Care Expertise Group Limited

# Holmwood Nursing Home

## Inspection report

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Date of inspection visit:
13 March 2019

Date of publication:
16 July 2021

## Ratings

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

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

# Summary of findings

## Overall summary

About the service: Holmwood Nursing Home is a care home that provides personal and nursing care to 25 older people living with dementia at the time of the inspection.

People's experience of using this service:
There had been improvements to the safety of the service made since the last inspection however, some people were sometimes still at risk of unsafe care and treatment. There was an inconsistent approach to risk management for people who may develop pressure sores or require support with their nutritional needs. Staff competency and responsiveness had improved but some staff did not always know people's needs well.
There was a new manager in post who had taken steps to improve staff training and had made changes to the environment to help people living with dementia. Whilst this was positive there were further improvements needed to help give people with dementia a better experience of living at the service. Activities had also improved but care planning remained a concern. The provider had introduced a new care planning system which had not been fully used at the time of the inspection. Quality assurance audits had identified and addressed some issues in certain areas but not all those that had been found at the inspection. Further improvements need to be made before we can be satisfied that these will be sustained and embedded into practice.

Rating at last inspection: The rating at the last inspection was Inadequate (3 September 2018). At this inspection the rating had improved. Despite an improvement in the overall rating the service will remain in special measures as the key question of Well-led was rated Inadequate.

Why we inspected: This was a scheduled comprehensive inspection based on the previous rating applied. We were following up to make sure that improvements had been made to the safety and quality of care being provided.

Follow up: We will be monitoring the service and will be re-inspecting to ensure improvements continue and are sustained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not always safe.<br>Details are in our Safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our Effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our Caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our Responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our Well-Led findings below. | **Inadequate** |

# Holmwood Nursing Home

**Detailed findings**

## Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was to confirm if improvements had been made since the last inspection in September 2018 when the service was rated Inadequate.

Inspection team:
This inspection was carried out by three inspectors and a specialist nurse advisor.

Service and service type: Holmwood Nursing Home 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. The service did not have a manager registered with the Care Quality Commission however at the time the manager was applying to become registered.

Notice of inspection:
This inspection was unannounced.

What we did:
We reviewed the information we held about the service. This included notifications and feedback from the local authority. Notifications are changes, events and incidents that the service must inform us about. We used information the provider sent us in their Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke to three people, one relative and 10 staff, including the chef. We reviewed care records and policies and procedures. We reviewed seven people's care plans and checked training and supervision records for staff.

Following the inspection further information was sent to us by the manager in relation to staff training and quality assurance checks completed.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were still not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations have not been met.

We inspected this key question to follow up the concerns found during our previous inspection on 3 September 2018. Whilst we found there had been improvements relating to infection control, staffing levels and safeguarding practice concerns remained about how risk to people was managed.

Assessing risk, safety monitoring and management

- Risks to people were still not always mitigated as staff did not always follow guidance. For example one person had poor skin integrity and required regular re-positioning. This was not always being done at the required frequency and meant they were at increased risk of developing pressure sores. Another person had their pressure mattress at the incorrect setting for their weight.
- People may be at risk in the event they needed to be evacuated in the event of an emergency. Each person had a personal evacuation plan (PEEP) however, the folder which held this information did not have their room numbers on and was not accurate. This would hinder safe evacuation of people.

Failure to mitigate risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other risks to people were managed well. For example some people required a hoist to move and we saw staff safely undertake this on the day. One person had to be peg (percutaneous endoscopic gastrostomy) fed via a flexible feeding tube placed into their stomach. This was carried out by nursing staff who ensured this was done safely and recorded appropriately. First aid boxes were up to date and there was useful guidance in people's rooms on what they could eat, how they could be moved and what size sling they needed.

Staffing and recruitment

- Staffing levels had improved and the use of agency staff had reduced since the last inspection. Staff told us, "There are more staff that before. We get things done better." The staffing levels had recently reduced but were still higher than necessary for the amount of people who required support.
- Staff were unhurried and were able to support people when they needed help. One person needed one-to-one support at certain times of the day which was provided.
- People were supported by staff who had been appropriately vetted prior to appointment. Checks included a full work history, references and a check with the Disclosure and Barring Service (DBS). The DBS keeps a record of staff who would not be appropriate to work in social care.

