Sherwood Court Care Home Ltd

Sherwood Court Care Home

Inspection Report

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Summary of findings

Overall summary

Sherwood Court Care Home can provide accommodation with nursing and personal care for up to 47 adults. The premises were built specifically for the purposes of a care home and are located in Sutton-in-Ashfield, Nottinghamshire.

The home had been open since August 2013 and at the time we visited there were just 17 people accommodated in the spacious premises. Only one person was accommodated on the ground floor. Staff told us that five more people were moving the next day from the first floor to the ground floor, having chosen their own rooms. The provider has informed us that there were no longer any people accommodated at the service after 27 June 2014.

There was no registered manager in post at this service when we visited. The previous registered manager left in November 2013. There had been an acting manager who had recently left and a new acting manager was due to commence following our visit. The service was not well-led and other areas were in need of improvement to keep people properly safe and provide a fully effective and responsive service.

During our visit we saw staff that were caring towards the people that lived at Sherwood Court, though they had not all been trained to meet people's needs effectively. One person said, "The staff are very kind to me." And a visiting relative told us, "The care staff are respectful and try to help people maintain their dignity."

We told the provider to make improvements to the service to ensure all Regulations of the Health and Social Care Act (2008) are being met. The regulations that were breached relate to monitoring the quality of service provision, safeguarding people, management of medicines, consent to care and treatment, complaints, staffing and supporting workers. You can see what action we told the provider to take at the back of the full version of the report. Improvements are also being monitored by the local authority to ensure people are cared for safely.

We found the location was not meeting the requirements the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults who use services by ensuring that, if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is needed. We saw evidence that at least one person who lived in the home was being deprived of their liberty. An application for DoLS had not been considered.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service was not safe because staff had not received training in managing challenging behaviour or in safeguarding adults since they had commenced working in the home.

Staff had not completed any training on dementia care and the Mental Capacity Act (MCA) 2005. Some people who lived in the home had needs relating to dementia and we saw that assessments about their mental capacity had not been completed. This meant there was no clarity about how staff should act in people's best interests and their rights were not protected.

We found the systems in place for the management of medicines did not ensure they were handled safely and held securely at the home.

Are services effective?

The service was not effective, because staff had not received sufficient training to enable them to provide care to meet people's needs.

An assessment had been made of people's day to day care needs. Arrangements were in place to ensure that people had their nutritional needs met and, where appropriate, expert advice had been sought.

Are services caring?

We found the service was not caring as the provider had not given staff appropriate training to meet people's needs, but people told us staff were kind and attentive.

People had their privacy and dignity respected and a visiting relative told us, "The care staff are respectful and try to help people maintain their dignity."

Are services responsive to people's needs?

The service was not responsive to people's needs. People had personalised care plans in place that staff understood and followed to meet personal care needs, but people did not have access to a wide range of activities that would meet their individual needs. Some people had needs relating to dementia and there were no specific activities to meet those needs.

Summary of findings

Are services well-led?

The service was not well-led, as there was no registered manager and no leadership. Staff understood their roles and responsibilities. Although people had made complaints, systems were not in place to record and manage these effectively. Also, no one at the service was able to demonstrate any learning from accidents and incidents as, although staff completed forms relating to these, the information was not managed to ensure all action was taken to prevent reoccurrences. The executive director was not aware of the systems to manage these and had not looked at the records.

There was no system to assess how many care staff were needed to meet people's dependency needs and the provider did not demonstrate that the number of staff was sufficient to meet people's needs at all times.

Summary of findings

What people who use the service and those that matter to them say

We spoke with seven people and asked them if they felt safe living at Sherwood Court. Of those that responded, two people said they did feel safe. Two other people told us it was safe, but they had to put up with a lot of shouting from other people who lived there. One person said, "Young staff don't know how to deal with people who have dementia."

We observed staff sitting closely to people and talking to them in a low respectful voice. They were trying to establish what was concerning them. They explained what was happening and offered some choices. This was not always working and we heard one person shouting and distressed for much of the day.

One person told us, "The staff ratio is not good sometimes". Another person said, "There is sometimes a delay in people being helped to go to the toilet, so they shout out a lot, which sometimes upsets other people."

