Ms Pauline Rodman

Hazelwood Gardens Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 18 May 2017. This was the first inspection since the home was registered with the current provider in January 2016. The inspection was unannounced. Hazelwood Gardens Nursing Home provides nursing and personal care for up to 36 people. At the time of our inspection there were 27 people living in the home.

The registered provider had registered with the Care Quality Commission to manage 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.

People were not always safe. Risk assessments and risk management plans did not identify and mitigate risks to people's safety. These included risks associated with the unsafe use of equipment and risk due to lack of operational systems to check the safety of fire, water and electrical provision. People's medicines were not safely managed.

Quality monitoring systems were not in place to identify, monitor, manage and mitigate risks to people's safety and welfare.

Staff that had received training and understood their responsibilities with regard to keeping people safe from abuse.

Consent to care was not always sought in line with legal requirements and there was insufficient detail of best interest decisions made on behalf of people.

People's healthcare needs were met. Staff had access to, and obtained support and guidance from, external health care professionals. People received the support they needed with eating and drinking.

Staff received training relevant to their roles. However, staff did not receive supervision in line with the provider's policy.

Staff demonstrated a kind and caring approach and they treated people with dignity and respect. Staff knew people well and were able to tell us about people's likes, dislikes and preferred routines.

There were activities that people could participate in and people were enjoying group activities on the day of our visit.

People, staff and relatives told us the home was well-managed. People and relatives told us the registered manager was readily accessible and available to them. Staff told us they were well-supported and described the home as a good place to work.

During this visit, we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the registered 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's medicines were not safely managed. Risks to people's health and safety were not managed and safe care was not always delivered. The premises were not safely maintained.

Staff had been trained and recognised their role in safeguarding people from abuse. Accidents and incidents were reported and actions taken to minimise risks of recurrence.

People told us there were sufficient staff to provide the care they needed. Care staff reported they were able to provide the care people needed.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not meeting the requirements of the Mental Capacity Act 2005. Best interest decision making was not always undertaken in line with legal requirements.

People were referred to and had access to healthcare professionals. When changes to people's needs were identified and recorded, these were implemented.

Staff received training to carry out their roles. Staff felt supported. However, their performance was not always monitored on a regular basis.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs and preferences.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind, caring and respectful and we saw people being treated with compassion and dignity.

Staff provided care in accordance with people's individual wishes preferences and choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were involved in planning and reviewing their care plans. Staff knew the likes, dislikes and preferences of people they cared for.

People had opportunities to participate in social activities and events.

A complaints procedure was in place. However, this contained inaccurate information.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Sufficient systems were not in place for the monitoring of quality and safety. The audits that had been completed had not identified the shortfalls we found.

The registered person had not completed notifications that are legally required to be sent to the Commission.

People and staff spoke positively about the registered manager, and told us the home was well-managed. People had the opportunity to provide feedback and this was acted upon.

Hazelwood Gardens 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was the first inspection since the home was registered with the current provider in January 2016.

We undertook a comprehensive inspection of Hazelwood Gardens on 18 May 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

Before carrying out the inspection we reviewed the information we held about the care home. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with eight people who lived at the home and two visitors. We observed the way staff interacted and engaged with people. We spoke with the registered person, a visiting health professional, an external trainer and six staff that included a registered nurse, care staff, catering and housekeeping staff. We observed how equipment, such as call bells, pressure relieving equipment, bed rails and hoists were being used in the home.

We looked at four people's care records. We looked at medicine records, staff recruitment files, staff training records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, the registered person sent us further information that we had requested.

Inadequate

Is the service safe?

Our findings

We spoke with people who told us they felt safe in the home. Comments included, "Feel safe because staff know what they're doing" and "Someone here to look after me all night." However, we found risks to people's safety were not always assessed and not always sufficiently managed. Safe care was not always delivered.

Risk assessments were completed, for example, for falls, nutrition, moving and handling and skin condition. We saw some risk management plans were in place and provided detail of the care people needed to keep them safe. However, we also saw risks that had not been fully considered. For example, we checked on people who stayed in bed during the day of our visit. Three people did not have call bells to hand throughout the day. We were told by staff that these people were not able to use call bells to summon assistance. The care records provided accurate guidance about how often one person should be checked during the day or at night to make sure they were safe. The care records for two people did not provide this detail. We checked throughout the day of our visit and the people were not able to call for help. We saw staff visited these people to provide personal care, support with eating and drinking and administer medicines. We did not see evidence of routine planned safety checks for the people. These meant risks to people's safety were not always fully assessed or mitigated. We brought this to the attention of the registered person during our visit.

