Care Quality Commission

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Essendene EPH

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11 May 2015 and was unannounced. This meant that the provider did not know we were visiting.

We last inspected this location on 17 January 2014 and found that the registered provider met all the regulations we looked at.

Essendene EPH is a care home providing accommodation and personal care to people over 65. It is registered for 13 people who are accommodated in nine single and two double rooms. At the time of our inspection there were 11 people using the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also one of the registered providers.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People we spoke with were happy with the care that they had received. They told us that staff were kind, patient and tried to help them to be independent. Relatives told us that they had no concerns about the care that they observed and felt that the service was good. Whilst we observed some positive interactions between people using the service and staff, we were concerned that staff described people to us in a way that did not afford dignity and respect.

Staff who provided care had been through recruitment and selection processes that ensured that they were appropriately skilled to carry out their job roles. We saw that there were enough staff working on the day of the visit to meet the assessed care needs of people. However, staff carried out a variety of other tasks including domestic chores, laundry and cooking and so were very busy. Staff had little time to engage with people aside from when delivering care.

We found the care that people received was not always safe. This was because people did not always get the medicines that they required. Also, the registered provider did not keep accurate and up to date records for each person. This meant that staff, who did not know a person well, may not provide the right level of care and support.

People told us that they enjoyed the food although there was not always a choice. We saw that people, who were able to help themselves, ate well. We saw that people who required assistance to eat and drink were not always supported with appropriately and did not get the dedicated time they required.

The registered provider did not have a system in place to ensure that they monitored and evaluated the quality, safety and effectiveness of the care and service being provided. This meant that they could not always identify potential risks and take steps to make the required improvements. We saw that, on occasions, they were reliant on other professionals to bring these to their attention.

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?

Requires improvement

The service was not completely safe.

People who used the service told us that they felt safe and that staff were kind to them. Staff were aware of the safeguarding process and how to report if they were concerned. However, staff were less aware what would constitute neglect or poor care.

The registered provider kept a log of accidents and incidents. However, there was no analysis of these occurrences to ensure that lessons were learned and any future risk of harm minimised.

Staff who provided care had been through recruitment and selection that ensured that they were appropriately skilled to carry out their job roles. However, the registered provider did not complete a written risk assessment to indicate measures they took when staff started prior to a full Disclosure and Barring check to ensure people who used the service were not placed at risk.

People did not always get their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not always effective

Neither the staff nor the registered provider had an understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. This meant that care and treatment may not be always provided in line with the law.

People enjoyed the food and told us that the meals were always good. However, accurate dietary intake records were not always kept when there was an identified concern.

Staff received training relevant to their job roles. Staff also received supervision and appraisal from the registered manager and registered provider.

Is the service caring?

Requires improvement

The service was not always caring.

People that we spoke with said that they liked living at Essendene EPH because the staff cared and were patient with them. They told us that some staff had been there a long time and knew them well. However, we heard staff talk about people in a way that did not afford them dignity and respect.

We saw that people did not have the level of support that they needed at meal times.

We saw that people's privacy was maintained and that records were kept securely.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us that staff helped them with the things that they found difficult. However, we saw that accurate and personalised information was not available in care files. Advice given by other professionals was not transferred into people's care plans for staff to follow so there was a risk that people may not be given the care required.

There was no evidence of an activities programme for people to participate in. Staff told us that they tried to make time for activities but this was difficult alongside the other tasks assigned to them.

People and relatives told us that they knew how to make a complaint and that it would be resolved. There was a complaints process in place but it did not give accurate information as to what people should do if they were not happy with the response from the registered provider.

Is the service well-led?

Requires improvement

The service was not always well led.

People we spoke with and their relatives told us that they had confidence in the registered manager and the registered provider.

Staff told us that they have stayed for many years at the service as they felt valued and listened to.

The registered provider did not have a system in place to monitor the quality, effectiveness and safety of the service and this could place people and staff at risk.

