Mrs Lorraine Wakerley

# The Lodge

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service: The Lodge provides accommodation and personal care for up to 20 older people who need 24 hour support and care. At the time of our visit 15 people were using the service.

What life is like for people using this service:

People who live at The Lodge were placed at risk of not having their needs met in a timely way or in line with their preferences. This is because the provider was not deploying sufficient numbers of staff.
The environment was poor and in need of attention in order for it to promote people's dignity.
People were not supported to remain engaged and did not have appropriate access to meaningful activity.
People were not offered a choice of good quality, nutritional meals. The service did not identify people's risk of malnutrition and take action where people lost weight.
Improvements were required to end of life care planning in line with best practice guidance.
The information in care plans and risk assessments was conflicting and in some cases did not reflect people's current needs.
Medicines were not stored, managed and administered safely.
The service was not clean and there was an intermittent hot water supply.
The provider and registered manager had failed to act on the findings of our previous inspection on 7 and 13 November 2019. The service provided to people had deteriorated further which placed people at risk of harm.
Prompt and appropriate actions were not taken between our three inspection visits to address serious concerns which placed people at risk of harm.
The service could not evidence that they consulted other healthcare professionals on some occasions where this would've been appropriate.
People and their representatives were not involved in the planning of their care and had not been given recent opportunities to feedback on the service they received.

See more information in Detailed Findings below.

Rating at last inspection: Requires improvement (Report published 21 December 2018).

Why we inspected: This inspection was carried out as a result of concerns we received about the safety of the service.

Follow up: Following the inspection we urgently raised our concerns with the local authority who responded swiftly to meet with the provider and discuss the concerns. People living in the service were subsequently moved to local residential homes with the support of the local authority and this service is no longer operating.

## 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 safe.

Details are in our Safe findings below.

**Inadequate**

**Is the service effective?**

The service was not effective.

Details are in our effective findings below.

**Inadequate**

**Is the service caring?**

The service was not always caring.

Details are in our caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not responsive.

Details are in our responsive findings below.

**Inadequate**

**Is the service well-led?**

The service was not well-led.

Details are in our well-led findings below.

**Inadequate**

# The Lodge

**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. This inspection was planned in response to concerns. Initially this was a focused inspection to look at specific areas. However, after identifying concerns in other area's the inspection was widened into a full comprehensive inspection to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The first two visits were carried out by two inspectors and our final visit was carried out by an inspector and inspection manager.

Service and service type:

The Lodge is a care home for older people, some of whom may be living with dementia. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided in line with the Health and Social Care Act 2008 and associated Regulations.

Notice of inspection: This inspection was unannounced.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We reviewed concerns that had been raised with us about the service. We used all this information to plan our inspection.

During the inspection, we spoke with three people who used the service and one relative to ask about their

experience of the care provided.

We spoke with the registered manager, two deputy managers, three care staff and two external health professionals. We looked at nine records in relation to people who used the service. We also looked at staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality.

Inadequate

# Is the service safe?

## Our findings

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

People were not safe and protected from harm. Regulations were breached.

At the previous inspection on 7 and 13 November 2018 the service was rated Requires Improvement in this key question. The service was found to be in breach of Regulation 12 because medicines were not managed safely and risks to people were not always planned for and managed appropriately.

At this inspection we found the service had deteriorated further and there remained a breach of Regulation 12.

Using medicines safely

- Medicines were not stored, managed and administered safely. This included controlled drugs for which there are standardised ways of managing and administering. Concerns with the management of medicines and controlled drugs had been identified by the service's own consultant but had not been acted on appropriately.
- Concerns were identified by the Clinical Commissioning Group's medicines team, who visited on 1 May 2019. Issues were identified with the way the service managed and administered the medicines for all of the people using the service.
- The number of controlled drugs remaining in stock did not tally with the doses recorded as administered on the medicines administration record (MAR). This meant a number of these tablets were unaccounted for.
- Two medicines of which people were taking two different doses were found in the wrong boxes. It was not clear whether the correct dose had been administered due to issues in recording and monitoring stock balance. This included a high risk blood thinning medicine, where it is important the correct dose is administered each day.
- Two people had not received a number of doses of medicines because they were asleep at the time of the medicines round. Attempts were not made to administer these later or contact health professionals to see if the time the dose should be administered could change.
- Where people had not received their medicines, the service had not contacted doctors to see whether or not there was any likely negative impact on the person's health.
- Protocols were not in place for as and when medicines (PRN) to advise staff on when it would be appropriate to administer these.

