the provider did not implement recommendations from

safeguarding investigations and did not learn from mistakes. People's privacy was not always respected as some people told us they were unable to have appointments or visits in private. People were not always treated with respect and dignity. People and relatives told us the care staff were kind, but also mentioned some staff showed more compassion than others.

People were at risk of the spread of infection because people's soiled laundry was not always handled in line with infection control guidelines, and moving and handling equipment which was shared, was not always cleaned between use. Staff were not always trained in correct infection control practices and the provider's knowledge about infection control was limited.

People's medicines were not always managed, administered and stored safely. Staff who were left in charge of the service in the absence of the manager or provider, were not always trained to administer people's medicines. This meant people's medicines were being pre-potted; an unsafe practice which was not in line with National Institute for Clinical Excellence guidelines (NICE).

People were not always protected from risks associated with their care because risk assessments were not always in place to provide guidance and direction to staff about how to keep people safe. People who were moved in wheelchairs were not always supported to use the footplates; this meant people were at risk of tipping forward and falling out.

People were not protected by the Mental Capacity Act 2005 (MCA) which meant their human rights were not always supported or respected. Where decisions were being made for people, there was no evidence to show that best interests meetings had taken place to ensure the least restrictive options were being considered. People told us there was not always enough to do to occupy their minds and to keep them entertained.

People were not always given a choice about what they would like to eat. People told us they liked the meals, but the quality sometimes varied. People's specialist diets were not always known or recorded to ensure they were supported correctly. People's weight was monitored; however action was not always taken to seek advice when someone had lost weight.

People's changing healthcare needs were not always referred to relevant healthcare services promptly to ensure they received responsive care. External healthcare professionals also raised concerns that there had been delays in obtaining people's medicines and responding to advice given.

People's healthcare needs were not always known by staff. People did not always have care plans in place to provide guidance and direction to staff, ensuing their needs were met in line with their wishes, preferences and advice from external health and social care professionals.

People, relatives, staff and some external health and social care professionals told us they did not feel the service was always well-led. The Commission shared people's, staff's and relatives' feedback with the local authority safeguarding team.

The provider did not always work constructively with external health and social care professionals. Safeguarding matters were not always dealt with in an open and transparent way. The provider was not always open and transparent during our inspection. For example, the Commission did not always get the correct information about people's care. This did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

The provider did not have effective systems and processes in place to help monitor the quality of care people received. The provider had not always informed us of significant events in line with their legal obligations, for example the provider had not informed us that someone had sustained a fracture. People's feedback about the provider was shared with the local authority safeguarding team.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from infection control practices to help prevent and control the spread of infection.

People's medicines were not always stored, managed and administered safely.

People told us there were not enough staff to meet their needs.

People were not protected from avoidable harm and abuse, because the provider did not implement recommendations from safeguarding investigations and did not learn from mistakes.

People were not protected from risks associated with their care.

Is the service effective?

Inadequate

The service was not always effective.

People were not protected by the Mental Capacity Act 2005 (MCA) which meant people's human rights were not always supported or respected.

People told us they liked the meals, but the quality of them sometimes varied. People were not always given a choice. People's specialist nutritional needs were not always known or recorded to help ensure staff knew how to support people correctly.

People's changing healthcare needs were not always referred to relevant healthcare services promptly to ensure they received responsive care.

Is the service caring?

Requires Improvement

People were not always treated with dignity and respect.

People's privacy was not always protected.

People and relatives told us the care staff were kind, but also

mentioned that some staff showed more compassion than others.

Feedback about the provider was shared with the local authority safeguarding team.

Is the service responsive?

Inadequate

The service was not always responsive.

People's healthcare needs were not always known by staff. People did not always have care plans in place to provide guidance and direction to staff about how to meet their needs.

People told us there was not always enough to do to keep them entertained

Is the service well-led?

Inadequate

The service was not well-led.

People, relatives, staff and some external health and social care professionals told us they did not feel the service was always well-led.

The provider did not effectively work in collaboration with external health and social care professionals. This meant the provider did not act in order to improve and develop the service for people.

The provider did not have effective systems and processes in place to help monitor the quality of care people received.

Safeguarding matters were not always dealt with in an open and transparent way.

The provider was not always open and transparent during our inspection.

The provider had failed to notify us of all significant events in line with their legal obligations.

