Vale House Oxford

# Vale House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| 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

This inspection took place on 12 and 17 September 2018 and was an unannounced inspection.

Vale House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Vale House accommodates up to 40 people in one purpose built building. At the time of the inspection there were 38 people living at the service.

There was 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. The registered manager was not present on the main day of inspection.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager did not always notify the CQC of reportable events.

The service did not always take the necessary steps to minimise the risks associated with people's care. Accidents and incidents were not always managed effectively to prevent reoccurrence and support future learning. The provider's procedures to formally assess, review and monitor the quality of the service were not always effective.

The service was not always responsive to people's changing needs. People were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities effectively and the service did not always follow the principles of the Mental Capacity Act 2005.

The home had not involved or sought the advice from a pharmacist to ensure that the decision to carry out covert medication was appropriate in relation to any impact that this could have on the medicine and its effects.

People told us they were safe living at Vale House. Staff were aware of how to safeguard people from harm and were aware of potential risks and signs of abuse. There were enough staff to meet people's needs.

People were supported appropriately to eat and drink sufficient amounts to help maintain their health and well-being.

People were very complimentary about the staff and management at the home. They told us staff were kind, caring and compassionate. Visitors were welcomed at all times and people were supported to maintain family relationships.

The provider had systems in place to receive feedback from people who used the service, their relatives and staff members about the service provided. People were encouraged and supported to raise any concerns with staff or management and were confident they would be listened to and things would be addressed.

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager) and yearly appraisals. The provider had safe recruitment processes in place, which helped to ensure that staff employed were of good character and suited to the roles they were employed for.

Infection control measures were in place to help reduce the risks of cross infection.

This is the first time the service has been rated Requires Improvement.

We identified three 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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

The service did not always take the necessary steps to minimise the risks associated with people's care.

Accidents and incidents were not always managed effectively in order to prevent reoccurrence and support future learning.

Staff were aware of how to safeguard people from harm and were aware of potential risks and signs of abuse.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The service did not always follow the principles of the MCA.

People were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities effectively.

People's needs were assessed and care planned to ensure it met their needs.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

The service was not always responsive to people's changing needs.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed.

Relatives knew how to make a complaint and information on how to complain was available in the home.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The registered manager did not always notify the CQC of reportable events.

The provider did not have effective systems in place to monitor the quality of service.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

# Vale House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 12 and 17 September 2018 and was an unannounced inspection. This inspection was conducted by two inspectors and an Expert by Experience (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a 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 looked at previous inspection reports and notifications received from the provider. A notification is information about important events, which the provider is required to tell us about by law. This ensured we were aware of any areas of concern.

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

We spoke with 14 people, six relatives, two visitors, two senior carers, three care staff, two nurses, the family support worker, one administrator, the assistant manager and the registered manager. We looked at seven people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

People's care plans contained risk assessments, which included risks associated with moving and handling, falls, medicines and pressure damage. However, risk assessments were not always accurate or up to date. For example, one person's risk assessment dated 5 September 2018 highlighted that the person did not have seizures but was at risk of developing them. However, the same person's moving and handling risk assessment dated 22 and 28 August 2018 stated that the person did suffer from seizures and prior to their admission into Vale House had been hospitalised as a result of a seizure. This practice was not in line with the provider's organisational policy on the procedure for the management of seizures dated October 2014, which states, 'A care plan and risk assessment will be written and reviewed appropriately'. In the absence of a seizure care plan and accurate information relating to the management of this person's condition, we could not be satisfied that the provider had taken appropriate action to mitigate the risks associated with this person's care.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person was at risk of presenting behaviours that may challenge others. This person's manual handling risk assessment dated August 2018 highlighted that '[Person] can be very challenging when personal care is offered. [Person] is verbally and physically aggressive and due to (medical condition) is not aware of (their) behaviour'. The guidance in this person's care records for staff to reduce the risk stated that staff were to work in pairs and if the person was to become resistive then staff should give the person space. The care record also stated that if necessary then a third member of staff should be called to assist and that staff should 'Use distraction techniques". However, there was no guidance in the person's care records regarding the role of each staff member, what distraction techniques were effective and how personal care should be delivered in the event that three staff were required to support.