Using medicines safely

- People received their medicines when they needed them. The service was in the process of moving to an

electronic medication administration record to help minimise medicines errors and encourage consistency.
● Medicines were stored securely and labelled appropriately. The medicine room had its temperature checked regularly however, these records required improvement. When medicines were administered these were recorded correctly with no gaps. Medicines in liquid form had dates recorded of when they were opened so staff would know when they would expire.
● Where people had medicines administered covertly we saw this had been done in consultation with the GP and relatives. There was appropriate guidance for staff to follow. Only suitably trained staff administered medicines and we saw they were up to fate with medicines training.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and told us they felt safe living at the service. One person said, "I do feel safe here because the staff look after me." Despite this the arrangements for reporting safeguarding concerns needed to be clarified. There was a safeguarding lead for the provider who reviewed and agreed whether incidents needed referral to the local authority under the safeguarding procedures. Whilst they were clear they were not authorised to decide if an incident was reportable to the local authority safeguarding threshold this was an area that needed to be made clear to staff so referrals were made in line with local arrangements.
● Staff confidently described the action they would take if they had concerns about people's care. One staff member said, "People are safer now because we have more permanent staff who know them better. We need to tell the nurse in charge about safeguarding or the manager. If they don't do anything we can talk to the local authority or CQC." Incidents had been reported appropriately to the local authority.

Preventing and controlling infection
● There had been significant improvements in relation to the cleanliness of the service and staff practice of infection control since the last inspection. One member of staff told us, "It's a lot cleaner and tidier." The smell of urine had gone and the flooring in communal areas had been replaced. The sluice rooms had been cleaned and refurbished. The laundry room had been updated and was clean and well organised. People's rooms were clean and smelled fresh.
● We observed staff using protective equipment and gloves when providing care and support to people. Staff had received updated infection control training since the last inspection.

Learning lessons when things go wrong
● The manager reviewed accidents and incidents to ensure lessons were learned and people were kept safe. Accidents and incidents were recorded centrally and reviewed regularly. Each incident had a record along with an overview and analysis to help identify patterns or trends. Staff responded appropriately to accidents or incidents and records showed this.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

We inspected this key question to follow up the concerns found during our previous inspection on 3 September 2018. Whilst we found there had been improvements in relation to staff competency and the food provided, concerns persisted about the application of the Mental Capacity Act 2005, the environment for people living with dementia and how staff worked with healthcare professionals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance

- People's consent was not always obtained appropriately. One person who lacked capacity had bedrails in place. This had been agreed by their next of kin who did not have the legal authority to make this decision. Other people had consent forms for 'care, care planning and photos,' which had been recently completed. Whilst a best interest decision had been completed this lacked detail and did not state what options had been considered. Another person had a stair gate in place but there was no decision specific mental capacity assessment completed for this.
- The communal area had a coded lock on the door that restricted people's movement around the service. We were told by a senior manager this was because one person repeatedly tried to leave the service. Other less restrictive practice had not been considered or attempted.
- Staff lacked understanding of the Mental Capacity Act 2005 and how it should be applied however, we did see staff ask permission from people before they supported them and respected their wishes when they did not want to do something. For example, one person was asked by staff if they wanted to move to the dining area but they declined to do so.

Failure to follow the requirements of the MCA was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● The environment for people living with dementia required further improvement. Whilst there had been changes since the last inspection there was still a lack of consideration on how the environment met people's needs. Memory boxes had been installed outside people's rooms in January 2019 but these were either empty or had limited information in them to orientate people to their rooms.

● The communal bathroom on the first floor was being used to store equipment which meant the toilet was not able to be used. Some people's rooms had not been personalised and lacked ornaments or personal items that would make the room feel homely.