Maddalane Care Home

Detailed findings

Background to this inspection

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

We visited the care home unannounced on 5 August 2016. The inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since our last inspection. A notification is information about important events, which the service is required to send us by law. We contacted Healthwatch Plymouth, and spoke with the local authority safeguarding and quality assurance and improvement teams (QAIT).

During our inspection, we spoke with seven people living at the service, two relatives, three members of care staff, a house assistant (domestic/helper), the business manager and the provider. We observed care and support in communal areas and people's lunch time experience. We spoke with people in private and looked at nine care plans and associated care documentation. We assessed the environment for safety and infection control prevention, and looked at staffing rotas, training records and catering menus.

After our inspection because of identified concerns we raised a safeguarding alert with the local authority. We also contacted a GP practice and district nurse to obtain their views about the service.

Inadequate

Is the service safe?

Our findings

Prior to our inspection the Commission received information of concern that the temperature of the environment was not always warm, there were poor infection control and medicine practices, and a shortage of staff. The local authority had also informed us that the provider had at times, been unwilling to participate collaboratively in respect of safeguarding investigations. We were told the provider did not always take responsibility for mistakes which had been made, and had been resistant to work with external professionals to help improve the service.

People did not comment about the temperature of the service and during our inspection we did not notice it to be uncomfortable. However, staff confirmed in the Winter one person's bedroom had been cooler, but no action had been taken to rectify this after it had been reported. We spoke with the provider who explained the heating system was on a timer and it could be altered at any time. The provider also explained there had been a problem with two radiators which had now been resolved and at the time people affected were provided with their own heater.

People's soiled laundry was not always handled in line with appropriate infection control guidelines. The provider told us soiled laundry was placed into a red, water-soluble bag, but removed from the bag and rinsed prior to being washed. However, these bags are designed to be placed unopened into the washing machine to prevent and control the spread of infection. Staff told us soiled laundry was handled differently and the water-soluble bags were not used. They explained they rinsed soiled laundry, and were then instructed to use a specific amount of washing powder dependent on the size of load so there was no wastage. There was signage in the laundry room confirming this. The provider told us she would speak with staff about laundry practices and showed us a new sluice room which had recently been created, telling us laundry practices would be changing. The environment was clean and free from odour; the provider told us she took pride in ensuring cleaning was of a high standard.

Moving and handling equipment which was shared between people was not always cleaned between each use to help reduce the spread of infections. The provider told us staff were expected to wipe the equipment down and had been given cleaning products to do so but a member of care staff told us this did not always occur, of which we observed. The provider told us she would speak with staff.

Staff told us and the provider's training records confirmed that not all staff had undertaken infection control training. The provider's lack of understanding about the use of water-soluble bags also demonstrated their knowledge was not up to date and in line with best practice guidelines.

People were not protected by infection control practices. The staff and provider did not have up to date knowledge in respect of infection control practices. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always handled and stored safely. On our arrival medicines had been left unattended in the kitchen. Prior to our inspection we had been informed that people's medicines were

being pre-potted, an approach which is unsafe and does not meet the National Institute for Clinical Excellence guidelines (NICE) for managing medicines. The provider told us that this did not happen, however staff confirmed that medicines were sometimes pre-potted and that pre-potted medicines were not always locked away. The provider later confirmed she had done this on occasions.

The providers and staff's knowledge and training regarding the administration of people's medicines did not always ensure people received their medicines safely and in line with NICE guidelines. For example, staff who had not received training were expected to administer medicines in the absence of a trained member of staff. We observed the provider give guidance to a member of staff who was training to administer medicines. However guidance about signing the person's medicine administration records (MARs) had been incorrect. People, who needed as required medicines (PRN) such as paracetamol, were not always asked if they required it which meant the person could be in unnecessary pain.

People did not always receive their medicines promptly and in line with medical advice. A GP explained one person had become progressively unwell because a prescription had not been collected from the pharmacy; this then resulted in the person being admitted to hospital. We spoke with the provider about this, who told us this was not accurate and that they had raised a complaint with the GP practice.

A community nurse was complimentary about how staff were supporting one person with a skin condition, however people's care plans did not always provide guidance and direction for staff relating to the application of topical medicines (creams). Topical medicine charts were also inconsistently completed, so it was not possible to determine if people's creams were being applied as prescribed. For example, one person's topical medicine chart detailed their cream should be applied twice a day, but the person's records showed this was not always occurring.

