

Mrs Susan Kay Hardman

Luke's Place

Inspection report

The Old Estates Office
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Tel: 01582 458201
Website: N/A

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Requires improvement



Is the service effective?

Inadequate



Is the service caring?

Requires improvement



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



Overall summary

We carried out an unannounced inspection at Luke's Place on 11 June 2015. This service provides accommodation and personal care for up to 4 people with learning disabilities, physical disabilities or mental health conditions. At the time of our inspection there were four people living at the service.

A registered manager was not required at this location as the registered provider was an individual rather than an organisation and managed the service them self. An individual who is the registered provider is a 'registered

person'. 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.

At our last inspection on 31 December 2013, the service was meeting the required standards that we looked at.

During this inspection we identified breaches of a number 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.

Summary of findings

There were sufficient numbers of staff on duty although some staff had not received adequate training to ensure they had the skills to support people effectively. Staff and the provider did not demonstrate an understanding of, or meet, the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards.

Staff recruitment processes were not safe.

Risk assessments were not always kept up to date and risk related to the environment had not all been assessed.

People were supported to eat well and were encouraged to choose healthier food options to maintain their health and well-being.

Staff were caring and respected people's privacy and dignity. People and their representatives were not always supported to make decisions and were not sufficiently involved in assessing their needs and planning their care. Staff supported people to maintain relationships that were important to them.

People and their relatives were aware of the provider's complaints system and information about this was available in easy read format. Some relatives did not feel their complaints were appropriately handled.

The provider did not promote a positive and open culture where people and their relatives were involved in developing the service.

The provider did not demonstrate strong visible leadership or give consistent direction to the staff team.

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

Special measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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?

The service was not always safe.

Medicines were administered and stored safely.

Staff had an understanding of processes to safeguard people from harm but concerns were not always reported to the Care Quality Commission (CQC) or the local authority appropriately.

Staff recruitment practices were not safe

Individual risk assessments were completed but were not always updated regularly.

Environmental assessments had not been completed in relation to some areas of risk

Requires improvement



Is the service effective?

The service was not effective

Staff training was not all kept up to date.

Consent was not always obtained before support was provided.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards were not met.

People had enough to eat and drink.

People were not always supported to maintain good health.

Inadequate



Is the service caring?

The service was not always caring.

Staff interacted well with people.

People's privacy and dignity were respected.

People and their representatives were not sufficiently involved in making decisions about their care and their confidentiality was not always maintained

Requires improvement



Is the service responsive?

The service was not responsive.

People and their representatives were not involved in assessing their needs and planning their care.

People's individual needs were not always met and care plans were not updated

Inadequate



Summary of findings

People and their representatives were aware of how to make a complaint but did not all feel that complaints would be appropriately acted upon.

Is the service well-led?

The service was not well led.

The provider did not formally notify us of significant events in the service as required to by law.

The provider did not promote a positive and open culture where people and their relatives were involved in developing the service

The provider did not demonstrate strong visible leadership or give consistent direction to the staff team

The provider did not have an effective system for assessing and monitoring the quality of the service they provided.

Inadequate



Luke's Place

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 11 June 2015 and was unannounced. One inspector carried out the inspection.

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 also reviewed other information we held about the service. This included information we had received from the local authority and the provider since the last inspection, including any action plans and notifications of incidents. A notification is information about important events which the provider is required to send us by law.

During our inspection we used the short observational framework for inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with one person who used the service in depth and had brief conversations with two others. We also spoke with two relatives of people who used the service, the manager of the home, the administrator, a senior support worker and two support workers. We reviewed the care records of three people that used the service. We checked medication administration processes and reviewed how complaints were managed. We looked at staff training and recruitment records, and reviewed evidence to demonstrate how the provider assessed and monitored the quality of the service provided.

After the inspection visit we contacted a further three care staff and six health and social care professionals who worked with the home in order to gain feedback from them about the quality of the care provided. We spoke with two more relatives of people who used the service by telephone.

Is the service safe?