We noted that there had been six incidents within nine days prior to our inspection where the person had demonstrated behaviours that challenged staff, in that staff were assaulted and the person damaged property within Vale House. One of the incidents described how four members of staff were required to support in deescalating the situation. However, we noted that this person's care records had not been reviewed following these incidents and it was not recorded that a fourth member of staff was required and what de-escalation techniques were to be used. In the absence of an effective support strategy we could not be confident that people using the service including staff were being kept free from harm.

Following the completion of one incident form the staff member reporting it had recorded in the accident and incident form 'I would recommend all staff have training in control and restraint techniques to maintain a safer environment for residents and care staff. To enlarge appropriate strategies and to reduce carer anxiety to increase confidence to manage this behaviour'.

However, the was no record or evidence that this had been considered further. Another staff member had recorded in another accident and incident form relating to this person's behaviour that an Antecedents,

Behaviour and Consequence (ABC) chart should be initiated. ABC charts can be used to record behavioural concerns, identify triggers and support staff to deal and understand behaviours that may challenge others. However, this had not been actioned. When we asked staff as to why this action had not been completed we were informed it was because the person was on respite. We explained to staff that this was an unacceptable response because those people who are not permanently living at the service have the right to receive the same level of support as someone who is living permanently at the service. The fact that this person was visiting for respite care was irrelevant.

Following these incidents, the provider had failed to carry out further investigations. This would have supported the provider in learning as much as possible about the causes of accidents that had happened in order to prevent reoccurrence and support future learning, which in turn would improve the quality and safety of the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Where people received their medicines covertly (medicine which is put in food or drink without the person knowing), records confirmed that mental capacity assessments and covert administration assessments had been completed. We noted that people's families and GPs had been involved in best interests meetings in relation to receiving their medicines covertly. However, there were no records to demonstrate that the home had involved or sought the advice from a pharmacist to ensure that the decision to carry out covert medication was the appropriate in relation to any impact that this could have on the medicine and its effects. This is not in line with national guidelines that states, 'A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist)' and "(the) medication (must be) review by the pharmacist to advise the care home how the medication can be covertly administered safely".

We spoke with a member of staff about this and we were informed that the decision to administer medicines covertly was discussed with the pharmacy during annual pharmacy inspections. This is not in line with the good practice and the best interest process because the appropriateness to carryout out the administration of covert medicines should be agreed prior to its commencement.

We observed a medicine round. Staff identified people who were to receive their medicines covertly, however, the staff member responsible for administrating the medicines did not attempt to try any other strategies to encourage the person to willingly take their medicines. This approach is not person-centred and not aligned to best practice. We noted that the administration of covert medicines was task orientated in that staff were focused solely on completing the task and not engaging with the person to ascertain if the covert method was the best option.

On the last day of our inspection we raised our concerns and findings with the registered manager. Subsequently the registered manager wrote to us following this inspection highlighting why the shortfalls in service provision had occurred and what action had been taken because of our findings. However, this was not in place on the day of our inspection.

Although the service was not always safe, relatives told us they felt people were safe. One relative told us, "Yes he is safe here, I know it is the best thing for him to be here". A second relative said, "She is very safe, extremely safe. I can go away for a fortnight and have no worries".

Staff were aware of how to safeguard people from avoidable harm and were knowledgeable about signs of

potential abuse. Staff were able to describe the process for reporting concerns both within the service and externally, if required. One staff member told us, "I would always report to the nurse on duty. I could go to [assistant manager] or [registered Manager]. If no action was taken I could go to CQC".

We observed, and staffing rotas confirmed, there were enough staff to meet people's needs. Relatives told us there were enough staff to meet people's needs. One relative said, "There are enough staff". During the day we observed staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. A staff member told us, "Staffing levels are pretty good. We have time to sit and spend with people".

Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they were employed for. We checked the recruitment records of five staff and found that all the required pre-employment checks had been completed prior to staff commencing their employment. This included a completed application form, two written references and disclosure and barring check (DBS). The DBS check helps employers make safe recruitment decisions and prevents unsuitable potential employees from working with vulnerable people.

People were protected from the risk of infection. The premises and the equipment were clean, and staff followed the provider's infection control policy to prevent and manage potential risks of infection. Colour coded equipment was used along with personal protective equipment (PPE). PPE equipment, such as aprons and gloves were available and used by staff. We observed good hand hygiene practices. One relative we spoke with told us, "I like it that there are no unpleasant smells here and others have commented on this too".

Requires Improvement

# Is the service effective?

## Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

The service did not always follow the principles of the Act. For example, one person's care plan highlighted how the person's needs in relation to their mobility had recently declined. The person's moving and handling risk stated that this decline had increased the person's risk of falling and that the person now used a recliner chair with a lap strap. Guidance for staff reminded them to 'ensure the lap strap was fastened when sat in chair'. However, there was no evidence that the service had followed the best interests process and that this person had consented to this aspect of their care being changed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

This person was being deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although the service had made an application to the authorising body they had not updated this person's DoLS application to include the use of lap straps. This meant that the home did not always meet the requirements of DoLS.

Records confirmed staff received and completed training, which included safeguarding, moving and handling, infection control, medicines management, first aid, fire awareness and food and hygiene. One staff member told us, "I've done an on-line dementia course at level two and we can ask for any additional training". However, people were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities effectively. For example, we were informed by staff, and records confirmed that, staff had restrained a person during an incident were the person had presented behaviours that may challenge others. However, staff had not received restraint training. When we spoke with staff about the use of restraints there was a lack of knowledge about what constitutes a restraint. For example, the assistant manager referred to restraints as having to put people on the ground. They failed to recognise that the need for four staff 'assisting' a person into a chair was in fact restraint.

People's needs were assessed prior to their admission to ensure their individual care needs could be met in line with current guidance and best practice. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. Where people had been identified as having swallowing difficulties, referrals had been made to Speech and Language Therapy (SALT). Care plans contained details

of recommendations made by SALT. We observed staff following these recommendations.

The home has a family support worker. The purpose of the family support worker was to ensure that the input from relatives and friends of people was included within people's care from the point of assessment. The family support worker also supported families of people who had been bereaved. Relatives spoke positively about this part of the service. One person told us "The role of family support is so important". Another person said "It is that family support function that distinguishes Vale House and is so important for me".

Staff received regular supervision, which is a one to one meeting with their manager. Staff told us they felt supported by the registered manager and the provider. One staff member told us "[Registered manager] or [assistant manager] do supervisions. We have them about every six months". Another staff member said, "Any problems I can go to nurses or the manager. I am very well supported. I can go to her [registered manager] with any issues".

Newly appointed care staff went through an induction period which reflected the Care Certificate. The Care Certificate is a set of standards that social care workers are required to work to. It ensures care workers have the skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. This included training for their role, shadowing an experienced member of staff and having their competencies assessed prior to working independently with people. One staff member told us, "I've just started my Care Certificate. I've done all my mandatory training and updates are ongoing".

Meal times at Vale House were 'protected space'. This meant that at the evening meal time, relatives were asked not to use the dining room during visits. Relatives could still visit during this time, however, they were asked to visit people in the privacy of their own rooms. People had access to food and drink. Breakfast was served at any time through the morning.

People appeared to enjoy their lunch and were supported to eat and drink at an appropriate pace. Staff encouraged people to eat independently, stepping in to support them and prompt where needed. Because the majority of people had difficulty communicating, the home liaised with relatives and friends to ensure that there was a constant discussion surrounding the menus and people's preferences, likes and dislikes. Where people required special diets, for example, pureed or fortified meals, these were provided by the chef who clearly understood the dietary needs of the people they were catering for.