People's medicines were not always stored, managed and administered safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the service was short staffed which meant staff did not always have time to speak with them or they had to wait a period of time to be assisted. On the day of our inspection there were two members of care staff, one house assistant (domestic/helper) and the provider on duty. The provider explained the manager was on holiday which meant she was providing managerial cover, cooking and administering medicines. Staff told us they helped prepare meals in the evening, meaning there was only one member of staff supporting twelve people. Staff explained this was a concern as some people required the assistance of two members of care staff.

People were not assisted promptly to leave the dining room after lunch. People had to wait until people's medicines were administered and staff were available. In the absence of staff, one person who was sat in a wheelchair became frustrated and started to move their wheelchair with their feet, in order to leave. Two people who lived at the service shouted at the person to stop, explaining to them that they would fall. This person was later assisted into an armchair at 2.45pm, after eating lunch at approximately 1pm. The provider told us they felt our inspection had been the cause of delay.

The provider told us from September 2016 a new staffing structure was being implemented which would improve staffing provision within the service; this included a new catering manager and a business manager. The provider explained this would help ensure care staff would be able to concentrate on providing care and support to people.

Safeguarding alerts had been raised regarding some people's care. We looked to see if the provider had

listened and learnt from previous safeguarding investigations and found action had not been taken to ensure people were protected. For example, people did not always have risk assessments in place to help provide guidance and direction for staff about how to minimise risks associated with their needs.

People were not always protected from risks associated with their care. For example, people's skin integrity was not always safely monitored to help ensure skin damage was prevented. For example, one person had a foam boot (skin ulcer prevention) in their bedroom. We asked staff why this was in place but staff were unable to tell us and told us it was not always put on. We looked at the person's care plan to establish the reasons however there was no information about it.

One person had diabetic healthcare needs however their care plan did not detail information about this. This meant staff did not have information about how to support this person safely. One person's care review stated they had become verbally and physically abusive towards staff; however there were no risk assessments in place to support staff and the person about what action to take when this occurred.

The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always kept safe whilst being transferred in wheelchairs. For example, footplates were not always used meaning people were at risk of tipping forward and falling out. One member of staff told us this was because one person was unable to bend their legs. However, there was no risk assessment in place regarding this.

Inadequate

Is the service effective?

Our findings

Prior to our inspection the Commission received information of concern about the quality of the meals at the service. We were told people's food was sometimes restricted, portion sizes were small, low cost and poor quality food was purchased and there were no food choices available. The local authority had also investigated concerns that changes in people's healthcare were not always referred promptly to relevant healthcare services.

At lunch time, people commented and were observed to enjoy homemade fish and chips. People told us they got enough to eat however, did confirm there were no choices available. Staff told us "People always have the same". People and staff commented about the varying quality of the food, with one person telling us that they had enjoyed the taste of the fresh fish, rather than frozen fish as it tasted better. Another person told us they usually enjoyed a particular cereal for breakfast, but since moving into the service they had asked for something different because it always arrived soggy.

One person was assisted to get up at 11.00am. When the person had been supported to get dressed, a member of care staff asked the provider if they would get the person some breakfast. The provider replied by saying "She won't want toast now it will be nearly lunchtime", but then later arrived with the person's breakfast. However, the person had not been asked if they would like breakfast or what they would prefer for their breakfast.

There was no chef employed so care staff, the manager and provider shared the cooking. The provider was in the process of making changes to improve the catering provision at the service. They told us a new catering manager was being employed from September 2016, and that this would help to ensure care staff did not have to make meals as well as provide care to people. The menu in place did not offer choice to people, however the provider told us people could have alternatives if they did not want what was on the menu.

Decisions regarding people's nutrition were sometimes being made by the provider and care staff without consultation with healthcare professionals or in line with the Mental Capacity Act 2005 (MCA). For example, one person's sweets were sometimes restricted because the person was suspected to be overweight. However, the person's care plan showed they had mental capacity to make their own decisions. There were no records in place to show this decision had been made in conjunction with the person and their GP.

