The Poplars Care & Support Services Limited

The Poplars Nursing Home

Inspection report

66 South Road
Smethwick
Birmingham
West Midlands
B67 7BP

Tel: 01215580962

Date of inspection visit:
17 December 2020

Date of publication:
23 June 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
The Poplars Nursing Home is a care home providing personal and nursing care to 58 older and younger people. The service had a self- contained unit with 15 beds to care for people who had tested positive for COVID-19 in hospital and needed to be discharged.

People's experience of using this service and what we found
At our last inspection we found people's privacy and dignity was not always maintained. This continued to be a concern at this inspection. The provider's governance and auditing systems had failed to ensure people were consistently treated with dignity and respect. Although they had taken some action since the last inspection this had not been effective.

Audits were carried out by the manager and the provider had commissioned an external consultant, but they had failed to ensure that people always received safe care. Risks for one person had not been mitigated.

Where people received medicines 'as and when required' the appropriate process was not always followed. There were mixed views from people and staff as to whether there were enough staff. Staff knew how to recognise and report concerns about people's safety and people told us they felt safe.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Decision specific mental capacity assessments were not in place where people had restrictions such as sensor equipment to monitor their movements.

There had been some consideration to the environment to support people with dementia, but this required further improvement. People had oral care plans in place, but support in this area wasn't always evidenced. We have made a recommendation the provider refers to best practice guidance to make improvements to the environment for people living with dementia and to improve oral care. People with specific dietary needs were supported.

People told us they would like more activities. People felt able to raise concerns although a review of the action taken wasn't always completed. End of life care plans were in place which included peoples individual wishes, although we received mixed feedback from relatives about whether they were involved in these plans.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 June 2020) and there was a breach of

regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last three inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about people absconding from the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Whilst we found evidence the provider had addressed the concerns in relation to people absconding, we found evidence that the provider needs to make improvements. Please see all the key questions of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to dignity and respect, safe care and treatment and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below	**Inadequate**

The Poplars 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector, an assistant inspector and a specialist advisor (who was a qualified nurse). An Expert by Experience worked off site making phone calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Poplars Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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. There was a manager in place who was managing the day to day running of the service and during the inspection we were advised they would apply to become the registered manager.

Notice of inspection
We gave a short period notice of the inspection because of the risks associated with COVID-19 and to ensure everyone remained safe during our inspection site visit.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group who commission care from the provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and six relatives about their experience of the care provided. We spoke with thirteen members of staff including the provider, manager, deputy manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who had regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- On one occasion the provider had not further explored a person's complex mental health needs, prior to them coming to the service. They had not completed their own assessment of the person and had used the information provided by other agencies. This increased the risk of the service being unable to meet people's needs.
- Risks to people who may self-harm were not adequately assessed and there was a lack of guidance in place for staff. Although staff were aware to remove objects from one person's room due to the risk, there was no evidence of regular environmental risk assessments. On the day of inspection, we found hazardous objects in the person's room which they could use to harm themselves. The provider and manager took immediate action to address this concern after we raised it with them.
- Staff did not always have the skills and competence to work with the people living at the service. Where people had mental health needs the staff had not received any training in how to support them and lacked understanding into their condition.
- Where people received medicines 'as and when required' (PRN) the appropriate process was not in place. For some people, there were no protocols in place for staff to follow and the reason why the medicine was being given and the effectiveness was not routinely recorded. Some people had received PRN medicines for a number of days and no medical advice had been sought to assess the effects of long-term use of this medicine or to determine whether this person needed a medication review.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection it had been identified the portable appliance (PAT) testing was out of date. Although we did not identify any concerns with the electrical equipment, at this inspection this was still out of date. We discussed this with the manager who advised they were booking one of their staff on a course so they would be qualified to complete these tests.
- When people received their medicines and nutrition via an enteral feeding tube (PEG) we saw evidence of good practice. There was a comprehensive care plan which covered all aspects of the care and management of the PEG, including a specific chart for the daily care of the PEG site.
- Staff completed records where people needed support to move position to reduce the risk of skin damage. Records showed people were receiving support in line with their care plans.