Assessing risk, safety monitoring and management

- The service did not identify all of the risks to people and ensure there was information to guide staff on how to reduce the risk. For example, there were no personal evacuation plans in place for two people to advise staff on the support they would need to evacuate the building in an emergency.

•□People's risk of choking was not assessed and there were no plans in place to minimise risks. One person who had been moved into the home should have been on a soft diet but was eating solid foods. Staff could provide no evidence to demonstrate this had been signed off as being safe by a healthcare professional.
•□Staff were not consistently assessing people's risk of developing pressure ulcers. Where a risk was identified, staff failed to put in place plans to guide staff on reducing the risk.
•□Risk assessments for falls did not lead to management plans to guide staff on how to reduce the risk. Staff had not considered and obtained advice on how they should support one person who had incurred serious facial and head injuries in a fall. This included obtaining advice on whether further head injuries could cause them serious harm due to their previous injury.
•□Staff had not identified that two exterior doors in the property were not appropriately secure. The registered manager told us one person was actively wishing to leave the service, but it would be unsafe for them to do so unaccompanied. Due to the doors being inscure, there was a risk people could leave unaccompanied. There was also a risk that unauthorised persons could enter the building without staff knowledge.

Preventing and controlling infection

•□The service was not clean. Carpets were soiled and dirty. The seat on one person's specialist chair was stained brown. Communal chairs were not clean and there was food debris on them. There was a malodour in parts of the building.
•□The kitchen was not clean. Appliances such as ovens, kettles and toasters were visibly dirty. As were areas where food, cutlery and crockery were stored.
•□There was an intermittent supply of hot water. It took two minutes and ten seconds for hot water to flow through the taps in the handwash basin in the kitchen. This was also the case in bathrooms. This could contribute to the potential for spread of infection.

Learning lessons when things go wrong

•□Accidents and incidents were not always appropriately recorded. Incident records could not be provided for two falls one person had experienced which resulted in an admission to hospital.
•□The registered manager and provider had not learned from previous breaches of regulation which placed people at risk of harm.
•□The registered manager and provider failed to fully address concerns we raised between our three inspection visits. This meant people continued to be placed at risk of harm.

All of the above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

•□The provider failed to deploy sufficient numbers of staff. Following concerns about staffing at our last inspection, the provider assured us they were taking action by raising the staffing level. At this inspection we found the staffing level had been reduced again.
•□Dependency assessments were not carried out to determine how many staff were needed to meet people's needs safely. We were told five people required the support of two staff for all their care. Despite this, on the afternoon shift there were only two staff available to support all 15 people using the service.

These staff were also required to complete records, administer medicines and prepare people's evening meals. This meant staff could not meet people's needs in a timely and personalised manner.

•□People told us there were not enough staff to spend time with them unless it was connected to a task, such as personal care. This confirmed our observations that all interactions were task focussed.

•□Staff told us they did not have time to sit with people and this confirmed our observations that people were left alone the majority of the day.

•□The registered manager had identified through a falls audit that there was a trend in people falling between 2pm and 8pm. They told us they felt this was in part due to there being less staff available between these times.

This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□It was unclear if robust recruitment procedures were followed. This was because inadequate records were kept where people had been employed. For example, there was no identification for some people.

Systems and processes to safeguard people from the risk of abuse

•□Staff had received training in safeguarding. However, the registered manager and care staff did not take appropriate action to safeguard one person who lacked capacity to make decisions about their finances from the risk of abuse and harm during an incident that arose during one of our visits. This was despite being advised of concerns by the safeguarding team at Norfolk County Council.

This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# 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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At the last inspection on 7 and 13 November 2018 the service was rated Requires Improvement in this key question. This was because staff had not had training in all appropriate subjects, recording of people's food and fluid was not always accurate and the service was not complying with the principles of the Mental Capacity Act 2005. The service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the service had failed to make progress to comply with Regulation 11. Other area's of the service had deteriorated and people's risk of malnutrition was not managed appropriately. This constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eating, drinking and a balanced diet

•□Staff had failed to identify and appropriately act on people's weight loss. Weight records confirmed that five people had lost a significant amount of weight in the months prior to our inspection. Risk assessments had not been carried out for some people to assess their risk of malnutrition, and for others these were out of date or had not been repeated when they lost weight.
•□For example, one person had lost 8.4kg, another had lost 5.7kg and one other person had lost 7.2kg in the previous two months. Staff could not provide evidence to demonstrate appropriate action had been taken to reduce the risk of these people becoming malnourished. There were no care plans in place to guide staff on how to support them to reduce the risk of further weight loss and staff were not aware of any specific actions they should take with regard to these people.
•□The registered manager told us they were not given a budget to buy food and the provider, who lived abroad, ordered the food online for them once a month. The food provided was low cost, value food, most of which was processed such as chips or chicken nuggets. There was very little fresh food such as vegetables or fruit.
•□The service had run out of ingredients used to fortify food to increase its calorific value, such as cream on the first of our visits. We raised this with the registered manager but at our second visit there was still no ingredients to fortify food. When we asked the cook if they increased the calorific value of some people's meals, they told us they did if the ingredients were available. The registered manager told us it was not uncommon for them to run out of these or other food items. This meant we were not assured that staff were consistently following a 'food first' approach to encouraging weight gain in those who had lost weight.
•□Staff failed to meet people's individual dietary needs. One person controlled their diabetes through their