Vale house is a purpose-built dementia home which supports a dementia friendly environment in that people are able to move around the home freely. There are viewing panels on communal doors and the use of colours and signage to help residents to recognise their location and reduce anxiety when feeling lost. There was a hairdressers, which families could use and a café which was key coded that enabled visitors and relatives to make drinks for themselves and people living in the home.

Good

# Is the service caring?

## Our findings

People and their relatives told us they benefited from caring relationships with the staff who supported them. One person told us, "Oh definitely, they all look after you, it is like being at home, you know that you couldn't really get any closer". Relatives comments included; "The carers are really kind", "It is a lovely place to be and a quiet atmosphere, I am content", "I know all the carers" and "They employ a good quality of carers and they always keep me informed".

During the day of the inspection, we noted there was good communication between staff and the people who used the service. People were treated with kindness and respect by staff, who understood their individual needs. For example, one person had difficulties communicating. This person's care records gave guidance for staff to recognise and respond to the person's communication needs. During our inspection, we observed staff communicating effectively with this person. Staff gave the person the time they needed to explain what they were asking or discussing. This demonstrated that staff knew and respected the people they were supporting.

Staff showed concern for people's wellbeing in a caring and meaningful way. For example, one person became anxious. Staff spoke with this person and gave them reassurance and held the person's hand. As a result, the person became less anxious and their mood improved. Throughout the interaction, staff spoke with this person in a warm and gentle manner.

Staff told us they respected people's privacy and dignity. One staff member said, "I make sure I keep them covered during personal care. Close doors to protect people's dignity. We call people by the name they prefer". Another staff member told us, "We always try to get better at what we do. I would want a family member here". A relative said, "Industrious care without being overbearing".

Staff spoke with people with respect using the people's preferred names. When staff spoke about people to us or amongst themselves they demonstrated compassion and respect. During our inspection,we noted that staff were always respectful in the way they addressed people. We observed staff knocking on people's doors and where people had their doors open staff still knocked and waited to be invited in.

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Where the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. We observed staff following this guidance. Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting people's independence. One staff member we spoke with told us, "Independence is what keeps people going and that's why it's important to promote it".

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive to people's changing needs. For example, one person's needs had changed in relation to a specific condition which caused the person discomfort. Staff had recorded concerns relating to the specific condition on seven separate occasions over the period of four days. However, this person had not been referred to their G.P for treatment.

We raised this with the assistant manager and they told us, "[Specific condition] is ongoing, we offer homely remedies only". A homely or household remedy is another name for a non-prescription medicine available over the counter in community pharmacies, used in a care home for the short-term management of minor, self-limiting conditions. However, when we checked the records relating to the administration of homely remedies there was only one record of medicines being given on the first day in which the specific condition had been recognised. There were no further entries after this. The assistant manager confirmed that there was no GP involvement regarding the specific condition and that the person had not been put on the list to see the G.P on the day of the inspection. The assistant manager informed us that they would contact the person GP and arrange for them to be seen. However, this was not in place on the day of our inspection.

On the last day of our inspection we raised our concerns and findings with the registered manager. Subsequently the registered manager wrote to us following this inspection highlighting why the shortfalls in service provision had occurred and what action had been taken because of our findings. However, this was not in place on the day of our inspection.

People had access to activities that included entertainment, music therapy and seated exercises. We observed people enjoying the music therapy, people were smiling and joyful. However, relatives we spoke with told us they felt there could be more things to keep people stimulated at reduce the risk of social isolation. Comments included, "The only thing I would say is I would like a lot more one to one being done, I think there could be more guaranteed input of this sort", "We noticed that often there is not much happening in the lounge", "There could be a lot more activities, things are often left to the individual", "In the lounge there is nothing going on most days, just occasionally" and "Lots of them are just vacant and just sit staring at the TV".

People's care records held personal information about people including their care needs, likes, dislikes and preferences. Staff we spoke with knew the people they cared for. For example, we spoke with one staff member about a person they supported and they were able to tell us the person's likes, dislikes and preferences that matched those outlined in the person's care records. Staff we spoke with were able to tell us people's preferences in relation to their care.

