Hazelwood Lodge Limited

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Inspection report

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Ratings

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

Overall summary

We carried out this unannounced 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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Hazelwood Lodge is a care home providing accommodation and support with personal care for up to ten people with learning disabilities, physical disabilities or mental ill-health. The service is provided in a large detached house in the residential area of Southgate in the London Borough of Enfield. There were nine people living there at the time of our inspection, eight of whom have learning disabilities.

Our last inspection was in May 2013. At that inspection, the service was found to have met required regulations for consent to care and treatment, care and welfare of people who use services, staff recruitment, and records.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

During our visit, people told us, and we observed, that the care and support they received from individual care staff was caring and compassionate, and that generally they felt safe. However, we found several areas in which people's safety was compromised. The registered manager did not understand the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), and we found that people may have been deprived of their liberty unlawfully. While risks relating to people's support were assessed, risk assessments and guidelines did not always include appropriate strategies for staff to ensure people's safety.

The service premises were not always cleaned to a high standard, and equipment was not always properly maintained. However, staff were aware of the principles of infection control when providing personal care and preparing food, and followed these.

People's health needs were met, and they were supported to access health and medical services quickly when they needed to. However, people were not always empowered to make decisions about their own health and well-being, and at times the service actively discouraged people from taking control over their own health and support.

People did not always agree to their care and support in ways that met the requirements of the Mental Capacity Act 2005, and we found little evidence that information was presented to people in ways they could understand so they could make informed decisions. Assistive and augmentative communication tools were not routinely used by the service to ensure people with complex communication needs could express their feelings, however staff were aware of people's individual communication styles and interacted well with them.

Staff were appropriately vetted to ensure they were suitable people to work with vulnerable adults. The provider had a good system in place to ensure they were appropriately supported through training, supervision meetings and appraisal of their work. However, we found that the culture of the service meant good work was not always recognised.

The provider had a number of mechanisms in place in order to seek feedback from people, however people told us these were not always effective and we saw evidence that showed they were not always listened to, nor changes made to the service as a result of their feedback.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and one of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe. People were not protected by the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards, because the registered manager did not have appropriate knowledge of these and the circumstances in which they apply.

People were not always protected from risks associated with their care, because risk assessments were insufficient and did not contain appropriate guidelines for staff to assist people to remain safe.

The service practiced the principles of safer recruitment, and staff were appropriately vetted to ensure they were suitable to work with vulnerable people. Most people who used the service told us there were enough staff to meet their needs.

Staff followed appropriate practices to reduce the risk and spread of infection, however the premises were not cleaned to a high standard and the guidance in the National Specification for Cleanliness in Care Homes was not followed. Service premises were not always properly maintained, and some equipment and furniture for use in the service was broken when we visited.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had the appropriate knowledge and skills to support people, and were well-supported in their roles through training, supervision meetings and annual appraisal of their work.

People were supported to eat a varied diet of mainly fresh foods, however their food preferences were not always considered when planning the menu and preparing meals, and the menu did not change from week to week.

People were supported to access a range of health services and have their health needs met, but the service did not always empower people to make decisions about, and take responsibility for, their health and well-being when they were able to. People did not have Health Action Plans, as recommended by the Department of Health for people with learning disabilities.

Is the service caring?

Requires Improvement

The service was not always caring. People told us the support staff were very caring, and “try their best to make sure we are happy”. They told us that staff were mindful of their dignity when supporting them with personal care.

Summary of findings

Staff demonstrated a good understanding of people's individual communication needs, however this was not recorded in the service's decision-making processes and people were not appropriately consulted about significant changes to the home and to their support.

Is the service responsive?

Inadequate

The service was not always responsive. People were regularly asked for their feedback about the quality of the service, but this was not always listened to or acted upon.

Staff supported people with a range of activities both inside and outside the home, however there was not enough flexibility in staffing to ensure people could attend all of the activities of their choice.

People's care plans were not always updated when their needs changed, and the goals for their support remained the same from year to year.

Is the service well-led?