Some people used pressure relieving mattresses. These are used to reduce a person's risk of developing pressure ulcers and to help prevent further deterioration in skin condition. The pressure relieving mattresses in use needed the pressure setting adjusted according to the person's weight. We checked the mattresses at random and found they were all set incorrectly. For example, one person's weight on 14 April 2017 was recorded as 55.9kilograms. The pressure relieving mattress was set for a person with a weight of 150kilograms. Another person weighed 64kilograms on 1 May 2017 and their mattress was set for a person with a weight of 150kilograms. This meant people were not provided with the pressure relief they had been assessed as needing. We brought this to the attention of the registered person. They told us they did not have a system in place to monitor the pressure settings for this equipment.

The environment was not maintained to ensure it was safe. Legionella, fire and electrical safety checks were not up to date and safety actions from previous reports had not been fully completed.

A fire risk assessment was completed by the previous care home owner, in January 2013. Remedial works were identified with a review date of January 2015. The registered person told us the works were in the process of being completed. However, there were some works still outstanding. We also noted a storage cupboard on the ground floor that should have been locked, was open. The cupboard contained electrical fuse boxes. Chemical cleaning products were also stored in this cupboard. A risk assessment had not been completed.

An electrical check was completed in January 2015 and the record assessed the provision as 'Unsatisfactory.' The required remedial actions had not been fully completed. The registered person told us

the works were near completion and the five year electrical safety certificate would then be issued.

A legionella check had not been completed since the home had been registered with the current provider. As a result of us bringing this to the attention of the registered person they arranged for a check to be undertaken after our visit and confirmed it was completed on 30 May 2017. They told us the certificate would be issued in due course.
We checked in peoples rooms and found that one bedroom did not have a window restrictor fitted. The room, on the second floor was not occupied. The registered person told us this was an oversight and the restrictor had not been refitted after decorative works had been completed. They told us they would make arrangements to address the shortfall. The Health and Safety Executive provides specific guidance about health and safety in care homes. This guidance includes actions to take because of the risks of people living in care homes, staff and visitors, falling from height. The guidance had not been followed.

People had individual personal emergency evacuation plans (PEEPS) in place that confirmed the support needed if they were to be moved in an emergency situation. However, we noted there were no records for one person who lived in the home. The registered person told us they did not receive nursing or personal care, and chose to live in the care home with their partner who received nursing and personal care. This meant the person may not be accounted for in the event of an emergency situation, and if the home needed to be evacuated.

Medicines were not always safely stored or administered. Medicines received into the home were checked and the amounts recorded on the medicine administration records (MARs). However, where medicines were left over from previous months, these amounts were not always recorded. This meant accurate checks of stock levels could not always be completed.

Most of the medicines were suitably stored in locked cabinets and cupboards in designated rooms. However, we found an antibiotic medicine had been left unsecured in the room next door to the person for whom it had been prescribed. This was not in accordance with the provider's policy that stated, 'All medication within the home must be safely stored away, including non-prescription medication'. We also found topical creams, these are creams applied to people's skin, stored in people's rooms that were not labelled with the prescriber's instructions. Dates of opening were not always recorded.

We saw medicine records for four people that stated their medicines should be crushed. Three people's records stated in addition to being crushed their medicines should be mixed with yoghurt. The GP and a pharmacist had agreed to the crushing of medicines for one person. The GP had agreed to the crushing of medicines for a further two people. The form used by the registered person to record the crushing of medicines stated that a pharmacist and a doctor must be consulted. The form also had a space for 'resident signature.' We saw for one person this was signed by the registered person. There was no further record of the person, their relatives or advocate having been consulted. The records did not provide full, consistent and clear details about the reasons for medicines being given in this way.

People did not always receive their medicines when they needed them and when they were prescribed. For example, we observed two people who were prescribed medicine to be given 30minutes before breakfast. The registered nurse told us that people living on the ground floor were given their medicines by the night staff, before 8am. People living on the first and second floors were given their medicines as part of the morning medicine round, by the day staff. We saw one person was given this medicine at 10am, after they had breakfast. This meant their medicine may not be as effective.

The registered nurse made a decision not to give the injection of insulin at the time it was prescribed, for one

person. They told us the person's blood sugar was 'low' so they made a clinical decision not to administer the insulin until later that morning and after the person had eaten. There was no guidance in the medicine records or the person's care plan to confirm what the usual blood sugar range was for the person. There was no guidance or instruction about reducing or omitting the dose.

