

Nightingale Residential Care Home Ltd

Cherrydale

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?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Cherrydale is a residential care home without nursing providing personal care and accommodation to up to 22 older people, including people living with dementia. There were 19 people living at the service at the time of our inspection.

People's experience of using this service and what we found

There were not always enough staff on duty to support people safely. People's care records did not always include important information about how to reduce risks associated with their care. We observed some unsafe manual handling practices at the service and pressure relieving mattresses were not correctly set to people's personal requirements. Care plans did not always include up to date information about people.

People were not supported to have maximum choice and control of their lives and staff did not 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.

Best interest decisions were not recorded for people who were assessed to lack capacity in relation to their care. Mental capacity assessments were not always carried out appropriately.

There was a lack of detail in people's care plans about their end of life care preferences. We have made a recommendation for the provider to review this.

There were gaps in management oversight and auditing at the service. Staff told us they were not always listened to when raising issues. There was a new manager in post who was not yet registered with CQC. Improvements had been made to the administration of medication and there were suitable infection protection and control procedures in place. People's needs were assessed before they moved to Cherrydale and access to health professionals was well supported.

People spoke positively about living at Cherrydale and liked the staff who supported them. People were treated kindly and had their privacy and dignity protected.

People were able to do the things they enjoyed and were supported to have contact with people who were important to them.

The provider had systems in place to enable people living at Cherrydale and their relatives to provide feedback about the service.

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

Rating at last inspection

The last rating for this service was requires improvement (published 10 February 2021). Breaches of legal requirements were found in relation to the safe care and treatment of people. 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

This was a planned inspection based on the previous rating.

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 COVID-19 and other infection outbreaks effectively.

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 monitor the service and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, people consenting to care, safe staffing and the governance of the service.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Cherrydale

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

This inspection was carried out by two inspectors.

Service and service type

Cherrydale 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 had a new manager in post who was not yet registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

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 professionals who work with the service. 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.

During the inspection

We spoke with five people who use the service about their experience of the care provided. We spoke with five members of staff including the manager, senior care worker and care workers. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. Following our initial visit, the provider sent us a variety of records to review away from the service. These related to staff training and the management of the service, including policies and procedures.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at further records, including details from a recent visit from Surrey Fire and Rescue service. We spoke with three relatives of people who live at the service.



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

At our last inspection we found medicines were not always administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risks to people were not suitably managed. There were several people living at the service who had been identified by Speech and Language Therapists (SALT) as being at risk of choking and required food to be prepared to a certain consistency. We saw that people's food was prepared to the correct consistency as the staff on duty knew what was required, however there were no risk assessments in place for these people to help mitigate the risk of them choking.
- Safety equipment was not always being used effectively. Several people were using pressure relieving mattresses to protect them from the risk of pressure damage. To function effectively pressure relieving mattresses must be set according to the weight of the person using them. However, we found that two people's mattresses were set at over 20kg more than their last recorded weight. There was no evidence that this had led to people developing pressure sores.
- Records showed that staff were carrying out daily checks of the pressure mattresses however they recorded that there were no concerns without checking that the mattresses were set correctly.
- We observed poor manual handling practices being carried out. During the inspection we saw two people being lifted under their arms by staff when transferring from their wheelchairs to another seat. Underarm lifts can be dangerous to the person being transferred as well as to the staff member lifting them.
- One person's care plan stated they needed encouragement and prompting when eating and they had lost 5kg over the previous two months, it was not known what the cause of this weight loss was. We saw this person sitting in the lounge at lunchtime not eating their meal which had been placed in front of them. After several minutes he was assisted to eat by the manager.
- We found the door to the laundry room had a sign on it stating it should be kept locked at all times as the room contained substances which could be harmful. We checked several times through the day and found this door to be unlocked each time, including when staff were not working in there.
- Care plans did not contain enough information about people's needs and preferences. For instance, one person's initial assessment stated that they suffered from depression but their care plan did not provide any detail about how to support them with this. Another person's moving and handling assessment referred to

them having a catheter however this had been removed for some time.