Two people who used the service told us they were involved in decisions about when they received certain aspects of their personal care on a daily basis, but they had not seen the detail in their care plans and were not concerned about this.

We spoke with two people waiting for their meals to be served and they were very complimentary about the food. The relatives we spoke with were satisfied with the range of food available. One person said, "There's no plain water. It's always juice." During lunchtime we observed that people were not routinely offered water with their meal, but juice was available. However, staff told us they often provided water for people.

One person said, "The staff are very kind to me." Another person described staff as "very kind and attentive". A visiting relative told us, "The care staff are respectful and try to help people maintain their dignity."

We saw how staff showed respect to one person who had behaviour that might challenge others by walking with them around the communal areas, talking to them and holding their hand. This attention was accepted by the person.

People felt there was a need for an activities organiser. Three people who used the service and one relative said, "There is not enough to do here". One person told us that all they had been offered was to throw a soft ball and they did not consider this to be an interesting or useful activity. People told us they did not go out on any trips.

One person said, "I'm not sure who to complain to if I needed to". No one knew where to find a complaints procedure. However, one person felt they would be able to raise concerns to the appropriate person should it be necessary to do so.

Sherwood Court 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process.

We visited the home on 8 April 2014. The inspection team consisted of an inspector and an Expert by Experience who had experience of using care home services.

Before the inspection visit we reviewed the information we held about the home. We also spoke with professionals who had visited the home and reported their findings in a multi-agency meeting prior to this inspection. This helped us to decide which areas to focus on during our inspection.

On the day of our visit we spoke with seven people who lived at the home. We also observed the way staff interacted with people. We spoke with five members of staff and the chief executive officer who represented the provider company. We spoke with five relatives who were visiting people.

We looked at the care and support plans and other records linked with the management of the service. We also checked the arrangements for managing medicines at the premises.

There was no registered manager in post at this service.

Are services safe?

Our findings

When we visited the home previously on the 19 March 2014, we found that the checks carried out by the provider when recruiting staff were not sufficient. This meant that people's safety was not protected and the provider was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan and told us that they would perform checks on every staff member and that they would ensure they had the training and experience relevant to their role before starting in their position. During this inspection visit there were insufficient new staff for us to check if all appropriate action had been taken by the provider and, therefore, we will visit again in the future to ensure improvements in the recruitment of new staff have taken place and been maintained.

We spoke with seven people and asked them if they felt safe living at Sherwood Court. Of those that responded, two people said they did feel safe. Two other people told us it was safe, but they had to put up with a lot of shouting from other people who lived there. One person told us that some of the staff were not able to manage the behaviour of the people with needs relating to dementia and there was constant shouting and aggression. When we looked at the care plan files, where people had been assessed as having behaviour that was challenging to others, we saw behaviour management care plans had been developed. They contained suggestions for staff such as, 'offer a warm drink to encourage relaxation' and 'distract (the person) from others' rooms'. They were not sufficiently detailed to direct staff about what they should do. The care staff told us they had not received any training in managing challenging behaviour or in safeguarding adults since they had commenced working in the home. There were no records of any staff being trained in these areas. This meant that staff did not have the skills to manage people's behaviour consistently to ensure safety.

We were aware from the local authority that they were investigating concerns about people's safety. We saw written evidence to confirm the provider had since taken disciplinary action against a member of staff as a result of the investigations. We also saw that the provider had accepted advice from the local national health service clinical commissioning group (CCG) about nursing practices.

When we looked at the accident records, we found that a recent incident, where one person who lived at the service had hit another, had not been investigated by the provider or reported to the local authority as was required. The nurse on duty told us the person also sometimes harmed themselves by hitting the door frame or wall and the nurse had witnessed another altercation with a visitor three days earlier, when the person who lived in the home was being aggressive. There was a body map within this person's care plan file showing the extent of bruising, so that staff could monitor if new bruising arose. At the front of the person's file we saw a note to direct staff to contact the local authority's multi agency safeguarding hub (MASH) if they had any concerns about this person's behaviour and well-being. This had not been done and therefore, we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We made sure the nurse contacted the MASH during our visit. You can see the action we have asked the provider to take at the end of this report.