Our findings

The provider did not have a robust recruitment process in place. We looked at the recruitment documentation for six members of staff and found that many of the required pre-employment checks had not been completed prior to them starting work. For example, one staff file we looked at contained no references and a Disclosure and Barring Service (DBS) check that was dated three weeks after the person started work. Another staff file showed only one reference and not two as required, and a DBS check which had been obtained three months after they started work. We found missing or delayed information in all the records we looked at. The administrator told us that new staff never worked unsupervised. However, due to the support needs of the people who lived at the service, the staff concerned did support colleagues to assist people with personal care. This put people at risk because the provider had not taken reasonable steps to ensure, as far as possible, that they were cared for by suitable staff.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

There were individual risk assessments which identified how the person was at risk and the steps put in place to minimise the risk were clearly documented. However, risk assessments had not been regularly updated when incidents occurred or when people's needs changed. We found that the steps to minimise risks identified the training staff required, rather than focussing on the individual's needs. We also noted that the assessments did not identify how people would be supported to be as independent as possible. We found little evidence to indicate that people had been involved in deciding which risks they wished to take. During the inspection the provider was not able to locate a record of any assessments to identify and address risks posed to people by the environment. Following the inspection the provider sent us risk assessments which covered issues such as risks relating to general cleaning, the use of glass picture frames and the use of machinery, such as a lawn mower. However, they did not produce other key environmental risk assessments, such as fire risk assessments or control of the risk of legionnaire's disease. Although the provider was able to explain how people would be supported in the event of an emergency requiring evacuation of the building, people did not have personal emergency evacuation plans (PEEP)

within their care records which detailed the assistance each individual required to vacate the premises. In the event of such an emergency, people may therefore have been at risk of not being able to leave the building safely.

These issues were a breach of regulation 12 of the health and social care act 2008 (regulated activities) regulations 2014.

Although the provider said they understood their responsibility to report incidents of concern to the local authority we found they had not always done so. In discussions with social care professionals following our visit, it emerged that the provider had failed to notify the local safeguarding authority about incidents until prompted by external professionals to do so. This indicated that people were not protected from the risk of harm because the provider did not utilise reporting processes and procedures appropriately.

This was a breach of regulation 13 of the Health and Social Care Act (regulated activities)

Regulations 2014

People and their representatives told us they felt safe. One person said, "I am safe here. I know the people here." A representative told us "I don't have any doubts about (family member's) safety. They care and generally keep [family member] safe from harm."

There was information on display in the office which gave staff on the details of who to contact if they believed that someone was at risk of harm. The provider had an up to date policy on safeguarding people which staff were aware of. Staff told us that they had received training on keeping people safe from harm and records confirmed that this was the case for most staff. They had a good understanding of what constituted abuse and told us of the procedures they would follow if they suspected abuse had occurred.

Records of incidents were kept. Although the provider told us that she did not have a formal system for analysing incidents and accidents, she said that, due to the small size of the service, she was able to identify any trends easily to ensure action could be taken to reduce them.

Relatives told us that there were enough staff on duty to support people safely and we observed this was the case. The provider told us that there was always a minimum of four staff on duty during the day and two at night. This number of staff was increased at certain times during the

Is the service safe?

week to support people to participate in certain activities safely, such as swimming or trips out. Staff absences or vacancies were covered by the regular staff picking up extra shifts to ensure that people were supported by familiar staff.

People's medicines were administered safely. People were assessed to establish if they were able to manage their own medicines and one person was doing this. Where this was not possible or where they did not wish to, then the staff

administered them. The system in place enabled an audit of the administration of medicines to be undertaken and we saw that, where errors had occurred, appropriate action, including retraining of staff members concerned, was taken. Storage of medication was in line with current good practice. Staff who administered medicines had received training to ensure they understood and were competent to do so.

Is the service effective?

Our findings

One person told us that they were usually supported well by staff although “Some are better than others. Some days are good and others are bad.” Relatives also said that the support from staff varied. They felt that some staff knew people well but, due to a high turnover of staff in the last year, some staff were less familiar with people’s needs. One relative said, “It is such a shame because this could be a great service. It was a great service, but some good staff have gone and those that are here now don’t seem to know so much.” Another relative said “Some staff are really good, but others do not really know [family member] very well.”