Inadequate

The service was not always well-led. The service had a system of quality checks in place, however they were not always effective and did not always result in improvements to the service for the people who live in the home.

Staff responsibilities were clearly documented, and staff told us their roles were clear. However, people who used the service told us that a critical culture had a negative effect on the quality of the service they received.

The provider and registered manager of the service did not always demonstrate a good understanding of the requirements of their role, and the service did not submit appropriate notifications to the Care Quality Commission about events affecting the service.

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Detailed findings

Background to this inspection

This inspection was carried out by a single inspector. We visited on 7 July 2014. 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 reviewed this information to plan our inspection.

At the time of our visit there were nine people living in the home. We spoke with three people who used the service and observed the care and support provided to all of them in the communal areas of the home. Some of the people who lived in Hazelwood Lodge had complex communication needs, and so were unable to tell us of their experiences themselves. We used the

Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with two relatives of people who live in the home, three care workers, the registered manager and the provider.

We viewed the personal care and support records for four people and viewed personnel, training and supervision records for five staff and the registered manager. We looked at other records relating to the management of the service and spoke with professionals involved with the service from the commissioning local authority.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

People who used this service were not protected against the risks of being deprived of their liberty, as the provider did not demonstrate a clear understanding of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and how these applied to the people who lived in the home. While the provider had a policy and guidelines in place for assessing capacity and applying for the Deprivation of Liberty Safeguards, dated June 2014, these contained old information that was no longer applicable. We asked the registered manager about this and they were not able to adequately describe the circumstances in which they should apply for DoLS, the process they should use or who such decisions applied to. The registered manager was also unaware of the recent Supreme Court judgement which broadened the scope of the DoLS.

Additionally, two weeks prior to our visit the provider had installed CCTV cameras in the home after the service's office was burgled in February 2014. These cameras were placed outdoors at the front and rear of the property, and indoors in the home's lounge area. We asked the registered manager how people's capacity to agree to this decision was assessed, and the decision made and recorded. They told us that all people who used the service had agreed to the decision through discussion at monthly residents' meetings. However, there were several people using the service who may not have had the capacity to understand such a decision, and mental capacity assessments had not been carried out nor 'best interests' meetings undertaken. As the installation of the CCTV in the lounge may be regarded as a deprivation of people's liberty due to continuous supervision and control, we have referred the matter to the local authority DoLS team for review. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks relating to people's support were assessed, and risk assessments were reviewed regularly, however we noted that these did not always include strategies or guidelines to ensure that people were safe. For example, at least one person had epilepsy, and in the months prior to our visit, the frequency and intensity of their seizures had increased. We viewed the risk assessment relating to their epilepsy and saw it did not contain information for staff on when they should phone an ambulance, or strategies to ensure the person was safe when undertaking high-risk activities such as bathing.

Three people's records that we viewed contained reference to them exhibiting challenging behaviours at times; behaviours which may pose a risk of harm to themselves, property or other people. None of the three records we looked at contained current information for staff on how to respond when people exhibited these behaviours, how to keep the other people who used the service safe, or strategies for staff to use when responding to such behaviours. One person who used the service told us, "I just get out of the way when someone kicks off, go into my room and lock the door." Staff records documented they had been trained in 'Coping with aggression', however we saw no evidence that staff applied this knowledge in ways that kept people safe. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service were safeguarded from the risks of abuse. Staff had been trained in safeguarding adults' procedures, and we saw records demonstrating that the provider had reported a concern to the local authority safeguarding team in a timely manner. Information was also available for staff on the noticeboard in the home's entrance, with a decision-making flowchart and contact details for the local authority safeguarding team.

The provider followed the principles for safer recruitment. We viewed the personnel records for five staff and saw that each contained an Enhanced Disclosure and Barring service check, demonstrating they were not barred from working with vulnerable adults, and a completed application form detailing their employment history and reasons for leaving previous positions in social care. All staff employed in the last three years had two written references in their records. All personnel records we looked at contained proof of the staff member's identity and right to work in the United Kingdom.