We looked at the process for managing medicines in the service to ensure they were looked after safely and that people received them as prescribed. We saw that most medicines were securely stored, but when we checked the controlled drugs (CDs) we found some had not been disposed of when they were no longer needed and the register of records about the CDs did not include all the drugs present. This meant that the provider did not have a true record of the drugs kept at the home and could not monitor the security and safe handling of these drugs.

The nurse on duty had received updated medication training from a previous employer, but confirmed that no such training had been given at Sherwood Court to any nurses. There was no system in place to check the competence of nurses in managing medication practices. This meant that people could not be sure their medication was always managed safely and this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We observed the nurse administering regular medication to four people that used the service. We watched as they sat

Are services safe?

with one person and explained why the doctor had prescribed each tablet and how they would help the person. We saw that these four people received their medicines from the nurse correctly.

We looked at the care plan files of four people who lived in the home and found risks associated with health and welfare had initially been assessed when people were admitted to the home. For example, the 'Malnutrition Universal Screening Tool' was used to assess people's specific dietary needs. We saw examples of when people had been referred to a dietician for support if there was any risk of malnutrition. There were also risk assessments about mobility and falls so that care staff would know if they needed to take specific action to reduce the risks of people falling. There were written evaluations of these assessments and plans had been completed within the previous month. This showed that there was information available to staff about how to reduce risks and keep people safe.

Staff had not completed any training on dementia care and the Mental Capacity Act (MCA) 2005. This is an act introduced to protect people who lack mental capacity. The staff we spoke with varied in their understanding of the MCA.

Some people who lived in the home had needs relating to dementia and we saw from three people's care plans that a previous acting manager had started to assess people's mental capacity, but that this had not been completed. In one person's care plan, the manager had documented that they did not have the capacity to understand their care needs, but the form was not completed beyond the first question. This meant there was no clarification about how staff should act in accordance with the person's best interests.

A nurse told us that one person's medication was hidden in their food as it was in their best interests to take it. There was a letter from a doctor agreeing to this, but not all medication could be given in this way and was recorded as refused. There was no evidence that the MCA had been used to assess the person's mental capacity about whether they could decide for themselves to take or refuse the medication or whether staff were to act in their best interests. This meant the Mental Capacity Act was not being used to protect people and there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. The staff we spoke with had no understanding of DoLS. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The person whose medication was given to them hidden in their food was being deprived of their liberty to choose whether or not to take it. Another person had constant supervision from staff which restricted their freedom as a result. An application for DoLS had not been considered to ensure all people are protected.

The provider told us there were always five care staff with a trained nurse on duty during the day. When we visited, we found there were only four care staff with a nurse to meet the needs of 17 people. This was because one care staff, who should have been on duty, was not available at short notice. We checked the staff rotas and saw that this had also occurred on the day before our inspection visit. We observed the four care staff who were on duty and saw two of them were constantly assisting people with personal care needs. The other two staff provided individual attention to the two people who needed constant supervision. This meant that other people had to wait for attention.

One person, who required two staff to use a hoist for transfers, was on a separate floor. They had to wait until staff were available, but told us they were used to waiting. Another person told us, "There is sometimes a delay in people being helped to go to the toilet, so they shout out a lot, which sometimes upsets other people."

Two visitors told us that the number of staff varied on a daily basis and sometimes there seemed enough and sometimes not. One of the staff told us, "There aren't enough of us really, but we just run around more quickly and make sure everyone is safe."

During the afternoon, there were more relatives visiting and they were able to provide the individual attention needed to keep people safe. The staffing arrangements were not sufficient alone to meet people's needs safely and the

Are services safe?

provider did not demonstrate that the number of staff was sufficient to meet people's needs at all times. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

Are services effective?

(for example, treatment is effective)

Our findings

We spoke with three care staff and one nurse. Two care staff told us they had received training in moving and handling people, but there were no records on any checks of their competency following the training and they told us they had not received training since they had started work at the home. They also told us they had received no supervision and appraisal, but they had attended a staff meeting during the previous week when arrangements for moving some people to the lower floor had been discussed.