A family member told us that staff had not received training to assist their family member to use a specific piece of equipment which meant their needs were not as well met as they could be. During our inspection we were not made aware that the person used this equipment. Following our inspection we checked the provider’s training record, and found no evidence that training in the use of this equipment had taken place.

Although the provider had an ongoing e-learning training programme for staff, the training records showed that some essential areas of training were not completed or kept up to date for many staff. For example, we found that only two staff had completed health and safety training, and only one staff had completed first aid. Despite working with people who sometimes reacted in a manner that other people may find challenging, training in relation to this had not been provided. A health care professional who had provided training to staff in relation to one person’s needs told us that they had repeated the training several times due to a high turnover of staff, but also said they were not confident that all members of the team had a good understanding of how to support the person effectively. People were therefore at risk of receiving inappropriate care because staff did not receive sufficient training to enable them to support people well.

Staff confirmed that they had supervision but some said it was not provided frequently. The senior support worker told us that they were responsible for supervising staff and were trying to ensure it was carried out on a more regular basis. However, this was difficult due to no time having been allocated for administrative duties. The provider did not have a system to log when supervision had taken place

so it was not possible to establish how often supervision took place. The provider told us that they were going to be conducting staff appraisals but that this had not been completed yet.

All of these issues were a breach of regulation 18 of the Health and Social Care Act (regulated activities) Regulations 2014.

Staff told us that they always asked people whether they wanted support before it was provided and we observed that this was mostly the case, although we observed one occasion when a person was moved in their wheelchair without being consulted.

However, the provider and staff did not demonstrate a sufficient understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). When asked, both the provider and two staff members confused this legislation with the Mental Health Act. Other staff told us they did not know what the MCA was about. No staff, other than the provider, had received any training in relation to this legislation and none were aware of its impact on the way in which they cared for people. As a consequence, people’s rights to make decisions for themselves was not fully understood.

When prompted, the provider told us that some people were able to make day to day decisions about their care but would need support with more complex decisions, such as those relating to health care. They said that other people were less able to make their own decisions and, in general, those decisions would be made in consultation with family members. From our observations of the complex needs of the people who used the service, it was apparent that they would need mental capacity assessments to ascertain whether or not they understood the consequences of certain decisions.

We found no evidence that people’s rights were protected by the application of capacity assessments to support the provider’s statements that people lacked capacity to make complex decisions. For example, one person required a device to treat a medical condition which, if left untreated, could put the person’s life at risk. They were not comfortable using the device and regularly pulled it off. The provider told us that, on occasion, staff physically intervened, against the person’s will, to provide the necessary treatment. However, there was no paperwork to support that intervention, or to demonstrate that it was

Is the service effective?

done in the person's best interests within the legal framework. The provider also stated that the person's choice not to use the device was sometimes accepted. However, there was no mental capacity assessment to indicate whether the person had the capacity to understand the consequences of not using the device. The lack of documentation to support staff actions when providing care and to minimise the risk of serious harm to the person, whilst also protecting their rights, put both the person, and staff at risk.

We reviewed three care records and found that neither people nor their relatives had consented to their care and support. We did find evidence in one person's care records that a relative had signed their consent to information about their family member being shared with other professionals. However, there was no evidence that a mental capacity assessment had been carried out to confirm that the person lacked the capacity to give this consent them self. There were no records of a formal process to make decisions in people's best interests in any records we looked at.

The provider was not familiar with DoLS or the circumstances under which it would be appropriate to make an application to the local authority and therefore no applications had been made. However, some people at the service were under constant supervision and were not free to leave the premises without a member of staff. This meant that, without a DoLS authorisation, their liberty may have been unlawfully restricted.

These issues were a breach of regulation 11 of the Health and Social Care Act (regulated activities) Regulations 2014.