● Following the inspection the manager advised us they had contacted a dementia specialist to seek support on how improvements to the environment could be made.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People told us they received appropriate support from healthcare professionals. One person told us, "I have a bit of a funny throat so will be seeing the doctor tomorrow." Staff confirmed there had been an increase of healthcare input for people. One said, "There's been various professionals in here doing assessments and checks that everything is being done correctly."

●Whilst we saw that appointments with healthcare professionals were made and attended by people, the advice they gave to staff to maintain peoples' health was not always followed. One person had received specialist input from the Speech and Language Therapist (SaLT) about their nutritional needs. The SaLT had recommended staff support them with their food and offer choices of meals. On the day of the inspection this did not happen.

● Another person had a poor posture and had been referred to a physiotherapist four months previously. Staff told us they had refused care so the physiotherapist had discharged them from their care. No other steps had been taken to try to support them with their posture.

● The local GP regularly visited the service and spoke to people staff had highlighted as needing medical advice. They told us they thought the communication in the service had improved. Other healthcare appointments for people had been made such as one person who had seen the Parkinson's nurse specialist.

● Following the last inspection the service decided to stop admitting new people until improvements had been made. As a result there had been no pre-admission assessments completed since then.

Failure to provide care or an environment that meets people needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Improvements had been made in respect of staff training however the learning from this needed to be embedded into practice. Staff told us, "There is a lot of training and advice, I have learned. We're having more supervisions now and more training." There had been concerns about staff competency at the last inspection, particularly in relation to moving and handling. We saw staff moved people that required hoisting safely and in a way that reassured the person. However, in other areas such as the MCA and dignity and respect staff awareness was needed. Nurses had a good understanding of specialist feeding techniques.

● The majority of staff had received updated training since the last inspection in areas such as safeguarding, dementia awareness, first aid, medicines and dignity and respect. Records detailed regular opportunities for staff to discuss their work through one-to-one supervisions with their managers.

● The GP told us that nurses competency had improved and the GP surgery received calls that were

appropriate.

Supporting people to eat and drink enough to maintain a balanced diet

● Improvements to people's mealtime experience had been made. One person told us, "The food is wonderful, the cook is brilliant," whilst another said, "The food has got a bit better. I am particularly fussy."

● Staff confirmed food quality had improved. One member of staff told us, "The food quality is much better, since the new chef had been employed."

● The service had introduced a 'protected' mealtime to give a "bespoke dining experience" which was to be reviewed after six weeks. Despite this there were further improvements needed. People were given only one meal choice and specific dietary needs such as vegetarians were not considered. People living with dementia were asked the day before what they wanted to eat however they would not always remember this choice due to their condition. We were told by staff that a list was kept of people's food choices but this could not be located.

● One person required staff support to eat. They asked staff to use the toilet before they had finished their meal. When they returned they were not offered the rest of their meal. Another person required staff to encourage them to eat however this did not happen. As the person was not eating staff took their meal without them finishing it.

● People were regularly monitored to ensure they were not losing or gaining too much weight and were offered drinks and snacks throughout the day. Fresh fruit was also available to people.

● The kitchen had undergone a thorough clean.

● The meal on offer was fresh pork and vegetables which looked and smelled appetising. For people on pureed meals these were made more presentable as the chef used food moulds. The chef was also aware of people who required their meals to be fortified and their likes and dislikes.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

We inspected this key question to follow up the concerns found during our previous inspection on 3 September 2018 when we found people were not treated in a kind and respectful way and were not involved in decisions about their care. On this inspection although there were improvements we found occasions where actions by staff were not always thoughtful and respectful towards people. Improvements were still required around people's involvement in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting
people to express their views and be involved in making decisions about their care:

- People were not always treated in a caring way. For example, one person was sat at the dining table with their lunch in front of them. A member of staff stooped down to the person and said, "[Person] don't play with your food, eat it. If you don't eat I will call [persons family member]." The member of staff then walked away. The person was startled by this and called out, "Have you gone away?"
- On another occasion a member of staff sat next to a person whilst they were eating their lunch. The member of staff did not communicate with them but instead spent time updating the care notes.
- Staff were not always thoughtful in their approach to care. A member of the maintenance team was working to fit a new door in the lounge where people were sitting. This caused a loud noise and spread wood shavings all over the floor. Senior staff were coming in and out of the lounge however no one addressed this until we spoke to the manager to ask them to.
- People were not always given the choice of when they got up or had personal care in the mornings. There were, "Night allocation check lists" where night staff were
advised of who needed to get up to give personal care to before they went off duty. On most mornings five people were allocated to be woken up for personal care. There was no evidence of how people were consulted about this.
- Senior staff were completing new care plans however people or their families were not involved in developing this with them. One member of staff was in the process of adding a care plan to the new electronic care plans. However, when we asked them questions about the person's religious needs they did not know. Care plans were being written without involvement from for a person that they did not have sufficient information about.
- People were not always treated in a respectful way. For example, we saw a member of staff stood next to a person and spooning their dessert into their mouth. The food was falling off the spoon onto the person's lap. The member of staff only sat next to the person once they saw that we were observing this. A person asked us for a bowl which we then requested from a member of staff. The member of staff replied, "Why on earth" and ignored the request.

As people were not always treated in a caring, respectful way and were not always involved in decisions about their care this is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were occasions where were kind and attentive to people at the service. One person said, "The staff here are so lovely, they really are."
● We heard staff greeting people when they walked into the lounge. One member of staff who said, "Good morning [Person], are you happy today?" Although the person struggled to verbally communicate the member of staff waited patiently, listened and responded to them. During lunch another member of staff placed a drink in front of a person. The person said, "Thanks [staff name]. You are a lovely girl." The member of staff replied, "You are welcome."
● One person was dozing in their chair. A member of staff came over, stooped down, gently rubbed their cheek and said, "[Person] would you like a cup of tea."
● There were staff who knew people and what was important to them. One member of staff observed that a cup that was special to the person was not in front of them on their table. The member of staff went and found it for them from the kitchen. The person was thankful to get their cup back.
● One person told us that their loved one used to bring them a cup of tea in bed and they missed that. They said, "Next thing I know, one of the staff had made me this cup and brought it up to me. They wrote [their loved ones] name on it and drew a butterfly as they know that we loved them and had a tree in a garden that would attract them all. I felt a little upset the other morning when I woke up so I cuddled the cup, which I know sounds odd but it made me feel much better."
● Staff ensured they knocked on people's doors before they entered and all personal care was provided behind closed doors. People visitors were welcomed whenever they wanted.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

We inspected this key question to follow up the concerns found during our previous inspection on 3 September 2018 when we found that people were not receiving person-centred care that always met their needs and complaints had not been responded to. At this inspection we found care planning and meaningful activities for people required improvement however complaints were now responded to appropriately.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

●People were still not always receiving personalised care from staff who knew their needs well. Whilst there were some improvements in the activities provided to people care planning had not progressed quickly enough which was a continuing cause for concern.
●The provider had introduced a new electronic care planning system and all paper care records for people were being transferred to this system. At the time of the inspection the service was still relying on paper records. We saw these had information in them that was sometimes difficult to read and at other times held inaccurate or incomplete information about people. For example, one person had no background information about them in either their paper or electronic care plan. The person was of a specific faith and was visited by a member of the church which staff were not fully aware of. There was a limited end of life care plan in place for them.
●Another person was immobile and called out when they "Had an unmet need" such as being hungry or requiring the toilet. The care plan detailed that staff should take steps to spend time with the person to try to calm them and to provide one-to-one support where possible. This was not always happening on the day of the inspection. This person also had a limited end of life care plan that lacked detail on what the person wished to happen in the event of their death. The last update of their care plan was in August 2018 which was prior to our last inspection.
●The service had employed new staff since the last inspection and used agency staff regularly. As care plans were not always up to date there was a risk staff would not know people's needs. Daily notes lacked detail about what people did and focused on tasks.