diet and their food charts evidenced a regular intake of sugary foods. The registered manager told us this was their choice but said they had not been offered any sugar free alternatives. This may have encouraged the person, who was living with dementia, to make healthier choices.

All of the above constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 with appropriate legal authority. In care homes 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•□People's capacity to make decisions was not always assessed. For example, where staff had made applications to deprive someone of their liberty, they had not first assessed their capacity in these decisions. Assessments that were carried out were generic and not person centred. Care records did not make clear what decisions people could make independently and what they required support with.
•□People's care records did not make clear who, if anyone, should be involved in supporting them with decision making. Staff did not understand a formal best interests process and felt it was their job to make decisions they felt were in people's best interests. This was without always knowing the person enough and having information about their likely preferences. Decisions made in the best interests of those who lack capacity should be made in conjunction with other persons such as healthcare professionals and relatives to ensure they are lawful.

This constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

•□Whilst people's needs were assessed before they came to live at the service, these assessments did not lead to the recording of sufficient information to guide staff on how to meet their needs. For example, for one person there was only one sentence in their nutrition care plan which didn't reflect all the support they required.
•□Assessments were not reviewed regularly to ensure people's care met their current needs. This meant staff did not identify where people's needs changed and did not implement changes to care plans as a result. For example, where people's mobility needs changed.
•□People's care records did not reflect best practice guidance such as is produced by the National Institute for Health and Care Excellence (NICE) guidance which is publicly available.

This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

•□Whilst staff had received training in key subjects, they did not display a full understanding of subjects they had been trained in. For example, medicines were not managed and administered safely. Staff displayed a lack of knowledge and understanding of the Mental Capacity Act and did not act accordingly to protect one person from the risk of abuse. Issues in staff competency had not been identified and acted on by staff.
•□The supervision record for one staff member stated they had raised concerns about not being confident in using the hoist or supporting people to eat in case they choked. There was no evidence staff had taken action to ensure this staff member felt comfortable in this area. They also failed to ensure care records contained sufficient information for staff to know what specific equipment to use for people.
•□Staff told us they felt supported in their role. However, they did not demonstrate that they had been given adequate opportunities to develop in their role and improve their skills.

This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

•□The environment of the service, including communal areas and people's bedrooms, was poor. The building required decoration to ensure it upheld people's dignity.
•□Improvements were required to make the environment easier to navigate for people living with dementia. For example, the décor was the same throughout the building so it was difficult for people to distinguish between corridors. There was no signage or decoration on people's bedroom doors so they could identify their bedroom.

Supporting people to live healthier lives, access healthcare services and support

•□Whilst there was evidence staff contacted health professionals for advice on some occasions, they could not demonstrate they had on other occasions where it would have been appropriate. For example, where people lost weight.
•□Records were not always kept of visits people had with health professionals so it was unclear what advice was given and how this could feed into care planning.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were not always well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At the last inspection on 7 and 13 November 2018 the service was rated 'Requires Improvement' in this key question. This was because people were not consistently involved in the planning of their care and people were not always supported to communicate according to their ability.

At this inspection we found that the the service remained 'Requires Improvement' in this key question as the provider had not made sufficient improvements.

Ensuring people are well treated and supported; equality and diversity

•□Whilst people told us staff were kind to them and we observed that staff were intuitively caring people, the widespread failures in the service and shortfalls in staff practice meant people were not always well treated and did not receive the support they needed.
•□The registered provider and manager had failed to make improvements following previous inspections, and this meant people had been receiving substandard care and treatment over an extended period of time. This was not caring.
•□The provider had failed to ensure sufficient improvements were made in a timely way which would ensure people had a better quality of life. They failed to provide the financial backing to improve the environment, provide good quality food, provide sufficient numbers of staff and to provide people with opportunities to engage in activity. This meant we were not assured that the provider ensured people were well treated and supported.

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

•□Staff had failed to make improvements to reflect the involvement of people and their representatives in the planning of their care.
•□There was no evidence to demonstrate that people were supported by staff to understand their healthcare options or express their views on their care and how this should be delivered.

