Bostan Care Homes Limited

Woodford Care Home

Inspection report

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Ratings

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

Overall summary

We undertook this unannounced inspection on the 9, 10 and 26 February 2015. The last inspection took place on 3 June 2014 and the registered provider was found to be complaint with all the regulations we assessed.

Woodford Care Home is situated on a main road in Hull near to public transport facilities and there are local shops within walking distance. The home was originally three terraced houses which have now been combined. It is registered with the Care Quality Commission (CQC) to provide accommodation and care for to up to 18 older people who may be living with dementia. On the day of the inspection 14 people resided in the home. A mixture of single and shared bedrooms where spread over two floors. Communal rooms consisted of a main lounge, an additional smaller lounge and a dining room. The home had several toilets and two bathrooms.

The service had a registered manager in post. 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.

Summary of findings

Systems used by the registered provider to assess the quality of the service were inadequate. A quality monitoring programme was in place however it failed to ensure shortfalls in the level of service were highlighted; therefore action was not taken to improve the service as required.

Infection, prevention and control practices were inadequate and ineffective; a skirting board in one of the toilets had blackened as it had been permeated by urine. Linoleum floor tiles had started to rise as these had also been permeated by urine. Towels and other linen were not stored appropriately to reduce the possibility of cross infection. Liquid soap or any other hand wash products were not available in the any of the toilets or bathrooms in the home except the staff toilet. Failing to provide products for people to wash their hands after using the toilet increase the risk of spreading infections through the home.

Staff had completed a range of training pertinent to their role. However, appropriate numbers of staff were not deployed to meet the assessed needs of the people who used the service and carry out their roles effectively. Staff were expected to complete cleaning and laundry tasks as well as conducting meaningful activities with people who used the service. During the inspection no activities took place; relatives we spoke with told there was no structured activity programme in place.

Consent to care and treatment was not always gained before it was provided. We saw restrictions were placed upon people without their consent. When people were deemed (by the service) to the lack capacity to make certain decisions the service had not held meetings to ensure the decisions made on the person's behalf were in their best interest. When restrictions were placed on people there was no evidence to show it was the least restrictive way to protect the person and meet their needs. The restrictions placed upon people were unlawful and the principles of the Mental Capacity Act 2005 had not been adhered to.

People who used the service and their relatives told us staff treated them with dignity and respect. We saw that people's needs were met by staff who knew their preferences for how care and treatment was to be provided.

A range of health and social care professionals were involved in the care and treatment of people who used the service. We saw evidence to confirm that when people's needs changed relevant professionals were contacted in a timely way to ensure people received the most appropriate care to meet their needs.

People medicines were ordered, stored, administered and disposed of safely. We checked a number of medicine administration charts and saw they had been completed accurately with omissions.

We have made a recommendation about providing meaningful activities to people who are living with dementia.

Breaches were found in regulations 10, 11, 12, 18 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with regulations 17, 13, 12, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have deemed this was a major risk to people who lived at the service. You can see what action we told the registered provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not protected from abusive practices that breached their human rights. We saw when restraint had been used within the service it was not monitored or reviewed appropriately, some practice was unlawful.

There was not sufficient numbers of staff deployed within the service at all times. Risks to people were not managed to ensure the safety and welfare of people who used the service

People's medicines were stored, handled and administered safely by suitably trained staff.

Is the service effective?

Inadequate

The service was not effective. Consent to care and treatment was not gained in line with legislation and guidance. The principles of the Mental Capacity Act were not followed.

Staff received relevant training in some areas. However, their understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards was found to be lacking. We saw staff received support and supervision.

People were supported to have sufficient to eat and drink.

People were supported by a range of healthcare professionals and had access to a range of services to meet their assessed needs.

Is the service caring?

Requires Improvement

The service was not always caring. When people requested changes to the treatment and support they received, action had not been taken to improve the service provided.

People were treated with dignity and respect during interactions with staff and it was clear during our observations that positive relationships had been developed.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always involved in decisions about their care and treatment. When people lacked capacity appropriate action had not been taken to ensure decisions made on their behalf were made in their best interest.

People were encouraged to provide feedback on their experiences of the service. A complaints procedure was in place that was displayed in the home.

People were not supported to follow their interests or take part in meaningful activities within the service.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. An effective quality monitoring system was not in place at the service to highlight shortfalls in care and treatment, staffing levels or the environment.

People who used the service, relatives and staff told us the registered manager was approachable.

The registered manager promoted a fair and open culture where staff felt they were supported and could raise concerns openly.