Most people who use the service told us there were generally enough staff to ensure their personal care needs were met safely and in a timely manner. One person who used the service disagreed, however. They told us, "There's not enough staff, and they don't put any extra on when people have additional needs. Someone had a seizure the other day and we had to yell and shout because the staff

Is the service safe?

were busy." The registered manager told us that the CCTV installed in the lounge assisted with this, as he could watch what was occurring in the lounge from the office and provide additional assistance and support in emergencies.

Staff and people who use the service told us they had a holiday planned for the week after our visit. We looked at the rota and staffing arrangements for the holiday, and saw that three staff were scheduled to support five people. The registered manager told us he would also be visiting the holiday site and could provide additional support if necessary.

Maintenance issues were not always addressed in a timely manner, which left people at risk of unsafe equipment and having furniture they could not use. The minutes of the residents' meetings we viewed contained discussion of maintenance issues. We saw that the same maintenance requests were raised two months in a row without being fixed, and similar issues were identified in previous meetings. These related specifically to broken toilet seats and one person's chest of drawers being broken. We noted that a kitchen cupboard was broken, and when we sat on one of the chairs on the patio during our visit, it broke and we fell. A second patio chair was also broken.

The provider had a policy relating to infection control, and we saw that staff used appropriate personal protective equipment (PPE), such as gloves and aprons, when supporting people or handling food. Hand washing facilities were available with soap and paper towels, and we saw staff using them. However, parts of the service premises were not cleaned to an appropriate standard, such as the kitchen. Care staff and the registered manager told us that care staff cleaned the premises themselves, and we saw a 'job allocation folder' which outlined the tasks staff were to complete each day. The tasks listed in the job allocation folder were not comprehensive, and did not follow the guidelines in the National Specification for Cleanliness in Care Homes. This provides a specimen cleaning plan and checklist to ensure service premises are clean, hygienic and reduce the risks of infection to people who use the service and others.

We viewed the service's staff training records and saw that most staff had been trained in the principles of food hygiene. The service also used the colour-coded chopping board system to reduce the risk of cross-contamination, and we noted that opened food jars and packages in the fridge had dates written on them to indicate when the package had first been opened.

The provider had made plans for foreseeable emergencies. The service had appropriate fire safety evacuation plans and equipment, and we saw that all staff had been trained in emergency first aid at work.

Is the service effective?

Our findings

People were not always empowered by the service to make decisions and take responsibility for their own health. One person's records included a letter, written by the service's registered manager, relating to the person administering their own medication. Although unsigned by the person, the letter stated "I wish to retain responsibility for taking my own medication, despite being advised against this by my GP and by staff at the home." The records also contained a letter from the person's GP, which stated "There is no reason why [they] cannot manage [their] medication [themselves]" and did not indicate in any way that the GP had advised the person against administering their own medication. Despite the discouragement of the service to do so, the person told us they safely and correctly administered their own medication.

Of the four people's personal care and support records we looked at, none contained a Health Action Plan as recommended by the Department of Health for people with learning disabilities. The registered manager told us that they had been developed with a community nurse for three people, but the service did not hold copies. Similarly, hospital passports had not been developed to ensure people's support, communication and health needs were appropriately documented when they went to hospital. As several of the people who used the service also used hospital services regularly, this left them at risk of not having their needs met.

People who used the service were supported by staff who had the appropriate knowledge and skills to do their jobs. One person told us, "The staff know what they're doing. They help me to do the things I need to do." A relative we spoke with told us, "I have no concerns about the staff. I know my relative is in safe hands here." A care worker told us, "We get lots of training here, training all the time." We looked at staff training records and saw that each staff member had attended training courses on topics relevant to their role, such as first aid, medication administration, safeguarding adults, coping with aggression, equality, diversity and inclusion, and moving and handling. Further training was planned for the remainder of 2014, with a number of sessions of the same topic offered so that all staff could attend without disruption to the service.