- Following our inspection, Cherrydale was visited by the fire service who advised that staffing levels at night were lower than what was recorded in the fire risk assessment and this could impact on the staff's ability to carry out a successful emergency evacuation. We discussed this with the provider who advised they will review this with the fire service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements had been made to medicines management since our last inspection. Medicines were administered in line with relevant national guidance and in accordance to people's care plans.
- Staff had received relevant training before they were able to administer people's medicines and the manager checked their competency regularly in relation to this.

Staffing and recruitment

- We received mixed feedback from people about the availability of staff. One person told us, "There are always staff around." However, another person said, "There is not enough staff. They have too much to do."
- Several members of staff also told us that staffing levels were too low at busy times. One member of staff told us, "There are not enough staff in the mornings." Another member of staff said, "Sometimes we have to leave people in bed for longer...it is very busy at the moment. We seem to have a lot of [people requiring two carers]. We need another member of staff in the mornings." Staff told us they had raised these concerns with manager but had been told that staffing would not be increased.
- We discussed the staffing numbers with the manager who told us they were in agreement with staff about the need for additional staffing during busy periods. The manager told us that she was frequently having to help out with people's care in order to support staff.
- We observed that at busy times of the day people were sometimes left sitting in the lounge without staff there to engage with them. There was an activities co-ordinator on duty in the morning of our inspection, but they spent a considerable amount of time getting people drinks as there were no other staff to do this. This meant they did not have time to engage with people in meaningful activities.
- At lunchtime there were not enough staff available to support people who needed help to eat their meals. We saw one member of staff supporting two people to eat at the same time due to the lack of staff available. This is poor practice and increases the risk of infection being spread in the service.
- The manager told us "The workload is very heavy here" and that the staff team did not have time to help with tasks such as writing care plans. The manager also said that she was on call for the service seven days a week without a break from this until a new senior carer could be recruited.

The failure to ensure there were enough staff to meet people's needs was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were recruited safely. Checks included verification of identity, references from previous employers and the Disclosure and Barring Service (DBS). DBS checks are important as they help prevent people who may be unsuitable from working in care.

Preventing and controlling infection

- 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 admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- Although there was regular cleaning taking place, we found some areas where improvements were required including the laundry room and a wheelchair which was stored downstairs and was visibly dirty.

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People and their relatives told us they felt safe living at Cherrydale. One relative told us, "I have never had any worries about [person] being there." Another relative told us, "They look after [person] very well. No worries on score."
- There were systems in place to protect people from the risk of abuse. Staff were provided with training to recognise the signs of abuse and were confident in how to identify and report any safeguarding issues if needed. One member of staff told us, "If there was an accident or unwitnessed fall, or bruises I would tell a senior or the manager and do a body map. It could be a safeguarding [concern] if the bruises were new."
- We reviewed safeguarding records and found concerns had been appropriately investigated, responded to and information was shared with the relevant organisations including the CQC and the local authority.

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.

At our last inspection we found effective MCA systems were not in place. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11

- There was no evidence of best interest decisions taking place for people who were assessed to lack capacity in relation to elements of their care and support needs. One person had a consent to care form signed by their relative, however there were no capacity assessments recorded to establish that the person was unable to consent to care themselves.
- Where mental capacity assessments had been carried out, these often covered several unconnected elements of people's care. Therefore, these were not compliant with national guidance as they were generalised and not decision specific.
- We observed people's walking frames stored away from them when they were sitting in the lounge area. This restricted people's ability to be able to get up independently and move around.

The failure to ensure mental capacity assessments and best interest decisions took place appropriately was a continued breach of regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

- Staff asked for people's agreement before supporting them with personal care and other tasks. People using the service confirmed that this was the case.

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

At our last inspection we found that the premises were not maintained to a satisfactory standard. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

- People told us they were happy with their bedrooms and the communal areas. People had personalised their bedrooms with their own decorations, pictures and ornaments
- The provider ensured the design and layout of the home was suitable for people living there. Communal areas were comfortable and homely. The bathrooms were suitably equipped to meet people's mobility needs.
- The manager informed us that plans are in place to replace all flooring in communal areas in the coming months.