We had been told the biscuit tin had "Just one biscuit" written on the tin, meaning people were only allowed to have one biscuit with their tea or coffee. We spoke with staff about this who told us this was an expectation; however one member of staff replied "I don't do this". The provider told us she had not seen this written on the biscuit tin and explained this was incorrect and that she would get a new tin. Some staff told us they wished we had inspected unannounced after 5pm, so we could see the limited portion sizes people received. The provider showed us the variety of food and snacks available and told us people could have what they wanted.

Staff were concerned that for some people there were significant hours between their last meal and their breakfast. For example, some people's final meal of the day was at 5.30pm, and then they would go to bed around 7pm. We looked at the care records for one person who had been assisted out of bed and given breakfast at 11am. However, we were unable to ascertain when they last had had something to eat and drink. Staff told us, records were not always completed.

People who had additional nutritional needs were not always provided with suitable meals. For example, one person told us they had seen a Speech and Language Therapist (SLT), but told us "I nearly choked the other day". They and their relatives explained this was because their meal should have been cut up and of a softer consistency. We spoke with the provider about this who told us the person had seen a SLT but only required their food to be cut because of a physical difficulty, and not because of a healthcare need relating to swallowing. The provider later, told us the person was not able to have sharp foods, such as roast potatoes as this could cause them to cough. However, the person's care plan was not reflective of how they should be supported and did not detail information about a SLT consultation. This meant we were unable to ascertain if this person's nutritional needs were being correctly met.

People's nutritional needs were not always met in line with their needs, wishes and preferences. People's care plans were not always reflective of how their nutritional needs should be met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's human rights were not protected by the legislative framework the Mental Capacity Act 2005 (MCA). Some people's care plans recorded their mental capacity, however some did not. Where decisions were being made for people, there was no evidence to show that best interests meetings had taken place to ensure the least restrictive options were considered. For example, one person smoked but their cigarettes were held by the provider and the number of cigarettes they could smoke was restricted. The provider told us the person had "agreed to this"; however there was no information in the person's care plan to confirm this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Decisions were made for people without taking into consideration the Mental Capacity Act 2005 (MCA). This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been asked for their consent to install covert surveillance in their bedrooms and in communal areas of the service. We asked to view the camera for one person who told us they had recently withdrawn their consent; this was to establish if their camera had been switched off. However, we were told that we were unable to do so because of "signal problems" with the equipment. We viewed the person's care plan but it did not record that their consent had been withdrawn. The provider told us they would take action to ensure this was recorded and explained people's ongoing consent was going to be obtained on an annual basis.

People's changing healthcare needs were not always referred to relevant healthcare services promptly to ensure they received responsive care. For example, one person's weight had been recorded as 65.8kg in April 2016 and in August they had weighed 60.9kg; however, their care records did not show that action had been taken to seek medical advice. The provider told us it had been discussed with the person's GP but

unfortunately not recorded; the provider also confirmed the person had been prescribed supplements. We spoke with the person's GP to ascertain whether action had been taken and were told that this was not recorded in the person's medical records and that food supplements had not been prescribed.

We were informed by the local authority and a GP that one person had been suffering pain, this person was later diagnosed with a fracture. The GP felt the initial detail of the provider's concerns had not been communicated effectively, which had led to a delay in diagnosis and treatment. The provider told us they felt they had responded appropriately and that the GPs were responsible for the delay.

People's changing healthcare needs were not always referred to relevant healthcare services promptly. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection the Commission received information that not all people were being treated kindly by the provider. We spoke with people, relatives and staff about the provider and shared their feedback with the local authority safeguarding team.

People's privacy was not always respected as some people told us they were unable to have appointments or visits in private. This meant there was an intrusion on people's privacy. During our inspection some people felt nervous about speaking with us, as they felt staff may have been listening.

People were unable to leave the dining room after lunch because some people were receiving their medicines. People, who received their medicines, were asked in front of others how they were feeling. This did not demonstrate a person centred approach to the administration of medicines and did not consider people's privacy and dignity.

People were not always treated with respect. A person, who had been eager to leave the dining room for some time, was assisted to the lounge by a member of staff. Just as the person was about to be assisted from their wheelchair into a chair, another person called out to be supported first. The staff member left the person they were assisting. So as a result of this, the person was left waiting whilst the other person was assisted into their chair, which took some time. The person, who had been left waiting, did not receive an explanation or an apology from the member of care staff, who had walked away.

We observed the registered provider switch the television off without seeking the permission of those sitting in the lounge; this did not show respect or consideration towards people.