Staffing and recruitment

- At the last inspection people gave mixed feedback about whether there was enough staff to meet their

needs. This continued to be the case and three people told us they regularly had to wait for the call bell to be answered. Another person said, "I sometimes have to wait for them to come around but not very often."

● Most staff told us there were occasions where people had to wait for care. Staff told us there was particular pressure at night. All staff told us this had impacted on the quality of care people received. One staff member told us, "The impact is the quality time we are able to spend with the residents."

● The provider used a dependency tool to assess the number of staff required and our observations were people did not have to wait to receive care. However, the majority of people were being supported in their bedrooms which people and staff told us had limited the number of interactions people were receiving. One person told us, "Sometimes I press the buzzer just to say hello to someone."

● The provider had a recruitment process which involved recruitment checks to ensure newly appointed staff were suitable to support people. A Disclosure and Barring Service (DBS) check carried out to ensure the provider had employed suitable care staff to support people.

Preventing and controlling infection

● We saw good infection control practices carried out in the self-contained unit supporting people with a positive COVID 19 test. For example, there were systems in place to ensure the safe transfer of meals and laundry to and from the unit which reduced risk of cross transmission.

● In the other part of the home current guidance for preventing the spread of COVID-19 was not always adhered to. Admissions to the service were not in line with recommended guidance and some staff were not wearing PPE appropriately, for example we saw some staff wearing their face masks under their nose when supporting people and one staff member was wearing a cloth mask instead of a surgical mask.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● The provider had a system in place to monitor incidents and accidents. Where an incident occurred, action had been taken to try and prevent future occurrences. For example, putting a safety alarm on the door following an incident when a person left the premises.

Systems and processes to safeguard people from the risk of abuse

● Most people and all relatives told us they felt safe, one person told us, "Yes I'm safe, there is always nurses about keeping an eye on you." A relative said, "I think they look after [person] well and keep them safe." One person said they didn't feel entirely safe and told us about having to wait for care.

● Staff had received safeguarding training and were able to describe the action they would take to report any concerns. On staff member told us, "I would report straight to my manager or team leader on shift. I would log, report and ensure it is followed up."

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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.
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.
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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Mental capacity assessments had been completed but the decision that was being assessed was not always clear. The assessment lacked sufficient detail to evidence how the person had been involved and how they had been supported to understand all the relevant information. This was not in line with the principles of the MCA.
- For some key decisions there were no decision specific MCA assessments or best interest decision in place for people who lacked capacity. For example, when someone was having their movements monitored through a sensor mat.
- Everyone in the service had a DoLS application even if they had been assessed as having the capacity to make a decision about their care and treatment. When we discussed with this the manager this wasn't due to lack of knowledge, they said they preferred to do it this way. This was not line with the MCA as the service were applying for people with capacity to have restrictions on their liberty.
- Staff had received training in MCA and DoLS and we saw that staff tried to obtain consent before delivering care. Most staff had a good understanding about MCA and what this meant for people. One staff member told us, "It's about making a decision on the persons behalf in their best interest."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- On one occasion the provider had not completed a pre-admission assessment for a person with complex needs, prior to them coming to the service. Instead they had used information from other agencies and there had been no further exploration of the person needs. Whilst they had liaised with the relevant professionals to ensure this person was supported when they lived at the service, the staff did not have the

training or skills to meet the person's needs and as a result had received inappropriate care.

Staff support: induction, training, skills and experience
● At our last inspection we found training was not up to date. At this inspection we found there was a mixed picture with most mandatory training being fully completed by staff but other training not up to date. There was also no specific training on supporting people with mental health needs or who may display distressed behaviours. This meant staff were not trained to meet some people's needs and one person had received inappropriate care.
● Most people and relatives felt staff had the skills to meet their needs. One relative told us, "My (relative) has quite complex needs. I would say they certainly know her and understand her well."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had oral health care assessments in their care plans however people's daily records were not always completed to evidence the support given and staff had not received training . One person told us they hadn't been supported to clean their teeth for a number of days. Staff told us the person often refused support, but there was a lack of evidence to show this.

We recommend the provider consider nationally recognised guidance on oral health for adults in care homes and take action to update their practice.

● People had access to support from external healthcare professionals such as dietitians and occupational therapists. Records showed that people were referred to specialist teams when required.