Staff were appropriately supported in their roles through supervision and appraisal. All care workers we spoke with told us they had regular supervision meetings and appraisal meetings once per year. We looked at the service's supervision and appraisal matrix and saw that staff had supervision meetings with the registered manager at least every two months. Appraisal meetings, in which the staff member's work for the previous year was reviewed and objectives set for the coming year, were scheduled for November and December 2014. We saw that these had taken place around the same time in 2013. Most staff held qualifications such as the Diploma in Health and Social Care to level two or three, and some were registered nurses. Staff employed more recently also completed the Skills for Care Common Induction Standards.

We checked the arrangements for food and drink, and how people's nutrition was monitored. People who use the service told us the meals were good, and sometimes they helped with preparing the food. One person said, "I peel the potatoes, it's my job! I like to wash the dishes as well. I do the big shopping with staff in the van every week. We make a shopping list and everyone can choose if they want something special from the shopping."

We looked at the pictorial menu which was displayed on the noticeboard in the kitchen, and saw that the same meals were served every week. We saw there was variety within the weekly menu, however no variety from week to week although one person told us they could request a special meal if they wished to. They said, "I am happy because many of the staff are from my country so I get my traditional meals when I want them."

We noted that menu choices were discussed in residents' meetings, however the minutes of these recorded that one person requested rice instead of mashed potato on Wednesdays in every meeting, and this was not provided. We saw there was fresh food available in the fridge, and people could freely access snacks and drinks when they wished to.

People were appropriately supported to access health and other services when they needed to. Each person's personal records contained documentation of health appointments, letters from specialists and records of visits. People's records also contained information from health professionals on how to support them safely, such as hoisting guidelines developed by an occupational therapist. We saw that assistance from medical professionals was sought quickly when people's needs changed.

Is the service effective?

One person's records showed they had required increased attention and support from medical professionals in the months prior to our inspection, and were choosing not to engage with them. One of the specialists involved in their support had assessed the person as not having the capacity to understand and make decisions about their health and safety, and the provider had appropriately participated in the 'best interests' decision-making process lead by health professionals to ensure the person's safety and welfare in relation to their health.

Is the service caring?

Our findings

People were not always involved in decisions about their care and support. We asked the registered manager how people who lived in the home had been consulted and agreed to being filmed by the CCTV camera while in the lounge. They told us that all people who used the service had agreed to the cameras being installed. However, we looked at the minutes of two residents' meetings in which the CCTV was discussed, and saw no evidence that the information was presented to people in ways they could understand, or documentation of how people with complex communication needs had demonstrated they agreed. Three of the people who lived in the home were not present at either of these meetings, and one person told us they had not been consulted, did not agree to the camera being installed in the lounge and had made a formal complaint to the provider. The registered manager told us the CCTV had been discussed with this person and their social worker at a meeting, however we viewed the minutes of that meeting and CCTV was not mentioned at all.

We looked at the records of monthly meetings held between each resident and their nominated keyworker. For most people, these meetings were very similar from month to month, and did not contain record of a discussion but were more of a report by the keyworker on the person's activities and health appointments. For people with complex communication needs, these meetings did not contain any record of how information was relayed to the person, how issues were discussed, or how the person demonstrated they had made a decision about a particular issue. We asked the registered manager about this and he showed us an album of pictures staff could use to assist communication when discussing issues with people who did not speak, however there was no indication this album was used in any of the records we viewed, and staff we spoke with told us they did not use it. People did not have individualised communication passports or similar tools to assist staff working with them, and the service did not use any augmentative communication system such as the Picture Exchange Communication System (PECS) or similar tools. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Additionally, some of the records we viewed, such as people's care plans and records of keyworker meetings, had a space for the person to sign to indicate they agreed to the information contained within the document. On several of these that we looked at, the person's name was written in the signature space by staff. There was no indication that the person had not agreed to sign, or did not have the capacity to sign to agree their own support. One person's care plan did note they had not agreed to sign as they did not agree with the information contained within the document, and another was signed by the person's relative. However, there was no record of their capacity to understand and agree to their support being assessed, or a 'best interests' meeting held to determine that the person's relative was the best person to agree to their support on their behalf. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also looked at the records of monthly residents' meetings, and these did not record how information was given to people in ways they could understand, or what methods were used to demonstrate that people had agreed. One person told us, "I have excluded myself from the resident's meetings as anything we say never goes anywhere. The meetings are a total waste of time." Minutes of these meetings we looked at showed that issues were raised repeatedly in these meetings without being addressed, and changes were not made to the support provided. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people who used the service told us the staff were caring, and they were happy living at the home. One person said, "The best thing about living here is that the staff make me happy. They try their best to find ways to make sure we are happy." Another person said, "I love it here, this is my home." A third person told us, "The director told us it's a family home, and it does feel that way. Well, it did until the CCTV was installed." A person's relative told us, "Thank God for here. I can't look after my relative as I am not well myself, but I know my relative is in good hands."