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

- The manager had carried out assessments of people's needs before they moved into Cherrydale to ensure they could meet their needs. Assessments from health and social care professionals were also used to plan effective care.
- Assessments guided by national framework and standards were completed to ensure that people's needs were assessed and met.

Staff support: induction, training, skills and experience

- Staff told us they had the opportunity to raise any concerns they had with management when they needed to. One member of staff described the manager as, "supportive and kind" and said, "[Manager] is definitely someone I could go to if I had a problem."
- Staff told us they received sufficient training for their roles and records supported this. For example, all staff received dementia awareness training. One member of staff told us, "The training is good. We get everything we need for the role." Another member of staff said, "I feel really confident now...I am totally up to date with my training." Although staff had been trained in how to safely support people to move and transfer, we observed staff not following good practice techniques, as detailed in safe.
- Staff received an informative induction when starting work at the service which included opportunities to meet people living at the service and time to learn how equipment worked. New staff also shadowed other staff before providing any care themselves.

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

- Food and fluid charts to monitor people's nutritional intake did not include any detail about the quantity of food or fluid consumed. This meant they were of little value in determining whether people were eating and drinking enough.
- People told us the food was good and there was plenty to eat. One person said, "[Food is] excellent. You always get a choice and the portions are ample." Another person described the food as "very good" and

said, "They give you a choice."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People told us they were supported to access healthcare services when they need to. One relative told us, "They let you know if there are any problems with [person's] health and will contact the doctor or nurse." Another relative told us, "They call out the district nurse [when needed]."
- The manager and staff team worked with healthcare professionals to ensure people's healthcare needs were met. They worked with services including GPs, social workers and community-based health professionals.
- Staff shared appropriate information when people moved between services such as admission to hospital or attendance at health appointments. This ensured people's needs were known, and care was provided consistently when moving between services.

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 now improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- We observed that staff were kind, caring, friendly and attentive. When one person became anxious and upset, staff were quick to support them. We observed staff reassuring the person and telling them they were there to help them. Staff then supported the person to speak to their family member on the phone which helped to reassure them.
- People spoke positively about the staff. One person told us, "They [staff] really do look after you. They make you feel happy." A relative told us, "We have been very happy with [person's] care."
- Staff told us they enjoyed working at the home and spoke to us about people in a way that showed they respected them. One member of staff said, "All the staff treat the residents as if they were their own mum or dad. We make sure that they are comfortable, safe and happy."
- Care records noted people's religious or cultural needs. People's birthdays, and religious or cultural events were celebrated at the service.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to make decisions about their own care. One person told us, "[Staff] ask you what you want... Sometimes I want to stay in bed a bit longer and I can do that." Another person said, "I can do what I want to do. If I don't want to be disturbed, then I won't be."
- Records we reviewed demonstrated people were consulted about the care and support they required. While some people's needs impacted on their ability to make decisions, staff made every effort and encouraged people to make daily choices and involved them in doing so.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was supported during lunch time by the use of aprons. However, we raised the use of plastic aprons with the manager and discussed the benefits of using a more dignified piece of equipment such as clothes protectors.
- Staff respected people's privacy. We observed staff knocking on people's doors before entering their room and closing their doors before supporting them with personal care.
- We observed staff supporting a person discretely and with respect when they required assistance to go to the bathroom.
- People were supported to remain as independent as possible. One member of staff told us. "I ask [people] to do as much for themselves as they can. We encourage them to be as independent as possible."

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 now improved to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- No one was receiving end of life care at the time of our visit. People had some basic information about their end of life wishes recorded in their care plans such as whether they had a 'do not resuscitate' order in place and any funeral arrangements. However, there were no further details about people's preferences for their end of life care.

We recommend the provider consider reviewing the information they hold about people's end of life care preferences.

- We observed that people's care was person-centred and individualised. People were supported by staff who knew them well. One relative told us, "Staff are very friendly. [Person] has a great rapport with them." Another relative said, "They let [Person] choose what she wants to wear, they help to put her jewellery on."
- Staff supported people to follow their preferred routines for daily living. Staff we spoke with knew people's needs and preferences well. One member of staff told us, "I look at their care plan and I try to talk to them and talk to their families to get to know what they want and what they need."