Adapting service, design, decoration to meet people's needs
● At the last inspection we found the overall décor of the home was not dementia friendly. At this inspection although some adaptations had been made to some parts of the home further consideration was needed.

We recommended the provider consider best practice guidance in relation to adapting the environment further to meet the needs of people who are living with dementia.

● The provider had adapted the service to provide a separate unit to support people who had tested positive for COVID 19 to be discharged from hospital. This unit had a separate entrance and staff were allocated to work solely within the unit.

Supporting people to eat and drink enough to maintain a balanced diet
● The chef was knowledgeable about people's individual needs and how to keep them safe from any risks such as choking, allergies and malnutrition. They kept up to date clear records of people's needs within the kitchen. Cultural options were also available to people.
● People were generally positive about the food provided and told us they received a choice.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to uphold people's privacy and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities).

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 10.

● We saw one person using a commode with their bedroom door open. Although they were able to do this independently, staff were aware and had not considered any dignity screens or the position of the commode in order to ensure their privacy and dignity was maintained.
● At the last inspection there were concerns about personal information not being stored securely. This continued to be a concern at this inspection, and we found one person's personal records had been left in a communal corridor.
● Some people did not feel they were always treated with dignity and respect. When we asked if staff were caring one person said, "You get good and bad." They told us one staff member, "talked down and at them."
● At the last inspection people told us their personal care needs were not met in a timely manner. Whilst we did not see anyone waiting to receive care, some people told us this continued to be a concern.
● Staff didn't always offer support that ensured peoples' dignity. We saw two people did not have their call bell within reach whilst they were in bed. One person told us, "I haven't got a bell so I shout, they hear me after a bit." We saw one staff member was not being discreet when asking someone in a communal area where other people were present if they needed the toilet.

Systems were not effective in ensuring people were treated with privacy and dignity. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2013.

Supporting people to express their views and be involved in making decisions about their care
● Some people and relatives told us they did not always receive information about their care. One person told us, "There's no feedback, no one tells you anything." A relative said, "Communication overall isn't very good." However, another relative told us, "They do keep me informed of [person's] overall condition."
● People told us they could not recall being involved in reviews of their care. Most care plans did not evidence people and relatives were involved in reviews.

Ensuring people are well treated and supported; respecting equality and diversity

● Although staff had received training in equality and diversity, it was not always put into practice. One person had been waiting for support from the manager to choose some sensory equipment but advised this had not been followed up in a timely way and they were still waiting. The manager had attended a workshop about supporting people's sexuality but had not taken any action to put this learning into practice or considered how people from the lesbian, gay, bisexual and transgender community could be supported at the service.

● We observed some kind and caring interactions between staff and people. We saw staff reassuring people and explaining the support they were giving.

● Some people told us staff were kind and caring. One person said, "The nurses are marvellous. Everyone I have is kind."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider had limited the number of people who were accessing the lounge due to the need for social distancing. This meant most people were in their bedrooms and both people and staff felt this had meant people were involved in less activities and quality time with staff. One person told us, "I would like to see more going on here." A staff member said, "Some residents are a little bit bored."

● Staff showed us a baby doll that could be used for doll therapy for people living with dementia. They advised some people really enjoyed this interaction. However, the time people could participate was restricted as there was only one doll used and the staff hadn't had any training to understand how this could be used to enhance people's well-being.

● There was an activity co-ordinator who arranged different activities. They also supported people to keep in touch with their relatives by video calls as the home was closed to visitors due to the COVID 19 pandemic. A relative told us, "They have been good and concentrated on safety and we have done video calls."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● We received mixed feedback from people about whether they received personalised care. One person told us they would like to have more showers, but it wasn't always possible due to the staffing. Another person said they were able to choose whether they would like a bath or shower.

● We saw care plans contained an "All about me" document which gave personalised information about people. Staff spoke about people in a person-centred way and knew their likes and dislikes.

End of life care and support

● We received mixed views from relatives about whether end of life support had been discussed with them. Some relatives were concerned there had been a discussion with the person without them being involved. One relative told us, "I think someone has discussed funeral arrangements with him although I was concerned, he didn't have anyone with him like me or an advocate." Another relative said, "They have discussed End of life in fact they have rung me to go through it all."