We observed medicines being given to people. Some people were prescribed medicines to be taken when needed, for example, for pain relief. People were not always asked if they needed these medicines. The care records did not provide detail about the circumstances in which these medicines were required. For example, three records stated the medicines were 'for pain' and to look for 'verbal and non-verbal signs.' The records did not describe the types of pain and did not explain what signs each person may show if they were in pain.

The above all amounted to breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No one in the home self-administered their medicines although arrangements were in place if people were assessed as safe to do so. Arrangements were in place for people to take 'homely remedies.' These are non-prescription medicines that people may take for short periods of time if needed. A written protocol and authorisation was in place that had been signed by the GP.

Arrangements were in place for medicines that required cool storage or additional security. We saw that the MAR's were signed to confirm when people had been given their medicines. Medicine storage rooms and refrigerator temperatures were recorded on a daily basis to make sure medicines were stored at suitable temperatures. Records were maintained for medicines no longer required.

Accidents and incidents were reported and recorded by staff. One member of staff told us, "We don't move anyone if they fall until they've been checked by the nurse. We just try and make them comfortable." The falls risk assessments were completed each month and the electronic records produced a graph that showed where people's levels of risk had changed and where further actions were needed to keep people safe.

The care staff we spoke with all told us they provided the personal care people needed, and that staffing levels were sufficient. The registered person used a dependency assessment tool to calculate staffing levels and monitored changes in people's dependency levels. They told us they reviewed this on a regular basis. We checked the staff rotas and saw that staffing levels were maintained at the levels the registered person stated were required. Where there had been staff sickness, the rotas showed that other staff had been called in, or had shifts changed.

Staff understood their responsibilities with regard to safeguarding people from avoidable harm and abuse. They were able to describe how they would recognise different types of abuse, and how they would act on concerns. Staff told us how they would report concerns immediately to the registered person. Comments from staff included, "I'd report straight away to [name of registered person]" and "There's information in the office if we needed to use to report abuse."

Safe recruitment processes were completed. Staff completed an application form prior to employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the registered person had ensured

that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

Requires Improvement

Is the service effective?

Our findings

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.

For some people their records did not provide the detail about how consent was obtained, how best interest decisions were made and how the outcomes that had been recorded, were agreed. For example, for one person their care plan recorded, 'May be incoherent with her responses at times and best interest decisions should be made on her behalf at these times to ensure she receives adequate nutritional and fluid intake.' This record did not provide detail about how this was to be achieved, what was an adequate nutritional and fluid intake and who had been consulted and involved in the discussion. The person's care records also stated the person used bed rails. The records stated the bed rails were provided in the person's best interests and, 'All support offered should be provided in the least restrictive way possible'. However, the records did not provide detail of alternative less restrictive options that had been considered.

The registered person told us that one person received their medicines covertly. The records confirmed that relevant external professionals had been involved and fully consulted. However, we saw that covert medicines were given to other people. For example, one person's MAR stated one of their medicines was given covertly. The instruction on the MAR was that the medicine was to, 'Place tablet on your tongue and allow to disintegrate before swallowing with or without water.' The MAR confirmed this medicine was administered each day. However the records did not provide any detail about how it had been given and whether the person had been offered it overtly or covertly. The person's care plan for mental capacity and for medication did not refer to the person receiving their medicines covertly. It was therefore not clear who had made this decision had who had been involved and in agreement this was in the person's best interests.

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

We saw some examples of mental capacity assessments that had been completed that were decision specific. For example, for one person their personal care assessment stated they lacked mental capacity and may not always dress appropriately. Their care plan stated they should be encouraged to participate in the decision making process. The care plan provided information about the person's specific personal care routines.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

The registered person had submitted 12 applications for people living at the home and were waiting for DoLS assessments by the local authority. Three people at the home had current authorised DoLS in place. The registered person had not met the legal requirement to notify the Commission when an authorised DoLS was confirmed. This is further reported on in the well-led section of this report.

We spoke with people who told us that staff spoke with them before they were supported with personal care. One person told us, "Agree to care. They do ask, they let me know what they are going to do."

We looked at the training records and saw training had been completed for topics described as mandatory by the provider. This included health and safety, moving and handling, food safety, mental capacity and safeguarding. Staff completed an induction programme when they started in post. The registered person told us the programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably trained to provide a high standard of care and support. We spoke with an external trainer who provided a training session for staff on the day of our visit. The training topic was tissue viability and pressure ulcers. They told us the training session had been very successful and they were impressed with the interest shown by the staff that had attended.