Essendene EPH

Detailed findings

Background to this inspection

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

This inspection took place on 12 May 2015 and it was unannounced.

The inspection was undertaken by two adult social care inspectors. Before the inspection we reviewed information that we held on the service such as notifications, complaints, and safeguarding.

During the inspection we spoke with five people using the service and four of their relatives. We also spoke with six staff. We looked at the records of five people using the service and observed staff interaction with people over a mealtime. The records relating to the management of the service were also reviewed.

Before the inspection we spoke with the local authority's quality and safeguarding unit and health care professionals, some of whom had previously raised concerns around pressure ulcer prevention and staffing levels. Following the inspection, we spoke with Cheshire fire and rescue service who visited on 12 May 2015 and the infection prevention and control team who had carried out an audit on 5 January 2015.

Requires improvement

Is the service safe?

Our findings

People who used the service and relatives told us that they felt safe and cared for by staff. "Yes I am safe here"," I am reassured with [my relatives] care".

Staff had undertaken safeguarding training to enable them to identify situations of potential abuse. Staff were able to tell us what constituted abuse, but they were less able to identify that poor care and neglect was also cause for concern. We spoke with the registered provider about the local authority requirements to report low level safeguarding concerns.

The registered manager kept a record of accidents and incidents involving people using the service. These included things like trips and falls. However, they did not analyse these occurrences in order to identify themes and trends, to learn from them or take steps to minimise the risk of further harm. For example, we saw that a person had slipped out of their chair on at least six occasions in the last four months and had developed a sore partially attributed to the friction caused in sliding. No risk assessment had been undertaken to look at ways of minimising risk and harm. We asked the registered manager to ensure that a seating assessment was carried out as a matter of priority.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 as there was no system or process in place to enable the provider to identify, assess or manage risks to health, safety and welfare.

People told us that there were enough staff on duty and that they did not have to wait for someone to come. "I have my buzzer and can call someone. They come quickly". We saw that there were enough staff to meet the assessed care needs of the people using the service. Care staff also undertook all other tasks such as laundry, domestic chores and food preparation. Staff told us that they were happy to do this and, "We are all used to the routine now."

Staff said there had recently been a change in shift patterns and now an extra carer is available in the morning and early evening. The registered provider told us the dependency levels of people using the service had increased and more staff were required at key times to meet personal care needs. Prior to the inspection, concern had been raised by the safeguarding unit and the district nursing service that only one carer was available over night and some people had required the assistance of two care staff to be turned or hoisted. A safeguarding investigation had concluded that this factor had contributed to two people developing pressure ulcers as their position could not be changed regularly throughout the night.

The registered provider told us that they sleep on the premises and so are always available to provide extra assistance to staff if required at night. When they are away, an additional staff member was on shift. We confirmed this following the inspection with night staff. Following the safeguarding investigation, the registered provider purchased additional equipment to allow people to be moved safely with one carer. The fire service have identified that evacuation could be compromised due to the number of staff available and the dependency of the people living at the location. They requested that the registered provider complete an assessment to identify how they are to mitigate any risk.

The registered provider had systems in place to ensure they recruited staff that were suitable to work within the service. We looked at the recruitment files for four members of staff and saw that the required checks with the disclosure and barring service [DBS] had been carried out as well as there being evidence of suitable references on file. We saw that two staff had commenced their employment before their DBS check had been verified. The registered provider showed us that an "Adult First check" had been received and that they had ensured the staff worked under supervision for this period. We spoke to the registered provider about the need to carry out a formal risk assessment if staff are to commence their employment prior to full checks being received.

The registered provider did not have safe systems in place for the ordering, dispensing or storage of medicines. We looked at the Medication Administration Records [MAR] for seven people. We saw that there were missing staff signatures on some records and it was unclear if medicines had been given or not been given on those occasions. Care staff had not recorded the quantities of medicine received into the home or carried forward from the previous month. This made it impossible to tell how much medication should be present and therefore whether or not these medicines had been given correctly. The health of people living in the home is placed at unnecessary risk of harm when medicines records are inaccurate.