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.

- People's communication needs, and preferences had been identified in their care plans and were followed by staff. For instance, one person's care plan explained how their communication needs were affected following a health issue. One relative told us, "Staff and [Person] have developed good communication and a rapport."
- During the COVID-19 pandemic, staff had supported people to use various electronic communication devices, such as tablets and mobile phones, to keep in touch with family and friends who were unable to visit the care home in-person.

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

- People were supported to do things which were meaningful to them. A relative told us, "They regularly do her nails which she would love as she was always well turned out." One person enjoyed playing cards and

staff supported them with this when they had time to do so.

- Staff had planned and supported people with different activities. During our inspection people were being supported to write Christmas cards to friends and family.

Improving care quality in response to complaints or concerns

- People and their relatives told us they knew how to make a complaint if they needed to and they felt confident that these would be dealt with appropriately.
- The provider had a complaints policy which detailed how people could raise concerns if they were dissatisfied with the service they received and the process for dealing with it.



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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Quality monitoring systems were not always effective. Audits of care records were carried out in some key areas, but these had not identified issues such as the checks on pressure mattresses being ineffective or the lack of best interest decisions being recorded.
- There had been no auditing of accidents and incidents which had taken place since September 2021. This meant there was no analysis to look at possible trends with concerns including people's falls.
- As reported in safe, a room with hazardous substances was left unlocked. We also saw that there was a large container of laundry powder in this room left with the lid removed in an open cupboard. No one had taken responsibility throughout the day to check that this room was locked and there was no system in place to ensure this task was delegated to a staff member. We mentioned this to the manager who was unsure whose responsibility it was and asked a member of staff to lock the door.
- There was not an effective system in place to review staff dependency. There had been an increase in the needs of the people living at the service which had led to difficulties for staff to provide people's care in a timely way. Staff told us they had raised this with management but had not had a response to their concerns.
- The last recorded date for a staff meeting had been five months previously but this was cancelled. The manager told us that a more recent staff meeting had been held in October 2021 however there was no record of what had been discussed. This meant it was not possible to review any actions from the meeting that had been agreed.
- There was a new manager in post at the service. They had been there for around six weeks at the time of our inspection and had not yet applied to register with the CQC. The manager told us she was in the process of doing this.
- We received mixed feedback from staff about support from the manager. One member of staff told us, "[Manager] is very supportive and kind. Definitely someone I could go to if I had a problem." However, other staff told us that a recent change in management had meant that there was less support available.

The provider had failed to implement effective systems and processes to assess and monitor the service. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Legal responsibilities were being met and notifications to relevant agencies were submitted in a timely

way to ensure effective external oversight and monitoring of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Records showed that residents meetings took place regularly with the opportunity for people to raise any concerns they had and discuss topics such as planned activities and what they would like to see on the menu.
- Regular surveys had been sent out to relatives giving them the opportunity to give feedback on the service and relatives told us they were kept involved with people's care. One relative told us, "We have asked them to check for a [health need] and they have done that as [Person] is liable to those." Another relative said, "When [Person's] leg was bad I could ring up and ask how she was getting on and they were very open with me."
- Staff had worked closely with health and social care professionals to support people's health and well-being. When people needed support from services such as district nursing and chiropody these were arranged promptly.

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; Continuous learning and improving care

- The manager understood their responsibilities regarding the duty of candour. They worked openly with families and kept them updated. Staff and people living at the service told us they felt comfortable raising any queries with the manager, and that the culture was an open one.
- The staff had taken part in supervision meetings where they had reflected on their work and how they could make improvements and learn from things that had gone wrong.
- The manager and staff showed commitment and enthusiasm to improve the service for the benefit of people using it. A member of staff told us, "We always put people at the forefront."

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	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff on duty to meet the care requirements of the people living at the service.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act 2005 in relation to people who lacked capacity to make an informed decision about their care.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were some unsafe practices taking place and there was not enough information available to staff to mitigate risks to people.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems and processes to assess and monitor the service.

The enforcement action we took:

Warning Notice