Staff told us they received individual performance supervisions and that they felt supported by the registered person. However, the records for 2017 showed that supervisions had not been completed in line with the provider's policy that stated, 'Formal supervision will take place at least six times per year on a regular basis.' The registered person agreed they would send us the records for 2016. We did not receive this information.

We spoke with people who were positive about the quality and choice of food available. Comments included, "[Food is] Pleasurable and healthy," "The food has improved and the two chefs are very good" and, "Meals are very good." A member of staff also commented, "The food here is excellent."

People told us they chose where they wanted to eat their meals. The dining rooms were laid in advance and we saw meals served to people in the dining rooms and in their bedrooms. People were assisted when needed and when this happened, we saw that staff sat with people, offered choices and provided support that was not rushed and at the pace of the person being supported.

People's weights were recorded and significant weight loss or gains were noted. The care records showed that they monitored people's weights each month and we saw advice had been sought from the GP and people had been prescribed food supplements.

People were referred to and had access to other external healthcare professionals. Specialist health care practitioners were accessed when people needed particular support to manage their health needs. For example, we saw where people had been referred to and had appointments with consultants, chiropodists and speech and language therapists. Comments from people included, "GP in every week, brilliant!" and, "I see the district nurse and person who sees to your feet." People also spoke positively about the support they received if they became unwell or if their needs changed. One person said, "The staff get somebody [medical assistance] in even if it's out of hours."

Good

Is the service caring?

Our findings

The people and relatives we spoke with told us that staff were kind, caring and respectful. One person told us, "They [the staff] are very kind" and another person commented, "I love being here, a very nice place to be." Relatives spoke positively and comments included, "[Staff are] marvellous and so kind." Another relative told us, "The care in here is lush. I wouldn't have it any other way, only the best for my [name of person using the service]."

Throughout the day of our visit, we observed positive interactions between staff and people using the service. It was clear staff knew people well. We saw staff acknowledge people as they passed by them, and call out with friendly and reassuring comments. For example, a member of staff commented to one person sitting in the foyer, as they passed by, "You had your hair washed and blow-dried this morning, it looks really nice." Another member of staff told us, "We get to know people well, what important to them, and that means we can care for them as they want to be cared for."

Staff were able to tell us how they made sure people's privacy and dignity was maintained. Comments from staff included, "Always make sure people are covered up [when being supported with personal care] doors and blinds shut," and, "Always make sure no one comes in when we're helping a resident with care." All personal care took place behind closed doors.

We saw one person being supported with their breakfast. The person was in bed and we were told they spent most of the time in bed because they were so frail. The member of staff explained to the person what the food was. They gently encouraged the person with each mouthful of food. They were respectful and spoke quietly with the person as they provided the support the person needed.

Relatives visited during the day of our visit. We saw they were greeted by staff when they arrived in the home. There were no restrictions and relatives told us they were always made to feel welcome.

When people moved into the home they, or their relatives, were given key information about the home and what people should expect from the service. Further details of how to make a complaint were displayed in the home. This ensured that key information was communicated to people.

The home had received five written compliment cards since January 2017. An extract from one card read, 'A token of our thanks and appreciation to the dedication and care given. Thank you again for your kindness.'

The home supported people at the end of their lives and staff had received training. People and their relatives were supported to express end of life wishes and preferences and these were recorded in end of life and last wishes documents in peoples' care plans. For example, one person's care plan was completed and stated their expressed needs for family and spiritual support. A member of staff told us how they provided support to one person whose condition had changed. The member of staff told us, "I know she used to like watching. 'You've been Framed' so I put it on quietly last night and sat and held hands and made sure she wasn't in any pain."

Requires Improvement

Is the service responsive?

Our findings

People were assessed by the registered person or a senior member of staff before they moved into the home to make sure their individual needs were known. Electronic care records were completed and these included risk assessments and care plans for each person. The people and relatives we spoke with told us they had 'some' involvement in the compiling of their care plans. One person, when asked about their care review told us, "Probably discuss every month, and I get a say." Another person commented, "Not sure how often we have reviews. Just tell them [staff] if you want something." The care plans we read had been reviewed and updated each month.

Care plans provided information about what people could do independently and what level of support they needed. We did find, in the care plans we looked at, statements were 'copied and pasted' from other peoples care plans, so they were not always personalised to each person's individual need. For example, in three of the care records we looked at the desired outcomes all noted for each person 'wishes to promote increased independence and confidence regarding personal care' and 'This may include reminding of hand washing, support whilst bathing or encouragement of washing hands and face before bed.' We checked this information and for one person, this was not accurate and the records showed this care was not recorded as provided.