Requires improvement

Is the service safe?

Day staff told us that night staff, although trained in medication administration, are not given access to the medication trolley or the MAR. Staff told us that day staff removed any required medication from the trolley and place them in another locked cupboard. The staff that administered night time medication did not sign for them but informed the day staff that they had been given. Day staff recorded this as "F" on the MARS. Therefore, the person who administered the medication did not make the record and this was not done at the time that was given. This places people at risk of receiving the wrong medicines at the wrong time.

We saw that where a person refused medication, there was no record of how often staff tried to give it or consideration of when this should be reported to the person's GP. For example a person had refused their eye drops at lunchtime and evening for nine consecutive days. When we spoke to the registered manager she told us that it was "Not a refusal but that staff were finding it difficult to administer". Staff had not reported this as a concern to the GP or sought further advise.

A number of people using the service had PRN (as required) medication. The registered provider did not have care plans in place to direct staff as to in what situation these medication should be given. One person had been prescribed a variable dose of diazepam to help with their agitation, but there was no information to help care staff decide when to administer the medication or what dose. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently, with regard to their individual needs and preferences. Failing to administer medicines safely and in a way that meets people's needs places the health and wellbeing of people living in the home at risk of harm. We also saw that the diazepam for this person had run out three days previously, so it was not available to them.

We saw that creams were stored in people's bedrooms and no risk assessments had been completed. Other creams and inhalers were stored in a warm pantry directly off the kitchen. Some medicines were stored in the food fridge but were not in a separate container to avoid contamination. If medicines are not stored properly and securely, they may be stolen, accidentally mixed up with medicines belonging to other people or other people might help themselves. Medicines stored at incorrect temperatures may alter in their effectiveness.

We spoke to the registered manager and referred them to current best practice guidance published by national institute for clinical excellence. We also made suggestion to seek the advice of their local pharmacist.

This was a breach of regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 as the provider did not have proper and safe management of medicines in place.

We saw that people were living in an environment that was clean and free from hazards. We saw that the registered provider had ensured that the required safety and maintenance checks were carried out for the building and equipment used. We observed care staff move people in wheelchairs that had no foot plates and peoples feet were getting caught. We saw that footplates were available but staff told us that they did not use them inside. We brought this to the attention of the registered manager who acknowledged that this was poor practice and that they would be used in the future.

The registered provider shared with us an infection control audit that had been carried out in January 2015. We noted that there were two double rooms on the premises. There was no risk assessment or business continuity plan in place should one of the people in the room have an infectious or contagious condition and require isolation. We discussed this with the infection prevention and control team following our inspection and they confirmed our concern as there were no "single rooms" and sanitary facilities were shared. The Department of Health and Health Protection Agency guidance 2013 "Prevention and control of infection in care homes - an information resource" states that " isolation of residents with an infection may be necessary to prevent further cases of infection. Ideally single rooms should be available for this purpose and registered managers of homes will need to consider how best to achieve this"." Residents who are vomiting should be kept in a single room, as long as symptoms persist".

We recommended that the provider carry out a risk assessment in regards to the sharing of rooms that outlines and addresses the associated risks in line with the best practice guidance.

Requires improvement

Is the service effective?

Our findings

People told is that staff "Know what they are doing, or at least I think they do".

People that we spoke to with said they liked food that was on offer. Some people said that "There was little choice", but they "Usually liked what was on offer". One person said, "I ask for something else if I don't like the look of it and I usually get something". We saw that the menu was planned some weeks in advance and the majority of main meals prepared and frozen. Care staff cooked the main meal from frozen and prepared the fresh vegetables on the day. Staff said "We try to get 'five a day' where were can". We saw that there was no choice at lunchtime as it was a set menu but staff told us an alternative would be found if somebody didn't like what was on offer. Staff also prepared special diets as some people who lived there had diabetes or were gluten intolerant. A variety of biscuits to suit all requirements and drinks were available throughout the day. People were encouraged to take fluids throughout the day and this was done in a caring manner "Please try to take a bit more for me".