Woodford 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 checked whether the registered 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.

This inspection was carried out by an adult social care inspector and took place on 9, 10 and 26 February 2015; it was unannounced.

Before the inspection took place the local authority commissioning and safeguarding teams were contacted to gain their views on the service and whether they had investigated any concerns.

During the inspection we observed interactions between people who used the service and staff. We spoke with six people who used the service and three relatives. We spoke with the registered manager, assistant manager, two senior members of staff, eight members of staff including the cook and a domestic. We also spoke with a social worker and a community nurse who attended the service during our inspection.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the use of DoLS; which are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control.

We looked at a selection of documentation relating to the management and running of the service. These included staff recruitment files, training records, staff rotas, meeting minutes, quality assurance questionnaires, quality assurance audits and maintenance of equipment records.

Inadequate

Is the service safe?

Our findings

When we asked people who used the service if they felt safe and were supported by suitable numbers of staff we received mixed responses. One person told us, "Sometimes there are no staff around and I have to wait for such a long time when I need them." Another person said, "There is always someone to help me when I need them."

People told us they felt safe, comments included, "Yes, I feel safe" and "I'm safe here, it's my home." However, we were also told, "I am safe but I don't like it when I can't get out of my room."

We saw adaptions had been made to bannisters and architraves at the top of three stair wells and three bedrooms. The adaptions were used to slide a large wooden board into place, adjacent to the bannisters or architraves effectively restricting the movement of people who used the service to their bedroom or a small shared hallway. The registered manager told us, "The boards are in place when people are in their rooms because we don't want them to fall down the stairs." Restricting people's movements in this way is a form of restraint; the restrictions in place were unlawful as they had not been consented to by people who had capacity or followed the correct procedure and legislation when people did not have the capacity to consent to them being in place.

There were no arrangements in place to monitor the use of restraint within the home. The use of the restrictive practice was not appropriately planned for, monitored or documented after its use. When people had restrictions imposed on their movements there was no assessment of the emotional or psychological impact incurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.

Staff had completed training in relation to the safeguarding of vulnerable adults and told us they were aware of what action to take if they suspected abuse had occurred. They were knowledgeable about the different types of abuse but failed to recognise restricting people's movements without gaining their consent was a form of restraint and abusive practice.

During the inspection we took a tour of the building and saw that there was no liquid soap or any other hand washing products available in any of the toilets. A downstairs bathroom/toilet had five toothbrushes stored in two uncovered containers and a number of towels were stored on opening shelving. When the toilet was used air borne spoors would disperse around the room and contaminate the toothbrushes and towels. We mentioned this to the registered manager who took immediate action to dispose of the toothbrushes and remove the towels for the bathroom. After the inspection we spoke the environmental health team who visited the home and recommended changes to practice to ensure the safety and wellbeing of people who used the service.

There was a distinct mal odour in one of the down stairs toilets, the rear skirting boards had blackened as it had been permeated and become urine soaked. The floor tiles had begun to lift at the corners and urine had permeated the floor beneath them. There was no liquid soap or any other hand washing products available and the sink was unclean. Failing to provide appropriate hand washing products increases the risk of spreading infections throughout the home.

The linen room used for the storage of clean linen and other clean laundry also contained two clinical waste bins. We checked the bins and one had a used continence aids inside it. Storing clinical waste bins next to clean laundry creates the risk of cross infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.

The registered manager showed us dependency assessments were completed on a monthly basis. People's abilities to complete daily tasks such as washing and dressing, eating and drinking, their mobility and continence were included in the assessment. However, the assessments were not used to calculate the amount of support people required or to plan staffing levels within the home. The registered manager told us, "The owner sends me the rotas, sometimes I am including with the care staff which means I don't have time to do other tasks."

The registered manager told us staff were expected to meet people's care needs, provide stimulating activities and

Inadequate

Is the service safe?

complete laundry and other cleaning tasks. We saw the standard of cleanliness in the home was poor and there was a lack of activities taking place, we found there were not enough staff deployed to complete all of the tasks expected of them. We checked daily activity logs and found that very few activities were recorded. A visiting relative we spoke with said, "I do have to say not a lot goes on, people just sit in the lounge all day." This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.

We saw evidence to confirm that staff were only recruited after appropriate checks were completed to ensure they had not been deemed unsuitable to work with vulnerable adults. A completed application, successful interview and two references were also required before staff commenced employment.

Investigations were undertaken in relation to accidents and incidents that took place within the home. We saw evidence to confirm that when incidents occurred they were reported appropriately, investigated as required and action was taken to prevent their reoccurrence. For example, when staff knowledge or competency was found to be lacking further training was undertaken.