We spoke to a new member of staff who told us they had five hours' experience of shadowing other staff before starting in their role. Some staff had previous certificates of training from previous employers, but there were no clear records of what training people had received and whether refresher training was required to ensure their skills and knowledge were up to date. Staff with no previous experience had no training and this meant there was no assurance that all staff had the knowledge and skills required to meet people's needs effectively. The provider told us they were aware of the lack of training for staff. They said training would be arranged as soon as possible for all staff. The provider is in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We looked at the care plans of four people and saw assessment information about people's needs, preferences and choices had been written down by staff. In addition to assessment information there were "This is your Life" documents that gave information for staff about people's life histories. One person told us how the staff always asked them which clothes they wanted to wear and said they could see their doctor whenever they requested one. We saw records of contacts with doctors and other health professionals.

We saw in the plans of care that people's weights were monitored and we saw examples of when people had been referred to a dietician and the subsequent advice that was given.

We spoke with the cook, who had details of people's individual food preferences and information about special diets. The cook told us about specific finger food that was prepared for one person and we saw this available for them when they did not want to sit to eat a meal.

The cook told us they went to each person every morning to offer a choice of food and cooked it to their requirements. We spoke with two people waiting for their meals to be served and they were very complimentary about the food. The relatives we spoke with were satisfied with the range of food available. Fruit juice was provided to people whilst they were waiting for their meals to be served. Other drinks were provided if people requested them.

Are services caring?

Our findings

Two people that lived in the home, and relatives of two others, told us they felt the staff were kind in the way they spoke to people and tried to help them. We saw that staff spoke quietly with people, individually, explaining what was happening. They spoke about their relatives and reminded them about who would be coming to visit them. We saw that staff were very attentive to people's needs in the dining room at lunchtime. Some people needed support to eat their meals and we observed staff assisting people and providing encouragement.

One person was isolated from other people that lived in the home, but said that most of the care staff had regular conversations with them when they came to attend to personal care or to bring food. Arrangements were being made for other people to move to the same floor as this person which might result in less isolation for them. Another person, who was looked after in bed, said that staff made sure they had everything they needed around them and staff were very kind and attentive.

There was no evidence that staff had received any specific training about maintaining people's dignity in care, but two staff told us they had received training from a previous employer and all staff demonstrated good practice. For example, when people were assisted with moving we saw that their dignity was respected, by keeping them covered and talking with them encouragingly. A visiting relative told us, "The care staff are respectful and try to help people maintain their dignity."

A visitor told us they were confused about the end of life medical care that was available for their relative, but they felt staff had tried their best and had shown that they cared. There was no evidence that any staff members had received appropriate end of life care training, but one of the care staff told us they had received palliative care training from a previous employer. This meant that people who used the service and their family members could not be assured that the staff members delivering their care and support understood what care was needed at the end of people's lives. The lack of training provided since staff had been employed at this home has been discussed in other parts of this report and is in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Three people told us they were involved in decisions about when they received certain aspects of their care, but not in the actual care planning and they had not seen their care plans. This reflected what we found in the written care plans. We saw that people's relatives had signed forms to say they had been consulted and had given background information, but we also saw some blank forms that were intended for people to sign to say they agreed to the detailed plans for their care. The people we spoke with were not concerned that they had not read the plans in full as they felt they had been consulted about how they liked to be supported. One relative told us, "I discuss things with the staff on duty and we agree who is going to assist with eating, for example, and what is the best way to assist."

A nurse told us, "The carers are good here. They respond to people's individual care needs and make sure they are toileted regularly." We saw that one staff member was allocated to sitting with a person who was distressed and we observed the staff member attempting to keep the person calm.

Another person who displayed behaviour that might challenge others had a member of the care staff with them at all times. This supervision was planned to keep the person calm and safe. We saw the care staff walking around the corridors with this person.

We saw that the staff kept daily care notes and records that they recorded at the end of their shift. We read some of these and saw that they were up to date and showed that staff were following the plans to meet personal care needs.

All the people we spoke with including staff members felt there was a need for an activities organiser. One relative said, "There is not enough to do here". One person told us that all they had been offered was to throw a soft ball and they did not consider this to be an interesting or useful activity. People told us they did not go out on any trips.