One person told us they were supported to see a doctor if they wished, and said that they had recently asked to see a dietitian which was being arranged by their keyworker. We saw from care records that people had been supported to attend routine health checks, such as GP and opticians appointments. However, some relatives expressed concern that their family member's health needs had not always been supported in a timely way, and that staff did not consistently recognise when it was appropriate to seek medical intervention. The provider confirmed that an incident had occurred where a person's health needs had been overlooked and that this had been addressed with

staff. We noted on the day of our inspection, that guidance for staff had not been formally updated in relation to this person's needs to ensure that their well-being was being promoted. Following our inspection, a professional who worked with the service told us they were concerned that the provider did not understand the risks relating to a person's specific medical condition and had not given appropriate guidance to staff about how to support the person appropriately. These issues indicate that people were at risk of their health needs not being appropriately met because staff and the provider did not have the skills, knowledge or information with which to support them effectively.

This was a further breach of regulation 12 of the Health and Social Care Act (regulated activities) Regulations 2014.

We saw that staff on duty appeared to know people well and demonstrated skills to meet their daily needs, such as assisting people to eat in a sensitive and dignified manner, and respecting people's dignity when supporting them with personal care. Staff confirmed that their induction included a period of shadowing other staff and getting to know the people who lived at the service. A senior member of staff told us that staff were encouraged to complete level two National Vocational Qualifications and that others had completed or were working towards their level three.

One person said they had enough to eat and drink and we saw that food and drink was freely available to people whenever they wanted it. One person told us, "I get a choice about what to eat. I don't always like what the others are having and I can have something else if I want." A relative told us that people ate and drank enough and that the food offered was pleasant. We saw that menus were varied and nutritionally balanced and the provider explained that they were written every three weeks taking into consideration people's preferences. Some people told us they were involved in menu planning and looked at recipe books for inspiration. Staff told us that people were encouraged to eat a balanced diet and we saw that fresh fruit and vegetables were included on the menus. The provider told us that referrals were made to a dietitian when any concerns about people's dietary needs arose. This was confirmed by one person we spoke with and our review of care records.

Is the service caring?

Our findings

People and their relatives had mixed views about the care they received, and many relatives told us they felt care at the service was not as good as it used to be when the service first opened. Some people attributed this to the loss of more experienced staff who knew people well. However, one person said “My key worker is good. I really think she is lovely.” A relative told us “I can’t fault the care. They do care.”

We observed staff interact with people in a caring way. We saw that they were attentive to people and chatted with them about day to day matters. There was a relaxed atmosphere in the home and people were clearly at ease in the company of staff. One member of staff told us about a recent trip out with people. They said “It makes [name] happy. They were so excited it makes me excited too. That’s the reason we are here. To make people happy.” The staff on duty knew people well and were able to tell us about each person’s needs and preferences. People were cared for in a well maintained and comfortable environment and we saw that people’s rooms were personalised and reflected their individual interests and tastes.

Staff told us that they respected people’s decisions about their daily care and support needs, such as the time they got up, what they wore or what they wanted to eat. One member of staff told us, “It’s important that people have the freedom to express themselves and do what they want. I am here to help.” We saw that staff took time to explain information to people, using simple language and gestures

where necessary. For example, a member of staff was supporting a person to apply sun cream and explained clearly what it was for and why it was a good idea to protect them self from sunburn. The provider had a key worker system in place to ensure that each person had a named worker who took a lead role in their support. Most people and relatives spoke highly of their key worker and felt that this relationship supported them to have their needs met.

People we spoke with said that staff spoke with them in private about personal or confidential matters. However, both family members and visiting professionals told us that it was difficult to have confidential conversations due to the layout of the building, and that there had been occasions when the provider breached people’s confidentiality by discussing them in front of others. We also found this was the case during the inspection, when we had to stop discussions with staff several times to maintain confidentiality when others entered the room. One person told us that staff respected their privacy and dignity, giving them the opportunity to attend to their personal care needs in private by stepping outside once they had offered necessary assistance. We saw that most staff spoke to people with respect, used their preferred name, and maintained people’s dignity at all times when offering them assistance. However, we also observed that some staff spoke to people in a childlike manner which was not respectful and did not uphold the person’s dignity. People were supported to maintain relationships with people that were important to them. Staff told us that people’s friends and relatives were able to visit at any time and relatives confirmed this.

Is the service responsive?