Equipment such as hoists and stand aids were checked periodically to ensure they were in good working order. Portable Appliance Testing (PAT) had recently been carried out within the service.

An 'emergency and contingency' plan was in place at the service. It provided guidance to be followed in the event of a fire, flood or severe weather conditions and who to contact. It also informed staff what action to take if one of the people who used the service could not be accounted for.

Medicines were stored in a lockable trolley that was secured to a wall as per best practice guidance. A medicine fridge was in use to store medicines at cooler temperatures as required. We saw temperature recordings were completed twice daily to ensure medicines had been stored as directed by the manufacturer. We checked a number of Medication Administration Records (MAR) and saw they had been completed accurately without omissions. A more effective system of key control was required as on two separate occasions the keys to the medicines trolley were left unattended. We discussed this with the registered manager who assured us more stringent key control would take place.

Inadequate

Is the service effective?

Our findings

People who used the service did not always give their consent to the care or treatment that was provided. People's movements were restricted without their agreement. One person who used the service told us, "I've said I don't want to be stuck in my room but all everyone ever says is; you know that it is done to keep you safe."

The registered manager told us of the four people who had restrictions placed upon their movements by the use of wooden boards placed in the doorway to their rooms. They said two people had capacity and two people were deemed not to have the capacity to agree to the restrictions.

We checked the four people's care files and saw that the only documentation in relation to the restrictions was a falls risk assessment in the files of the two people who had capacity. There was no evidence to show people had consented to the restrictions or were consulted before its implementation.

When people were deemed (by the service) to the lack the capacity to consent to the restrictions placed upon their movements; the principles of the Mental Capacity Act (2005) were not followed. Mental capacity assessments concluding that people did not have the capacity to consent to the restrictions placed upon them had not been undertaken. Therefore best interest meetings had not been held and best interest decisions to restrict people movements had not been reached. There was no evidence to show the restriction used by the service was the least restrictive method to keep people safe.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was not aware of their responsibilities in relation to DoLS and had not made any applications to the local authority at the time of the inspection.

Only three members of staff from the 22 employed by the service, including the registered manager had completed training in relation to the Mental Capacity Act (MCA) and no staff had undertaken Deprivation of Liberty Safeguards (DoLS) training. During discussions with the registered manager and staff it was clear that their understanding of the Mental Capacity Act was limited. The registered manager and registered provider did not understand the difference between lawful and unlawful restraint practices and did not see the restrictions placed upon people's movements as restraint.

The concerns we have raised above means there was a breach of Regulation 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with Regulations 13 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Which corresponds with Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.. The action we have asked the registered provider to take can be found at the back of this report.

People's preferences for how certain aspects of care were to be delivered was recorded in their care plan. A 'how best to support me' document included information about people's likes and dislikes, for example 'I like to have music playing when I am in my room' and 'I like my drink in a beaker not a cup'. A member of staff told us, "You get to know what people like and how they want things doing" and "If I'm honest though not all of the things we (the staff) know are in the care plans."

We saw evidence to confirm that staff were supported through regular supervisions and annual appraisals. The registered manager told us, "I do one to one's with the staff but because I work on the floor (as a carer) I see what they are doing and if I aren't happy with what they are doing I can talk to them about it straight away." A member of staff told us, "I have just started, everyone has been great. I got shown round and where everything is so I felt like one of the team straight away."

We spent time observing the lunch time experience of people who used the service and noted that the choices were limited. The daily choices were displayed on a menu board in the dining room, however; the service did not have pictorial aids to assist people with their selections. Displaying what choices were available would be an effective way to remind people what food was on offer or remind them of what choice they had made. This issue had been highlighted to the service by the dementia mapping team but at the time of the inspection no action had been taken. The registered manager assured us they were

Inadequate

Is the service effective?

compiling a picture menu which would be implemented in less than one week. There was a lack of signage in the home to enable people living with dementia to remain as independent as possible.

The cook told us they were aware of people's dietary requirements including those who needed soft diets, high calorie meals or drinks and what allergies people had. Portion sizes were varied to meet people's personal requirements and we observed people being offered assistance to eat their meals as required. We were told by staff that a variety of fresh fruit was always available but when we checked there were only three apples left. The cook told us that fresh fruit was ordered every week but was quickly consumed which meant there were usually only apples left as they were harder for people to eat than softer fruit like bananas.

A range of healthcare professionals were involved in the holistic care of people who used the service. We saw amongst others GPs, dieticians, speech and language therapists, emergency care practitioners and district nurses had contributed to people's care and treatment.