Staff underwent an induction programme that consisted of orientation to the home, familiarisation of policies and procedures as well as shadowing more experienced staff. Some training was based upon DVD learning with questions to test knowledge. Staff told us there were opportunities for on-going training but that they would prefer more face to face training. We saw that, following a recent safeguarding investigation, staff had received additional training in pressure ulcer prevention and moving and handling. A staff member had also been nominated as the "infection control lead". Staff received supervision on a one to one basis three times a year and an annual appraisal from the registered manager but also attended staff group meetings.

Staff, and the registered manager had limited knowledge of the principles of the Mental Capacity Act 2005 and what the code of conduct meant for them. Staff were unable to tell us how they would assess mental capacity in their day to day work and told us "[We] get the mental health team involved in such instances". Staff also felt that it was acceptable for "Families to decide" where a person is not able. We saw that, where daily records indicated that a person receiving care had difficulty with understanding, care plans did not take into consideration the person's capacity to consent to care and treatment. For example, there was no evidence to demonstrate that people, who appeared to lack capacity, had made an informed decision to share a room and were aware of the associated risks such as cross infection and disturbed sleep.

We also identified that a number of people had bedrails in situ, but there were no mental capacity or risk assessments in place. Consent forms for their use had been completed and signed by family's members. We spoke with the registered manager about the importance of knowing which people using the service had representatives that held a Lasting Power of Attorney. This document gives the appointed person/s the legal authority to make decisions in regards to finances and/or health and welfare. Staff and the registered provider did not recognise that the use of bed rails as a restriction could possibly constitute a Deprivation of Liberty.

This was a breach of regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 as the provider had not ensured that care and treatment was provided with the consent of the relevant person.

We saw that people were supported to have access to health care services and support. There were regular visits from a local GP to people using the service. Professionals providing clinical guidance or support indicated to us that staff and the service were "Reactive rather than proactive" in identifying concerns with individuals and therefore needed regular input. Due to the increased needs of people using the service, there was intensive support from the district nursing service who visited daily at the time of this inspection. They provided education, guidance and practical support to care staff.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us that they liked living at Essendene. They said that "The staff are great", "The staff will do anything for you, and you don't have to be rude in order to get their attention!", "Get on great with them all", "I have no grumbles" and a relative said "they are full of compassion and caring". People and relatives told us that they could visit at any time or the day or night and were always welcome.

People told us that staff were patient with them and tried to encourage them to be more independent with care and choices. One person said "They always ask: am I rushing you?" We also saw that staff offered people a choice with day to day decisions such drinks and snacks, "What is your preference". We observed that staff knew people well and they were able to tell us about the care that people required, their daily routines and preferences.

We saw some positive interactions between staff and people using the service and staff were caring in their approach. However, during the inspection, a staff member referred to someone who used the call bell frequently as, "Trigger happy" and to a person who had a bad day as "A misery". Therefore, staff did not always describe people's behaviours in a way that afforded them dignity and respect.

We observed staff interaction with people during lunch time. We saw that some people required help with eating and drinking but this assistance was not given in a dignified way. We observed carers stand over people whilst assisting rather than sitting down and letting them eat at their own pace. Carers provided assistance to more than one person at a time so assistance was interrupted. We also saw a number of people given hot puddings before they finished their main course. We discussed this with the registered manager who informed us that a number of people now require assistance and consideration had been given to "Sitting them all together to make it easier for staff". We suggested to the registered manager that they considered dedicated meal time support for those that required assistance so that care was person centred and provided in a caring way.

We saw that people had their doors closed during personal care and throughout the day if this was their choice. Where people shared a room, there were screens provided to ensure privacy when undertaking personal care tasks. We saw that information kept about people who used the service and staff was stored securely and appropriately.

Relatives told us that they were kept up to date with any concerns or incidents involving their family member. They were also told about any changes to the service. Relatives felt that, overall, there was good communication with staff, the registered manager and registered provider.