● Some staff had received training in end of life care, but a number of staff had not completed it.

● End of life care plans had been completed and included personalised information about peoples wishes in the event of their death.

Improving care quality in response to complaints or concerns

● The provider had a complaints process in place and some people had shared concerns by responding to a survey. The provider had identified action points in response to the concerns but there wasn't any review to

check these had been completed.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff were able to communicate with people in their preferred languages. Staff also ensured a Punjabi speaking radio station was available for people who enjoyed this.
- The provider used photographs to support people to make a choice about their meals.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to ensure there was a culture of continuous learning in the service. Concerns about people being treated with dignity and respect which had been highlighted at the last inspection had not been addressed. Although this had been identified on the providers action plan, and some action had been taken such as a dignity audit and increased training this had not been effective.
- Systems had failed to ensure good practice and adherence to the Mental Capacity Act. Mental capacity assessments were not clear on the decisions being assessed, people were being referred for DoLs when they had been assessed as having capacity and some consent forms had been signed by a person without the legal authority to do so.
- Governance systems had failed to ensure government guidance in relation to COVID 19 was being followed at all times on the part of the home where people did not have a COVID 19 positive test. When we raised concerns regarding some staff wearing PPE inappropriately, the manager advised they had discussed this with staff previously, but we still observed these concerns on inspection. This increased the risk of unsafe care and transmission.
- Systems to ensure pre-assessments were completed and risk assessments contained clear guidance to minimise risks had mitigated were not robust. This meant people were placed at increased risk of harm.
- Medication audits had not been effective in identifying the concerns about the management of 'as and when' required medicines. This meant people's health was not always reviewed when required and they were at risk of receiving inappropriate treatment.
- The provider had not made sufficient improvements since our last inspection to drive forward the quality of the service. An action plan had been completed by the provider but had not been effective in making the changes needed to ensure people always received safe and good quality care.

The provider's failure to ensure that effective systems were in place was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not appropriately submitted notifications to the Care Quality Commission. Whilst they had notified us of deaths and allegations of abuse they had failed to notify us of Deprivation of Liberty Safeguards (DoLS).

This was a breach of Regulation 18: Notification of other incidents (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is

finalised.

● At the time of the inspection there was no registered manager in post as they had de-registered in October 2020. However, after a short absence they had returned to the service and had begun the process of reapplying to become the registered manager again.
● It is a legal requirement that the overall rating from our last inspection is displayed. We saw the rating displayed within the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had completed surveys for people to give their feedback with action identified to address any issues that had been raised. Two people had raised they at times had to wait for care and people continued to raise this as a concern at the inspection. The provider's governance of call bells response times had not been effective and the manager advised they would look into a more effective system.
● Most relatives had not been able to visit due to the pandemic. They did not feel involved or engaged with the service and had not been contacted to express their views. One relative said, "We have never had a questionnaire or anything in fact they don't ask me if I am happy with the care when I ring." Another told us, "There have been no questionnaires or newsletters although a bit of information about the current situation would be nice."
● Staff told us they attended team meetings and the management was approachable if they needed to raise concerns. One staff member told us, "Whatever we ask [manager] tried to accommodate for us."

Continuous learning and improving care
● The provider had failed to ensure there was a culture of continuous learning in the service. Some concerns which had been highlighted at the last inspection had not been addressed.
● The provider had commissioned an external person to complete audits and offer training to staff. An action plan had been produced which included an action to improve the quality of care plans. We saw some care plans, when people had specific health needs with catheter care or PEG care were comprehensive and contained good guidance for staff to follow.

Working in partnership with others
● The service worked in partnership with social workers, tissue viability nurses and other health care professionals and relatives to ensure people were getting the care they needed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not always been assessed to mitigate risk. Where people required medicine to be given as and when required (PRN), the appropriate recording and review was not always in place.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to notify the Care Quality Commission of authorised Deprivation of Liberty Safeguards (DoLS).

The enforcement action we took:

We issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured people were always treated with dignity and respect.

The enforcement action we took:

Conditions were imposed on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems had been ineffective to ensure people received safe and good quality care.

The enforcement action we took:

Conditions were imposed on the provider's registration.