Our findings

Although the provider was keen to offer a person centred service which was developed to meet people's individual needs and preferences, many relatives told us that this did not reflect their family member's experience of the care provided. One person told us they had not been involved in planning their care and had never seen their care plan. Similarly, all of the relatives we spoke with said they had neither seen, nor been involved in the development or review of their family member's care plan. One relative told us that, although they had provided written information to the service when their family member moved in, they found that staff were not familiar with the support issues contained within the document when supporting their family member. Two relatives told us that they had asked on several occasions to see their family member's care plan, but had always been told it was either being developed or reviewed.

We looked at the care plans for three people. Although the plans identified people's support needs, in some instances, there was a lack of clear guidance to staff on how to meet these needs, and there was very little information which detailed people's preferences, interests or preferred lifestyle. There was very little evidence of any input from people or their families, which supported their comments that they had no input in their development. People's care records were not regularly updated to reflect any changes required. For example, following a high risk incident, one person's care plan and risk assessment had not been updated to reflect the action the staff were required to take to support the person's individual needs appropriately in the future. This put the person at high risk of harm because the staff did not have up to date information about how to respond to their individual needs.

On the day of our visit one person had gone out to a local day service and two people had gone bowling. One person had remained at home, although they told us this had been their choice, and we saw that they were doing some art work. The provider told us that people were supported to attend music and dancing groups in the community and to go out into town. They also had use of the onsite hydrotherapy pool. A trip away to Blackpool was planned for later on in the year. However, the administrator

informed us that this was planned to coincide with refurbishment work within the service and confirmed it had not been arranged in response to a choice made by the people who would be going.

After our inspection, several relatives expressed concern about the lack of support people received to engage in activities that were meaningful to them. They told us it was unusual to see people doing anything other than watching television, and that the art activity we saw did not happen on a regular basis. Other relatives expressed concern that their family member was losing skills because they were not given the opportunity to be involved in everyday tasks such as meal preparation.

Community activities were limited because, due to the location, transport was required if people wished to go out, and the communal minibus was in need of repair. A second minibus was owned by one person who used the service so was restricted to activities that they attended. This meant that, although others could go along when that person went out, their choice of activity was restricted. The provider told us that it was difficult to support some people to engage in activities, and that many options had been offered but take up was low. However, apart from the music and dancing groups, and single event trips out, we did not see evidence that activities were planned in a manner which took full account of people's personal interests and hobbies.

All of these issues were a breach of regulation 9 of the Health and Social Care Act (regulated activities) Regulations 2014.

People and their relatives were aware of the provider's complaints policy and we saw that information about this was available in easy read format which was on display in the service. However one person said that when they complained about the service, "Sometimes it gets sorted out and sometimes not." However, they also said, "My key worker is really good though. I talk to her." The provider told us that they tried, where possible, to resolve issues before they escalated and that because of this, there had not been many formal complaints made. However, when we asked relatives about this, all of them expressed concern that issues raised with the provider were not responded to or dealt with appropriately. Some relatives told us that it was difficult to express concerns to the provider, because their response was defensive and they did not want to cause the provider to be upset. One relative told us they had

Is the service responsive?

previously felt it was not worth complaining about concerns which, individually, did not seem serious enough to warrant it. However, they stated that communication with the provider was, “Nigh on impossible” and that, “Things are always about to be dealt with, but then never are.” They went on to say that, if they sent an email, it was rarely responded to.

A complaints form was in use at the service, but these were not used consistently and we found some were stored

within the accidents and incidents folder. The provider was unable to demonstrate how she monitored concerns and complaints as they did not have a system with which to do this. This made it difficult for the provider to learn from complaints and use the information to improve the service offered to people.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Is the service well-led?

Our findings

The service was not well led.

The provider was managing the service with support from an administrator and a senior support worker. Whilst they had personal experience of caring for people, they did not have previous experience of managing a registered service and held no formal management qualifications. We found that they did not have a sufficient understanding of their role and legal responsibilities in relation to both leading the service and monitoring the quality of care. Although the provider acknowledged that it would be beneficial to undertake a management qualification, they said that they had no immediate plans in place to address this.