Staff we spoke with knew the personal histories and support needs of people who used the service. We asked staff about how they ensured they could communicate with, and understand, people with complex communication needs. One staff member told us, "I know

Is the service caring?

what they need even though they can't speak. They point to things and make noises, and I look at their facial expressions. I can tell when they like and don't like something, because I know them very well."

People told us they were supported to maintain relationships with families and friends. One person said, "I phone my sister in America occasionally, the staff help me." A person's relative told us, "I am welcome to visit whenever I can, and the staff always chat with me and give me a drink. I usually bring them snacks too, we are like a family now."

The registered manager showed us a folder which he said was given to all people who used the service when they first moved in. The folder contained the service's brochure, statement of purpose, most recent CQC report, the service user guide and information about how to make a complaint. We asked two people whether they had received this information, and they told us they hadn't. One person said, "I had to ask the manager how to make a complaint when I wanted to. I wasn't given any information about that when I moved in."

People told us that staff always knocked on their bedroom doors and waited to be invited in before entering. One person said, "The staff are very mindful of my dignity when supporting me with personal care. They always talk about what they're doing and make sure we have privacy. The CCTV is another matter altogether though."

We saw that most people were well-dressed when we visited, however one person was wearing a dirty, stained and torn apron bib over their clothes, several hours after breakfast.

Inadequate

Is the service responsive?

Our findings

People's care plans were not always updated as their needs changed. The goals for people's support as outlined in the care plans were not individualised and did not change from year to year, except for the date. For example, one person's care plan for July to December 2013 stated as a goal "Referral to be made to [a] Resource Centre." This was also included in the person's care plan for January to June 2014, with no indication of what action, if any, had been taken to support the person to achieve this goal and what the outcomes were. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Feedback mechanisms were in place however we noted that these were not particularly effective for people. For example, one person had requested a change to the weekly meal plan for four months in a row and there was no indication this had been listened to. Another person told us they had made a complaint and were not confident it would be responded to appropriately. We looked at the service's complaint records, and saw that complaints were received, recorded and acknowledged. However, we saw no evidence to demonstrate that changes were made as a result of complaints, nor lessons learned and practice changed to improve the quality of the service that people received. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People were supported to attend a range of activities of their choice. Some people attended day services or college, and others had a regular timetable of activities they enjoyed.

We saw that the service encouraged development and maintenance of people's skills around the home and in the community. One person told us they had retired, and had jobs they performed around the house as well as assisting with other household tasks. They said, "I have my jobs, and I go to the hairdresser and to the post office on my own. Others go out, even at night. They use their phone if they need to." Another person told us they could go out whenever they wished to, but always planned going out in advance as they needed one-to-one support from staff when in the community. They said, "I can go out when I want to, but I plan it with the staff as I need support."

There were activities available for people to do while at home, such as puzzles, Lego, colouring and crafts. There was a computer in the dining room that people could use if they wished to. Staff told us they helped people to use the computer when necessary.

We noted that attendance at a place of worship was listed in some people's care plans. We saw that one person was regularly supported to attend on a weekday, however the minutes of one staff meeting documented that people wishing to attend services on Sundays had to negotiate as the service did not have the staffing resources to support people to attend different services. One person told us they were not able to attend services as often as they wished, and a relative also told us they wanted their relative to attend services more frequently. The relative said, "I'd take my relative myself, but it's too far for me to come every week. The staff should be supporting them to go."