The registered provider had produced a service user guide that was made available for people that used or had planned to come into the service. We noted this did not contain accurate and up to date information. For example, it was misleading and inaccurate to state that "In addition, the Home's staffing requirements have been approved by the Commission for Social Care Inspection (CSCI) as part of the process of registration of the Care Home" or that "The home employs an activities coordinator". The registered provider told us that they were in the process of revising this document.

Information was not readily available on the use of advocates, but the registered manager told us that all of the people who used the service had families that were actively involved in their care.

Requires improvement

Is the service responsive?

Our findings

People using the service could not recall involvement in the writing or reviewing of their care plans. Some relatives confirmed that they had been involved in discussions at the point of admission about care that was required but in most cases that had been “A while ago”. We saw that people did not sign or consent to their own care plans where they had the capacity to do so.

We looked at five care plans and saw that none were dated or signed by staff that had completed them. This meant that we were not able to tell if they were up to date or reflected the current needs of the person. The care plans that we looked at were not personalised in that they told us very little about someone’s likes, dislikes or personal preferences. The care plan were not a full and complete assessment of need and failed to identify risks.

Following safeguarding concerns in relation to pressure care and prevention, the registered provider had arranged extra training for staff and had introduced a Waterlow Assessment tool. This assesses someone’s risk of developing a pressure ulcer. These were not dated or signed. Some were not accurate. For example a person was last weighed on 31 December 2014 with a weighed 6 stone 7 pounds and this was a loss of one stone in 12 months. Their Waterlow did not indicate any weight loss, they were deemed to be an average body mass index.

A number of people had been identified weight loss but there were no risk assessments or management plans in place to direct staff as to how to manage this. The provider did not use any of the recommended assessment tools to identify those persons who might be at risk of malnutrition so there were no preventative measures in place. We saw that where referrals had been made to the GP or dietician but staff had not implemented a care plan following any subsequent advice or guidance. Some people were unable to be weighed as they were not weight bearing and the provider did not have suitable scales. Staff were not using any of the alternatives methods of determining whether someone was losing or gaining body weight such as measuring mid upper arm circumference.

We had received information to indicate that somebody had difficulty with swallowing. Staff told us that “They were on a soft diet but would also eat a sandwich”. We saw at lunchtime that this person struggled to eat and heard a carer tell the person "Don't put any more in your mouth; try to swallow what you have got first.” We also saw that this person had significant weight loss and had been prescribed supplements. The care plans did not indicate what support was required. We asked the registered manager who had recommended a soft diet and on what clinical evidence. They told us “That it was due to age deterioration” and “No formal advice” had been sought. In light of the apparent swallowing difficulties and weight loss, we requested that the registered manager to inform the person’s GP with a view to ascertaining advice from speech and language therapy.

We looked at how people were moved using a hoist and saw there were no moving and handling assessments to confirm the level of support and assistance that someone required, when being hoisted, during the day or night. We saw that one person was transferred with two staff in the morning but then staff used a hoist later on in the day. There was a possibility that staff could transfer a person in a way that was not safe and this placed themselves and others at risk. The registered manager told us that some people were moved with one staff member and a hoist, especially at night following a fall to the ground but there were no risk assessments carried out to demonstrate that it was safe to do so. The Health and Safety Executive guidance” Getting to grips with moving people” clearly states that staff should “Consider whether a hoist is the most suitable handling aid and, if so, devise a handling plan to match the individual’s ability and meet their needs and those of the workers involved. It should specify the appropriate hoists and slings for the individual and the type of transfers required.” “The handling plan should cover the range of activities where a person may require assistance with moving and handling e.g. transfers bed to chair, into bath etc. The plan should be easy to read and clearly state the control measures for moving and handling the individual, including: specific equipment needed; techniques to be used; number of handlers required…etc.”

These were breaches of regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 because the provider had failed to ensure that there was a full assessment of the need for each individual as demonstrated with the examples above.