Failure to provide personalised care to meet people needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were more activities in place for people since the last inspection but more work was needed to ensure these were meaningful to them.
●One person told us, "They do the same activities every day for people living with dementia here because they've forgotten what they did the day before. They forget I can remember and I don't want to colour in

every day."
●The activity in the afternoon was a tea party. Staff put music on and sat with people in the communal area. On the day of the inspection people were involved in different activities such as puzzles and crosswords. In January 2019 relatives had suggested there should be chair exercises and more activities for people in their bedrooms. We saw the activities co-ordinator was also providing hand massages to people who were nursed in bed.

We recommend that further work is carried out in relation to providing meaningful activities to people.

Improving care quality in response to complaints or concerns
● Improvements had been made to the way complaints had been recorded and responded to. There had been a number of complaints received since the last inspection which the manager recorded and responded to. For example, one complaint had been raised about missing medicines, this was recorded and contact was made with the relative to apologise and ensure there were stocks of medicines held in the future. On the day of the inspection the complaints policy was visibly displayed around the service.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

We inspected this key question to follow up the concerns found during our previous inspection on 3 September 2018 when we found that there was a lack of management and provider oversight which affected the care people received. Audits had not been effective in identifying concerns and the culture of the service was poor. At this inspection whilst improvements in management had been made there were still breaches of regulations identified which affected peoples safety.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection people and staff were being affected by a lack of leadership and direction at the service. Since then the registered manager had left and a new manager appointed who was in the process of registering with CQC. A new deputy manager was also in post. Staff spoke positively of the management changes and said the new manager was, "Fantastic" and "Fair."
- The manager was visible around the service and conducted daily walk around to monitor the care provided. Staff were now being given direction which meant the atmosphere at the service was calmer and more organised than before.
- The provider had added additional resources to make sure improvements were being made. This included refurbishment of certain areas of the service as well as providing additional management support and additional staff whilst these improvements were being made. There had been an acknowledgment by the provider that the findings of the last inspection were not acceptable and a commitment by them to put this right.
- At the last inspection audits had failed to identify significant concerns in the safety and quality of care to people. Whilst there had been improvements made this was an area that needed to have renewed focus to ensure timely improvements were made.
- Quality audits of the service included infection control, care planning, medicines, call bells and health and safety. The recent improvements to the environment were positive and meant the strong smell of urine noticeable in September 2018 had been removed.
- Despite this, some of the audits in place had still not identified the concerns and breach of regulations we found in relation to the application of the MCA, inconsistent approach to risk management and care planning. Furthermore, a call bell audit in February 2019 detailed there were nine times when peoples call bells rang for more than 10 minutes. There had been no analysis for the reasons for this or action taken to address why this had happened.
- In the recent care plan audits it had been identified the need for improvement in this area, however this

had not been addressed. Effective auditing should have identified these issues.

Failure to ensure an effective system of quality assurance is in place is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Previously significant events, accidents and safeguarding incidents were not always reported appropriately. This had now been rectified and all incidents that required reporting were done in line with the regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● Relatives and residents' meetings had been re-introduced by the new manager so opportunities to seek feedback was now being sought. These covered all aspects of the service and covered topics that were important to people and relatives. For example activities, laundry, mealtime menus were discussed and suggestions for improvements made.
● Staff also told us they now felt better supported by the management team that was now in place. One member of staff said, "We do feel valued," whilst another member of staff said the manager was, Very supportive. I feel management are respectful and treat us equally."
● Staff now had regular supervisions and attended team meetings where important issues were discussed.
● Previously there had been no evidence of how the service worked in partnership with other agencies. Improvements in this area had been made with the local GP stating they had been pleased with the level of engagement they were now seeing.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br>People were not always receiving care that fully met their needs. |

**The enforcement action we took:**

We issued a Notice of Decision

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br>People were not always involved in their care or treated with dignity and respect. |

**The enforcement action we took:**

We issued a Notice of Decision.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br>Consent was not always obtained in line with the Mental Capacity Act 2005. |

**The enforcement action we took:**

We issued a Notice of Decision.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>Risks to people were not always managed well. Staff did not always follow good practice to reduce the risk of harm. |

**The enforcement action we took:**

We issued a Notice of Decision.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality assurance processes were not effective. |

**The enforcement action we took:**

We issued a Notice of Decision.