No activities took place during our visit, but one of the care staff told us they sometimes played a ball game when they had time and they had been painting gnomes with some people a few days earlier. Also, a few people decorated some cupcakes on one day. We did not see any records of these activities and there was no evidence that information in people's care plan files was used to provide appropriate activities. For example, we had seen information that one person was interested in gardening and visits to parks, but these activities had not been offered or arranged. The chief executive officer told us they had plans to employ a new part time activities worker.

We saw in the care plan files there was a section to record people's wishes about how they wanted to be cared for at the end of their lives. For three of the care plans we looked at, these had been completed to show that people wished to continue to be cared for within the home. For one we saw an Allow Natural Death (AND) form had been completed by a doctor and staff we spoke with were aware that this meant they were not to attempt to resuscitate this person. The form did not clarify whether or not the person was involved in this decision. A nurse told us they were dependent on the doctor and local nursing service to provide specific equipment for end of life medical care and would be guided by them.

Are services well-led?

Our findings

We found the service was not well-led. There was no manager working at the home when we visited. There had not been a registered manager in place at this service since the previous registered manager left in November 2013. This meant that the provider was carrying on regulated activities in breach of the conditions imposed upon registration. These state that each of the regulated activities must be managed by an individual who is registered as a manager. Having no such registered individual is contrary to section 33 (b) of the Health and Social Care Act 2008. We are considering whether we need to take other action with the provider.

In the absence of a manager, the chief executive officer of the provider's company was spending time at the home, but was not there every day. Two staff told us they did not feel anyone was taking responsibility for the day to day running of the home.

From our own records, we were aware of three complaints that had been made and we asked the chief executive officer for the records of complaints. There was a file for keeping such records, but it was empty. Two relatives told us they had complained to the previous manager and to the chief executive officer and action had been taken, but they had not received a written response. There was no procedure available for people to see so they would know how to make a complaint or how long the process would take. There was no effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by people who lived in the home or persons acting on their behalf. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We looked at records of accidents and incidents and found these remained all together in the record book. Staff had completed the forms, but had not passed them to the acting manager or the provider to check that all action had been taken to prevent a recurrence of the accident and meet the person's needs. In the absence of a manager, we spoke with the chief executive officer about accidents and found they had no knowledge of the accidents that had occurred and therefore no one was monitoring the information to ensure appropriate action was taken. This meant that the service was not able to demonstrate any learning from accidents and incidents. There was, therefore, no assurance that changes would be made to the treatment or care in order to prevent further incidents that might result in harm to a person who used the service or staff. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

There was no system to assess how many care staff were needed to meet people's dependency needs. The chief executive officer told us there were always five care staff with a trained nurse on every shift during the day, as that was the number they found was sufficient to meet people's current needs. We found there were just four care staff with a nurse. There were no other staff employed who could cover for the staff member who was absent at short notice, as there were insufficient staff employed to call on for this purpose. There was no system for a nominated staff member to contact an agency to request a member of staff.

Although we observed that people's personal care needs were being met whilst we were in the building, this was partly due to relatives visiting, who were able to provide the individual attention needed to keep people safe. We were concerned that the layout of the building had not been taken into account and one person, who required two staff to use a hoist for transfers, was on a separate floor. They had to wait until staff were available. Also, two visitors told us that the number of staff varied on a daily basis and sometimes there seemed enough and sometimes not. The lack of an effective system in place to ensure there were always sufficient members of staff available was a further breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** How the regulation was not being met: People who used the service and others were not protected against risks of injuries as there was no analysis of incidents that resulted in harm. **Regulation 10(2)(c)(i)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** How the regulation was not being met: People who used the service and others were not protected against risks of injuries as there was no analysis of incidents that resulted in harm. **Regulation 10(2)(c)(i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse** How the regulation was not being met: People who used the service were not fully safeguarded from abuse as the provider had not taken reasonable steps to identify and report allegations of abuse. **Regulation 11 (1) (a) and (b)**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse How the regulation was not being met: People who used the service were not fully safeguarded from abuse as the provider had not taken reasonable steps to identify and report allegations of abuse. **Regulation 11 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines** How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage and recording of all medicines. **Regulation 13**

Regulated activity	Regulation
	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage and recording of all medicines. **Regulation 13**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to Care and Treatment** How the regulation was not being met: Where people were unable to give consent due to their mental capacity, full assessments had not been carried out and the Mental Capacity Act was not being used to protect people. **Regulation 18**