The staff we spoke with understood people's individual needs, preferences, likes and dislikes. They knew what was meant by personalised care and described how they provided this. Comments from staff included, "Person centred care is about giving the person the care they need" and, "It's noticing little things, and changes, like if they're [people using the service] off their food." Staff completed entries into the daily care records several times each day. The entries were categorised and included repositioning record, bath, shower, fluid intake, fluid output, visitors, Doctors note and progress note.

An activity programme was in place, and the weekly programme was displayed in the home. The programme included visits from external entertainers. We saw entertainment taking place on the day of our visit and this was enjoyed by the people who chose to take part. The theme for their activity was 'food and drink' and included singing, poems, quizzes and a discussion. A record of activity was completed after the event with detail about the session and how people had responded to it.

The registered person told us that one to one visits took place with people in their rooms. They told us all staff visited people in their rooms to communicate and engage with people who were unable or declined to attend communal events and activities. The social visits were not always recorded. We saw one person was checked and staff spent time with them on a regular basis on the day of our visit. We checked two other people during the day of our visit

People told us they could not recall having seen or been given a copy of a complaints policy. However, people and their relatives told us they would feel comfortable raising issues of concern with the registered person. They told us they were confident the registered person would address their concerns. The provider maintained a complaints folder and had received one complaint since the home was initially registered in

January 2016. Following our visit, the registered person sent us additional information we had requested. This included the complaints policy. We saw this contained inaccurate information and brought this to the attention of the registered person.

Requires Improvement

Is the service well-led?

Our findings

We spoke with the registered person about the quality assurance systems that checked the quality of the service provided. We also spoke about audits that ensured risks to people's health safety and welfare were identified, and actions taken where required. We checked the auditing records and found examples for moving and handling, bed rails and infection control. However, there were insufficient checks and audits completed and the significant shortfalls we identified and reported on, mainly in the safe domain of this report, had not been identified. Actions had not been taken.

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

The registered person had not fully understood their responsibilities with regard to notifications that are legally required to be sent to the Commission. For example, we had not received notifications for the three people who had authorised DoLS in place. In addition, we had not received a serious injury notification for a person who had fallen in August 2016 and had sustained a fractured femur.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulation 2009.

People told us they considered Hazelwood Gardens was well-managed. We received positive feedback from people about the management of the home. Comments included," [Name of registered person] is the manager. I see her once a day and she keeps me up to date", "The person in charge is a very nice lady" and, "I love being here. I hope no one takes me away." However, one relative commented, "Nobody seems to be in charge when the boss [registered person] is not here."

People and their relatives had been given the opportunity to provide feedback about the service. A survey was completed in 2016 and actions had been taken in response to the comments and feedback received. The registered person told us they had introduced a key worker system and that this had been well received. They told us they were also planning to increase the hours for employed activity staff.

Staff spoke positively about the registered person and how Hazelwood Gardens was managed. Comments included, "This is a nice place to work and well managed. If we ask for things, like equipment, we get them," and, "[Name of registered person] is brilliant and always checking that we're all ok", and "I love the job and I love working here."

Staff told us they had the opportunity to express their views, and that they felt listened to. Staff meetings were held to make sure communication was effective throughout the home. We looked at the agenda for a recent staff meeting, and this included headings for discussion about changing morning start times for some staff, the role of senior health care assistants and mandatory training.

A business continuity plan set out the procedures to be followed in the event of an incident that caused disruption to normal working. If this incident affected the ability of the care home to give care as usual, maintain adequate safety and the well-being of people and staff, the plan had guidance on the action that

should be undertaken. These could be events such as disruption to gas, water or electric supply or failure of equipment within the service.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications were not submitted to the Commission in line with legal requirements. Regulation 18 (1) (2) (a) (b) (4B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Peoples rights were not always protected in line with the Mental Capacity Act 2005. Consent to care and best interest decision making was not always obtained in line with legal requirements. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not in place to assess, monitor and mitigate the risks to peoples safety. Regulation 17 (1) (2) (b)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Equipment was not always used correctly. Risk assessments and risk management plans did not mitigate risks to peoples safety. The premises were not safely maintained. Medicines were not safely managed. Regulation 12 (1) (2) (a) (b) (d) (e) (g)

The enforcement action we took:

We served a Warning Notice.