The provider stated that they were keen to offer a person centred service and wanted to take action to make improvements to the home. However, some people's relatives and staff told us that, although they could talk to the manager about any issues they may have, they were not always confident that they would take action to address the matters raised. Others said they were not comfortable to raise concerns as the provider tended to take offence. The provider was unable to produce any evidence of action they had taken to address suggestions for how the service should be improved and said that this was always agreed verbally with people. The provider showed us information that had been produced to inform people and their relatives about the service. We found that this information did not accurately reflect the service and could have been considered misleading. For example, it stated that, "Care plans, daily support plans and daily diaries are produced in easy to read formats." However, we found this was not the case.

Almost everyone we spoke with said they felt the provider had good intentions and cared about the people who used the service, but that they did not lead the service well. This view was shared by relatives, health and social care professionals who visited the service, and some staff, although other staff considered the provider's leadership style to be good. The service was described as "chaotic", "disorganised" and "inconsistent". Many of those we talked with spoke of conflicting priorities on the part of the provider due to their family connections with one person who used the service. Many felt that this had a detrimental impact on the experience of people who used the service.

We found that, although people appeared comfortable and well cared for, much of the good care was intuitive rather than imbedded through a clearly defined and understood model of care. The provider had not put the structure in place to achieve a consistently good service or to identify where there were shortfalls in the care. The provider was unable to produce any evidence of action they had taken to address suggestions for how the service should be improved and said that this was always agreed verbally with people.

Staff were aware of the provider's whistleblowing policy and one member of staff told us that they had spoken up about poor practice, and the provider had taken appropriate action to address their concerns. However training and guidance for staff, record keeping and effective consultation with people and their families, were not sufficient to support the development of a high quality, well managed service. Staff did not have a clear sense of what the values of the service were, and some stated that it was unclear who was managing the home. Some staff and relatives said that the provider was not consistently professional and did not deal with issues in a manner they would expect from the manager of a service. The provider also commented that they sometimes struggled to be in charge of the day to day running of the home and found it difficult to strike a balance between managing staff and trusting them to deliver good quality care.

Apart from a system to monitor the administration of medication, the provider had no systems in place to monitor the quality of the service and despite several explanations they found it difficult to understand what we meant when we asked for this documentation. We looked at the policy manual which contained a quality monitoring policy from 2010 which identified the author as being the provider. However, they were not aware of the policy and were not able to explain the contents. We concluded from this that they did not have systems in place to support the service to deliver high quality care.

All of these issues were a breach of Regulation 17 of the Health and Social Care Act (regulated activities) Regulations 2014.

At the time of writing this report, there had been three significant events at the service in the last 12 months that the provider was required by law to notify us of, but failed to do so.

Is the service well-led?

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

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.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People were not involved in planning their care and their preferences were not identified. They were not sufficiently supported to make decisions about their care and their individual needs were not always met.
Regulation 9 (1), (2) and (3) (a-g)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The registered person did not act in accordance with the Mental Capacity Act 2005 and the associated Deprivation of Liberties Safeguards

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1), (2) (a), (b) and (i). Risk assessment were not always updated and people were not always supported to maintain their health in a timely way.

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Enforcement actions

The registered person did not utilise systems and processes to report allegations of abuse of improper treatment effectively. Regulation 13 (3)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider did not receive, record, handle or act on complaints appropriately, Regulation 16 (1) and(2)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have effective systems in place to monitor the quality of the service, and did not actively seek the views of people and their relatives to make improvements to the service. Regulation 17 (1), (2), (a),(b),(e) and (f)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not taken reasonable steps to ensure they or their staff had appropriate training and support. Regulation 18 (1) and(2)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered provider did not have a robust recruitment process which included all appropriate pre-employment checks Regulation 19 (1)(a),(b),(c), (2) (a) and 3 (a)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009
Notification of other incidents

The registered provider failed to notify the care quality commission of notifiable incidents within the service.
Regulation 18 (1),(2) (b) and (e)

The enforcement action we took:

We are currently taking enforcement action. We will report on this once it is concluded.