Regulated activity	Regulation
	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to Care and Treatment How the regulation was not being met: Where people were unable to give consent due to their mental capacity, full assessments had not been carried out and the Mental Capacity Act was not being used to protect people. **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Complaints** How the regulation was not being met: People could not be assured their comments and complaints were listened to and acted on, as there was no complaints procedure available to people and no records of complaints previously received. None were available for inspection. **Regulation 19 (1), (2) and (3)**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Complaints

How the regulation was not being met:

People could not be assured their comments and complaints were listened to and acted on, as there was no complaints procedure available to people and no records of complaints previously received. None were available for inspection.

Regulation 19 (1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing** How the regulation was not being met: Staffing levels were not always maintained and arrangements had not been made to replace an absent member of staff in order to ensure there were enough staff to meet people's needs safely. **Regulation 22**

Regulated activity	Regulation
	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing How the regulation was not being met: Staffing levels were not always maintained and arrangements had not been made to replace an absent member of staff in order to ensure there were enough staff to meet people's needs safely. **Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers**

This section is primarily information for the provider

Compliance actions

How the regulation was not being met:

There was no assurance that all staff had the knowledge and skills required to meet people's needs effectively as staff had not been given appropriate training, professional development, supervision and appraisal.

Regulation 23 (1)(a)

Regulated activity	Regulation
	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers How the regulation was not being met: There was no assurance that all staff had the knowledge and skills required to meet people's needs effectively as staff had not been given appropriate training, professional development, supervision and appraisal. **Regulation 23 (1)(a)**

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** How the regulation was not being met: People who used the service and others were not protected against risks of injuries as there was no analysis of incidents that resulted in harm. **Regulation 10(2)(c)(i)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** How the regulation was not being met: People who used the service and others were not protected against risks of injuries as there was no analysis of incidents that resulted in harm. **Regulation 10(2)(c)(i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse** How the regulation was not being met: People who used the service were not fully safeguarded from abuse as the provider had not taken reasonable steps to identify and report allegations of abuse. **Regulation 11 (1) (a) and (b)**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse How the regulation was not being met: People who used the service were not fully safeguarded from abuse as the provider had not taken reasonable steps to identify and report allegations of abuse. **Regulation 11 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines** How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage and recording of all medicines. **Regulation 13**

Regulated activity	Regulation
	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage and recording of all medicines. **Regulation 13**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to Care and Treatment** How the regulation was not being met: Where people were unable to give consent due to their mental capacity, full assessments had not been carried out and the Mental Capacity Act was not being used to protect people. **Regulation 18**

Regulated activity	Regulation
	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to Care and Treatment How the regulation was not being met: Where people were unable to give consent due to their mental capacity, full assessments had not been carried out and the Mental Capacity Act was not being used to protect people. **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Complaints** How the regulation was not being met: People could not be assured their comments and complaints were listened to and acted on, as there was no complaints procedure available to people and no records of complaints previously received. None were available for inspection. **Regulation 19 (1), (2) and (3)**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Complaints

How the regulation was not being met:

People could not be assured their comments and complaints were listened to and acted on, as there was no complaints procedure available to people and no records of complaints previously received. None were available for inspection.

Regulation 19 (1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing** How the regulation was not being met: Staffing levels were not always maintained and arrangements had not been made to replace an absent member of staff in order to ensure there were enough staff to meet people's needs safely. **Regulation 22**

Regulated activity	Regulation
	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing How the regulation was not being met: Staffing levels were not always maintained and arrangements had not been made to replace an absent member of staff in order to ensure there were enough staff to meet people's needs safely. **Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers**

This section is primarily information for the provider

Compliance actions

How the regulation was not being met:

There was no assurance that all staff had the knowledge and skills required to meet people's needs effectively as staff had not been given appropriate training, professional development, supervision and appraisal.

Regulation 23 (1)(a)

Regulated activity	Regulation
	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers How the regulation was not being met: There was no assurance that all staff had the knowledge and skills required to meet people's needs effectively as staff had not been given appropriate training, professional development, supervision and appraisal. **Regulation 23 (1)(a)**