People and relatives told us the care staff were kind, but also mentioned that some staff showed more compassion than others.

We observed staff speak respectfully to people and provide reassurance when people experienced anxiety or confusion. For example, one person became disoriented about where to go, so staff took time to speak with the person and assist them to the lounge. Staff took an interest in people and spoke with them about their family and friends. Staff knew people well and spoke fondly of them.

Inadequate

Is the service responsive?

Our findings

Prior to our inspection the Commission received information of concern that people were unable to have a shower when then wanted to. People and staff told us showers were offered once a week, but they could have more if they wanted to.

People did not always receive prompt and responsive care. Records for one person showed they had been suffering with constipation for over twenty three days. We asked the provider if action had been taken to seek medical advice and were told the person was prescribed and was being given laxative medicine. We spoke with a GP to confirm if this was correct and to establish if the concerns regarding the person's constipation had been reported. The GP told us the person had not been prescribed laxative medicines and that staff had confirmed recently that there were no concerns with the person's bowels.

People did not always have care plans in place to provide guidance and direction to staff about how to meet their needs. One person was staying at the service for a short break and their family had written some important information about their needs, this included risks associated with their care and the best way to support the person with their shoes. We asked to review the person's care plan; however there was not one in place. The provider explained the person was due to go home soon and that if we had not inspected we would never had known there was no care plan in place. We spoke with staff about how they met this person's needs. Staff's descriptions did not match what their relative had written and one member of staff was unable to tell us the person's full name.

People's care records were not always completed to record the care which was being delivered; this meant we were unable to ascertain if people's needs were being met in line with their care plans. When people's care plans had been reviewed changes had not always been made. For example, one person had been suffering with frequent urinary tract infections. However, their continence and eating and drink care plans had not been updated to reflect what this meant for the person and for staff.

People told us there was not always enough to do. The provider explained trips had been organised in the past and social activities were planned, but these had reduced because of staffing difficulties. On the day of our inspection some people participated in a singing activity, which had been led by a member of staff.

People did not always have care plans in place to provide guidance and direction to staff about how to meet their needs. Care plans were not always effectively reviewed to ensure they were reflective of the care being delivered. Responsive action was not always taken in relation to people's healthcare needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Records showed the provider had not learned from previous safeguarding alerts which had been raised and investigated. For example, records were not always completed accurately to reflect the care being delivered or action taken and responsive action in relation to people's healthcare was not always taken.

The provider did not act on feedback from health and social care professionals in order to improve the service for people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective quality monitoring systems to help identify when changes to people's care occurred and when action was required, and quality monitoring systems were not in place to help develop and improve the service. Following our inspection, the provider shared with us their quality assurance questionnaire dated 2016, it showed that overall people, friends and family were satisfied with the service they were receiving and the day to day management of the service.

The provider did not have systems and processes in place to ensure the ongoing monitoring and quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always open and transparent during our inspection. For example, the Commission did not always get accurate information about people's care and the provider had not been open and transparent about the administration of people's medicines. We were also informed by the local authority safeguarding team that the provider had been unwilling to share documents relating to one person's care. These actions did not reflect the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

People, staff, relatives and some external health and social care professionals told us they did not always feel the service was well-led, telling us the provider did not always demonstrate a consistently kind, positive and professional attitude.

The provider had not always informed us of significant events in line with their legal obligations, for example we had not been informed that someone had sustained a fracture.

The provider had failed to notify us of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify the Commission without delay of all significant events in line with their legal obligations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always acted in accordance with the Mental Capacity Act 2005 (MCA).

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 RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (3) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of service users did not meet their needs and reflect their preferences. People's nutritional needs were not always met in line with their needs, wishes and preferences. People's care plans were not always reflective of how their nutritional needs should be met. People did not always have care plans in place to provide guidance and direction.

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (1) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment of service users was not always provided in a safe way. The provider had not assessed the risks to the health and safety of service users and had not taken reasonable steps to mitigate risks. People were not protected by the proper and safe management of medicines. The provider had not assessed the risk of,

prevented, and controlled the spread of infect

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (1) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes were not in place to assess, monitor and improve the quality of the quality and safety of the services provided. The provider did not act on feedback from relevant persons, in order to continually evaluate and improve the service for people.

The enforcement action we took:

We have issued a notice of decision (NOD) to cancel the provider's registration.