Requires Improvement

Is the service caring?

Our findings

When we asked people who used the service if they were supported by caring staff we received conflicting responses. People told us, "The staff are nice, they treat me really well", "I'm settled; all the staff are lovely" and "It is very pleasant here, my carer is my number one friend." However, we were also told, "Certain staff are very good but others act like they don't even know I exist."

We found that people were not always consulted about their care and treatment. Opportunities to involve people with decisions about the delivery of their care were missed. People's views were not acted upon when they were known which meant people felt they were not listened too.

During the inspection we spent time observing how people spent their time in the main lounge. People's needs were attended to promptly by staff when in this area; however, throughout the inspection call bells were not answered quickly and often rang for over two minutes. A visiting relative we spoke with said, "The call bells do ring a lot, sometimes it feels like they (the staff) don't answer one before another one goes off."

When personal care was provided people were treat with dignity and respect. We observed staff discreetly asking people if the need to use the toilet or required support. Staff engaged with people and knelt down to make eye contact before speaking to people in a considerate and respectful way. A member of staff we spoke with said, "I always make sure that people are covered up when I provide personal care and make sure there door is shut." Another member of staff said, "We are all one big family here so treating people with respect is easy, I just treat everyone like I treat my family."

It was clear staff were aware of people's life histories. We witnessed staff speaking to people about their childhoods, places they had lived and important people in their lives. When people became distressed or agitated staff engaged them in conversations about these aspects of their lives which helped to calm and comfort people.

People were supported to be as independent as possible. Staff told us they encouraged people to remain independent. One member of staff said, "You can't just do everything for people, on some days they will need more support than others but I always try and get them to do the things I know they can." A visiting relative told us, "I think the staff do a good job, they had to balance the care Mum needed without taking her independence away" and went on to say, "Mums care has changed now, she needs so much more support but the staff are really good with her."

The registered manager confirmed that there were no restrictions on visiting times. A visiting relative told us, "I can come and go as I please; no one ever says I can't come or it's too late for me to be here." A second relative said, "Mum is getting end of life care and a couple of times the doctor has said we should say our goodbyes so there has been family here at all hours, there has never been an issue."

Requires Improvement

Is the service responsive?

Our findings

A person who used the service told us they knew how to make a complaint but did not feel that their concerns were listened to or acknowledged. We were told, "I grumble to everyone when I am unhappy; to the manager and the staff but no one ever seems to listen or pay any attention to me."

Whenever possible, people were involved in their initial assessment and planning aspects of their care. We saw evidence that when reviews took place they were attended by people who used the service or by people acting on their behalf. A relative we spoke with told us, "I am here today for Mum's review; I make sure I am here for them all." A social worker attended the home at the time of our inspection to conduct a review. They told us, "My job is to make sure the person is getting the care they require. I like to have the person and their family if needed at the meeting so they can let me know how things are going."

People gave their views on their levels of independence so that staff could support them in the most suitable way to meet their individual needs. For example, one person's care plan stated their abilities to wash and dress themselves but indicated they may require prompting from staff. The registered manager told us, "You get to know people's ways over time, some of the men prefer not to get assistance with personal care from the younger staff and some people just have their favourites and they want them to help them with everything."

Risk assessments where in place for a range of topics including moving and handling, choking, fire evacuation, falls, skin integrity and pressure sores. People's abilities were assessed and personalised risk assessments were developed to ensure the risks to health and welfare were minimised. However, a number of the assessments lacked detail and failed to ensure people were supported in the least restrictive way to meet their needs.

Suitable adaptions had been made to enable people to maintain their independence including a bath hoist, hand rails, ramps and several stair lifts. A member of staff told us, "We have just ordered some special cutlery to help one of our ladies eat without our support" and "Some people have their drinks in a beaker because they struggle to grip a mug, it's the little things that make a big difference."

We saw that people were encouraged to maintain relationships with important people in their lives and were supported by staff as required. A member of staff told us, "Family members will call the home or people will ask us and we will contact their families for them." The registered manger explained how they had used social media and emails to converse with people's family members at their request.

There was a lack of activities that took place within the service which led to people's social care needs not being met. A visiting relative told us, "I know they can't do certain things but just activities to pass the time would be better than nothing." Another relative said, "That's one of the things they don't really do, Mum gets her hair done and her nails painted but they don't really do any activities. The registered manager told us they had tried to introduce movie nights but they had been unsuccessful.