During the day we observed that there was little stimulation for those people sat in the lounge. The television was on all day but no one was actively watching

Requires improvement

Is the service responsive?

it. There was no one employed specifically to provide social stimulation and activities for people living at the home. The care staff told us they tried to do things such as nail care, board games etc but this was alongside their other tasks and sometimes there was little time. We saw that staff were busy throughout the day and that care was "task" orientated. There was a timetable of events where people from the community came into the home to provide entertainment. Some people told us, "I like it when the weather is better as we get to go out". Staff confirmed that in the warmer months the registered provider arranged trips out to enable people access events in the community. A number of people using the service told us that they were "Lucky to be able to go out with family and friends".

People who used the service and their relatives told us that they knew how to make a complaint and would be confident in it being resolved. There had been no complaints made or logged since the last inspection. The complaints policy was not up to date and last revised in 2010. It directed people to the Care Quality Commission to resolve their complaints and the registered provider was of the opinion that this was correct. We asked the registered provider to review the complaints process to ensure that it is accurate and up to date.

Requires improvement

Is the service well-led?

Our findings

People that we spoke with and their relatives told us that the registered manager and registered provider were approachable. They felt that they had confidence in them to address and resolve any concerns. They told us that there were no concerns currently regarding the management and the running of the service.

We saw that the registered provider did not have robust systems in place to monitor the quality and the safety of the service that they delivered. There were no formal audits carried out to assess compliance with record keeping, infection control, medication management etc. This meant that the registered provider was not able to identify where the quality and safety of a person was being compromised. For example: the registered provider had failed to carry out audits (checks) to determine how well medicines were handled. They had, therefore, failed to spot the concerns and discrepancies that we found during our visit. The infection control team were not able to establish when items such as duvets and curtains had been cleaned as the registered provider did not carry out their own infection control audit or cleaning schedules. It is essential to have a robust system of audit in place in order to identify concerns and make the necessary improvements

This is a breach of Regulation 17 as the provider did not have systems and processes in place to assess, monitor and improve the quality and safety of care.

The registered provider had standard policies and procedures for staff to refer to in order to inform and direct their practice. These had been written by a "home management consultancy". However, they had not been made personal to the service and some had not been updated to reflect changes to legislation, policy and guidance. We spoke with the registered provider about the requirement to have up to date policies and procedures so that staff worked with the most current best practice and legislative guidance.

Staff meetings were held annually and the last recorded meeting was held in July 2014. The registered provider told us that staff meet informally during handovers to discuss things of concern but that these were not recorded. The service user guide indicated that "Residents meetings are held periodically, these are usually run by a Senior Staff member, actions are identified and the minutes circulated to all Staff, for feedback and implementation". We saw that these were only held twice yearly and the last one held on 23 February 2015. The minutes of this meeting reflected mainly positive feedback. However, some people had highlighted the lack of meal time choice but our evidence demonstrated that this had not yet been resolved.

The registered provider told us that questionnaires were sent to relatives once a year in March around the time that they reviewed annual fees. They told us that there "Was always a poor response" because people "Preferred to talk to them directly". The most recent questionnaires indicated that the service was, "Caring in the real sense", "Pleasure to visit" but that "More cover is needed in the lounge "and "I want to be more included in care planning". The registered provider informed us they will address these issues in the new business plan. The registered provider did not have a way of sharing the overall feedback and action plan with people using the service or their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care **The provider had failed to ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences.** 9 (1)(a)(b)(c) (2) (3)(a)(b)(c)(h)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had failed to ensure that care and treatment was only provided with the consent of the relevant person and did not take regard of the Mental Capacity Act 2005.** 11 (1) (2) (3) (4) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to have a proper and safe system for the management of medicines in place.** 12 (1)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had no system or process in place to enable them to identify, assess or manage risks to health, safety and welfare.**

This section is primarily information for the provider

Action we have told the provider to take

17(1) (2) (a)(b)(c)

This section is primarily information for the provider

Enforcement actions

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