People told us the service held parties to celebrate birthdays and religious festivals. One person said, "It's marvellous, I have a lovely party every year for my birthday." The registered manager told us they held barbecues occasionally on the back lawn in summer.

People told us they were able to have their friends and relatives visit whenever they wished. One relative told us they were "always welcome, and I always get a cup of tea and a biscuit when I visit".

Is the service well-led?

Our findings

People who used the service gave us mixed feedback about the culture of the service, and this was reflected in the documents we viewed. While there were systems in place to gain feedback from people who used the service, their relatives and representatives, and professionals involved in people's support, these were not always effective and feedback was not always acted upon.

For example, we saw surveys that had been completed by people who used the service, and their relatives. The survey asked "Does the home appear to involve residents and families in resident care and the affairs of the home?" In the surveys we looked at, this was most often answered 'sometimes', yet no action had been taken by the provider or the registered manager to improve how people and their families were involved in decision-making about their support or the running of the home.

The registered manager undertook a number of spot checks of the service, at different times of the day and night. We looked at the records of these and they often resulted in warnings to staff about their conduct. However, we noted that there were a number of other areas in which the quality of the service was not checked, such as file audits or regular health and safety checks of the service premises and equipment.

We reviewed incident and accident records, and noted these were not comprehensive and did not result in ongoing learning for the service. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The provider had also not submitted appropriate notifications to the Care Quality Commission about incidents affecting the service and the people who use it, as required by the Care Quality Commission (Registration) Regulations 2009. We were not notified of the theft of belongings of people who used the service, nor of incidents involving the police, all of which were documented in the incident and accident records. We were also not notified of safeguarding alerts to the local authority safeguarding team regarding people who used the service. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We read through a number of staff meeting minutes, which occurred sporadically throughout the year, and saw that the language used in the minutes was often critical of the staff and their work. We noted that the minutes recorded feedback from staff that they were not often praised for the good work they did. One person who used the service told us, "The staff are on edge… It's just a nicer place to be when the staff aren't so stressed and being careful about every little thing."

The registered manager had a job allocation folder which outlined the tasks that were to be performed by which staff on each shift. Staff told us they found this useful as it clearly stated what they were responsible for. One staff member said, "If I can't do one of my allocated jobs I let my colleagues know and we share the work. We always work as a team."

The provider was not always aware of the requirements of their role. For example, they did not know they needed to register as a Data Controller with the Information Commissioner's Office when the CCTV was installed, and had to abide by the CCTV code of practice to be compliant with the Data Protection Act 1998.

The registered manager received regular supervision from a person independent of the service. When we visited, they told us they were undertaking the level seven Diploma in Leadership and Management in Health and Social Care, and the independent supervision was a requirement for this qualification. They also told us they attended all of the training the staff did, to ensure they kept their knowledge up to date. However, we noted there were some areas in which they had not kept their knowledge updated, such as the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, and this resulted in the requirements of the MCA not always being followed and people being at risk of being unlawfully deprived of their liberty.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not protected against the risks of receiving unsafe or inappropriate care, be means of the planning and delivery of care to meet service user's individual needs, ensure their welfare and safety, and reflect published research and guidance. Regulation 9(b)(i), (ii) and (iii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People were not protected against the risks of unsafe or inappropriate care by means of the effective operation of systems to regularly assess and monitor the quality of the services provided, and identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others. The registered person did not have regard to the complaints and comments made, and views expressed by service users and those acting on their behalf. Regulation 10 (1)(a) and (b), and (2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The registered person did not make suitable arrangements to ensure that service users are enabled to make, or participate in making, decisions relating to their care. The registered person did not treat service users with consideration and respect; provide service users with appropriate information and support relating to their care;

This section is primarily information for the provider

Action we have told the provider to take

encourage service users, or those acting on their behalf, to understand the care choices available to them, and express their views. The registered person did not involve service users in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care. Regulation 17(1)(b), and (2)(a), (b), (c), (d) and (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation their care. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered person did not notify the Commission without delay of specific incidents which occurred whilst services were being provided. Regulation 18.