We asked the assistant manager to provide evidence of how the service ensured it worked within the Accessible Information Standard (AIS) framework. AIS was introduced by the Government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The deputy manager was not aware of AIS. However, after we explained AIS they were able to demonstrate to us an example of where

information relating to people's care had been supplied in large font to support people with poor eyesight.

People's individual, diverse needs were respected by staff who understood equality and diversity. One staff member we spoke with told us, "We must respect people as individuals otherwise we can't deliver person-centred care". Another staff member said, "We are all different. What is good for one person is not always good for another person". We also noted that people of different faiths were supported to follow their faith in a way they choose to.

Relatives knew how to make a complaint and information on how to complain was available in the home. One relative told us, "I would speak with [registered manager] she's approachable and would listen". Records showed that where complaints had been made they had been dealt with in line with the provider's complaints policy.

At the time of our inspection there was no one receiving 'end of life' care. However, the provider was able to evidence how the service had previously recorded and respected people's preferences and wishes. Records confirmed that people's funeral wishes in relation to burials, cremations and family arrangements had been discussed with people.

Requires Improvement

# Is the service well-led?

## Our findings

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager did not always notify the CQC of reportable events. For example, one person developed a grade four pressure sore. This is a notifiable event; however, this was not raised with CQC.

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

The provider did not have effective systems in place to monitor the quality of service. The issues relating to the safety and wellbeing of people using the service, found during the inspection had not been identified. For example, the absence of a seizure care plan for one person, the handling of accidents and incidents to prevent reoccurrence and support future learning, the absence of an effective support strategy for people who present behaviours that may challenge others, effective strategies to keep staff free from avoidable harm and the principles of the Mental Capacity Act not being followed.

We also noted that the provider's restraint policy dated October 2014 did not cover necessary action that staff may need to take when supporting people who present with behaviours that may challenge others.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The service was not always well-led. For example, in November 2016 concerns had been reported to the registered manager about the behaviour of a staff member. We reviewed the action that the registered manager had agreed to take following the incident in order to safeguard other people who used regulated services like Vale House. We found that the registered manager had not carried out the agreed actions in that they did not refer an ex staff member to Disclosure and Barring Service (DBS) following allegations of inappropriate behaviour which resulted in the staff member being dismissed. DBS is a government organisation that helps to prevent unsuitable people from working with vulnerable groups of people.

On the last day of our inspection we raised our concerns and findings with the registered manager. We requested that the registered manager respond to our concerns and findings in writing to ensure that actions would be taken to improve the quality of the service. Subsequently the registered manager wrote to us following this inspection highlighting why the shortfalls in service provision had occurred and what action had been taken because of our findings.

Although the service was not always well led, relatives told us people enjoyed living at the service and were positive about the management team. One relative told us, "The senior management line is good". Another second relative said, "They always phone us to update us". A third relative we spoke with told us, "If you disagree with them you can still have a healthy conversation and discussion with them".

The service encouraged open communication between the staff team. A staff member told us, "I am very

comfortable to have my say at team meetings. I feel valued and know that my ideas get passed on ". Another staff member said, "[Registered manager] is good. She listens, she helps. She is very approachable".

The home sought people's views and opinions through residents and relatives' meetings. We viewed records that confirmed these meetings were taking place. One relative told us, "We have meetings with [provider]". Another relative said, "[Family support worker] does a monthly meeting in the Village Hall, a tea party and a chance for relatives of residents to share experiences and an informal support network opportunity". People we spoke with told us they felt confident in giving feedback on the service and that they would feel listened to.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, and CHSS.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager did not always notify the CQC of reportable events. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service did not always follow the principles of the Mental capacity act 20015. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service did not always ensure that the risks associated with peoples care were mitigated. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have effective systems in place to monitor the quality of service.<br><br>The service did not always assess and monitor the service to ensure the safety and welfare of those people using the service, including staff was being met. |