Staff responded quickly when people's needs changed. We saw that referrals to specialist professionals including dieticians, speech and language therapists and the falls team had been made in a timely way. A community nurse told us, "The staff are really good, whenever someone needs us they contact us straight away and follow our advice which is important."

The registered provider had a complaints policy in place and we noted the complaints procedure was displayed within the main entrance of the home. When information was received by the service we saw evidence to confirm investigations took place and action was taken to improve the service as required.

A visiting relative told us they were aware of the complaints policy but had never felt the need to use it. The registered manager said, "We haven't had any complaints for a long time but we send out surveys quite regularly to get feedback and if anyone raises anything we will take action."

We recommend that the service finds out more about providing meaningful activities, based on current best practice, in relation to the specialist needs of people living with dementia.

We recommend that the service finds out more about providing meaningful activities, based on current best practice, in relation to the specialist needs of people living with dementia.

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was a registered manager in post who had registered with the Care Quality Commission to manage the service. However, the service was not managed effectively which led to numerous concerns being found during the inspection and breaches to regulations 10, 11, 12, 18 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with regulations 17, 13, 12, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We deemed this had a major impact on people who lived at the service. After the inspection took place we met with the registered provider and were informed that the registered manager has resigned. The deputy manager was currently performing the role of acting manager.

The quality monitoring system in place to highlight shortfalls within the service was not robust or effective. Although a care plan audit was conducted by the registered manager on a monthly basis, decisions made on people's behalf that were unlawful were not identified. The lack of consent to specific aspects of care and treatment was also not highlighted by the care plan audit. Restrictions placed upon people's movements and failings to safeguard vulnerable people were not picked up through the registered providers auditing system.

Infection, prevention and control issues within the home were not addressed. The registered manager told us, "I do a walk round every day to check how clean the home is and if there are any issues." The system was ineffective and inadequate to identify issues with cleanliness and general infection, prevention and control practices within the home as mentioned earlier in this report. The registered manager informed us all staff had responsibilities for cleaning tasks as part of their role. Staff shortages leading to cleaning tasks not been completed was not identified by the services quality monitoring programme.

The service did not always follow best practice guidance and were not fully aware of the principles of the Mental Capacity Act (2005). Innovation in the delivery of care was not encouraged or implemented. A member of staff we spoke with said, "The boards (mentioned earlier in this report) do keep people safe but there will probably be better ways to do it. The boards have been here since before I started so I guess no one has really thought about removing them." This demonstrates that the service had not reviewed practices with the home against current legislation and guidance.

The concerns above were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.. The action we have asked the registered provider to take can be found at the back of this report.

People who used the service and their relatives told us they knew the registered manager and felt they were approachable. A person who used the service said, "I know that manager, she is nice and seems good at her job." A relative told us, "The manager is great; she is always here and will always make time if you need to ask something."

Throughout the inspection we observed the registered manager's open door policy. Staff, people who used the service and relatives approached the registered manager confidently to discuss day to day aspects of the home. A member of staff told us, "The manager's door is always open; we can talk to her about anything."

The registered manager notified relevant agencies when accidents or incidents occurred. An error with medicines had prompted the service to seek support and retraining to raise the level of competency levels of the staff. The registered manager said, "We had some issues with medication and spoke to the local safeguarding team and got some specialist advice and training organised" and "We don't hide from our mistakes we just work out how we can stop them happening again."

We saw evidence to confirm team meetings were held regularly. Handover meetings took place after every shift to ensure staff were fully aware of the support people required. The assistant manager said, "The manager encourages staff and relatives to have their say about everything that happens." The registered manager told us, "I give my personal mobile number to the staff and people's families so they can contact me anytime."

Service user meetings were held periodically and used as a forum for people to raise concerns or request any changes in how they received their care. We saw that changes to the home's daily menus, future activities and entertainment were discussed. The registered manager explained, "We

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Is the service well-led?

have planned meetings that happen every couple of months but whenever I get the chance I will just go and sit in the lounge and speak to people about how they are or if they need anything."

Satisfaction surveys were sent to people who used the service, relatives and relevant healthcare professionals. We saw people's responses were evaluated and the action the registered manager had taken was displayed on the notice board in the main entrance to the home.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who used the service were not protected from abuse and unlawful restraint practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People were not supported by suitable numbers of adequately trained staff.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service were not protected against the risks of inappropriate or unsafe care and treatment because an effective system was not in operation to enable the registered manager to assess and monitor the quality of the service.

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not cared for in a clean environment and effective systems were not in place to reduce the risk and spread of infection.

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People were not consulted before care and treatment was provided. Regulation 18.

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.