Respecting and promoting people's privacy, dignity and independence.

•□Staff did not always treat people with dignity and respect. Staff showed limited understanding of people who presented behaviour they found challenging. A staff member wrote in the daily notes for one person that they had told them they would "behaviour chart them because of their behaviour". This did not promote this persons dignity and respect and demonstrated a lack of understanding from the staff member.

•□A note in another person's daily notes described in unpleasant terms that they had become agitated, shouted at staff and refused to wait until they finished vacuuming. The time of this incident was noted as 2am in the morning.
•□Care records did not make clear the tasks people could carry out independently and what they required support with. This means we were not assured people were supported to be as independent as possible.

Inadequate

# Is the service responsive?

## Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

At the last inspection on 7 and 13 November 2018 the service was rated 'Requires Improvement' in this key question. This was because care plans were not always sufficiently detailed, there were no adequate end of life care plans in place and care plans were not updated where people's needs changed.

At this inspection we found that the service had deteriorated in this area. It is now rated 'Inadequate' in this key question.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•□Following the last inspection, the provider told us that they would be switching from their current electronic care planning system to paper care records. At the time of our visit this was still ongoing and there was no one place for staff to access information about people.
•□The registered manager told us staff could either refer to the person's electronic care records, paper record or a risk assessment folder. However, the electronic records had been archived so they were difficult to access. The paper records we reviewed were very brief, not personalised and did not contain sufficient information for staff to provide people with personalised care.
•□The information contained in care plans and risk assessments often conflicted which increased the risk of people receiving incorrect care. For example, the care records for two people stated they could mobilise with a stand aid but we observed and the registered manager confirmed they now required the use of a hoist.
•□People's needs were not reviewed regularly which meant that changes in their needs were not reflected in care planning. For example, the care plans for five people did not reflect their recent weight loss and how this should be managed. The nutritional supplement for one person had changed but their records had not been updated.
•□Care plans were not in place for people's specific needs, such as for those who had diabetes, epilepsy or other conditions. This meant staff did not have information to refer to about any specific individualised support they may require.
•□Care records for those with limited verbal communication did not make clear their preferences or information about their past likes and dislikes. There was no information for staff about the other ways they may communicate their needs, such as via body language or facial expression.
•□The service no longer had a member of activities staff and people looked socially isolated and disengaged throughout our inspection visits. The provider had not increased the staffing level to ensure staff had time to spend with people and engage them in activity.
•□People told us staff did not have time to spend with them and they did not see them unless they had a task to complete. We observed people spent the majority of their time alone and disengaged. Care records did not state what people liked to do with their time and what support they required to follow individual

hobbies and interests. We observed one person seated in the lounge alone throughout all three of our visits. The only activity recorded on their activity chart was 'Television' every day that week. It was not clear whether this was their choice as there was no information in their care records about activity and engagement. The person had limited verbal communication and may not have been able to reflect their preferences and the support they required to remain engaged and stimulated on a day to day basiss.
•□The registered manager told us they had no budget for activity and no money to organise external entertainers to come in or purchase materials for activities.

End of life care and support

•□Care planning around end of life care and support was still not in place. The registered manager told us one person had been returned from hospital for 'TLC' and they were told the person would not benefit from further hospital admissions. Despite this, there was no end of life care planning in place for them to reflect their preferences nor the complex physical needs staff would need to meet as they approached the end of their life.

All of the above constitutes a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

•□There was a complaints policy in place at the time of our visit. No formal complaints had been recorded.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection on 7 and 13 November 2018 the service was rated Requires Improvement in this key question. This was because improvements were required to the quality assurance system to identify shortfalls which could be acted upon. The service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the service had deteriorated further and there were widespread shortfalls across all areas of service provision. The service is now rated 'Inadequate' in this key question and remains in breach of Regulation 17.

The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. Services in special measures 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.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider has a history of non-compliance with fundamental standards and regulations with this and another two services they previously owned. Despite being reminded of their responsibilities and the concequences of failing to meet the required standards, they have failed to bring about sufficient improvement.
- The provider failed to inform the Commission that they no longer had a presence at the address they registered with us. Important correspondence sent to this address was returned. This was a breach of Regulation 15 of the Care Quality Registration Regulations 2009.
- The provider failed to deploy sufficient staff, provide activities, improve the environment and buy sufficient quantities of good quality food. This meant they were not promoting high quality care and support.
- Organisations supporting the service continued to raise concerns about the quality of the care people received.
- Following our previous inspection, the provider had employed a consultant to carry out audits of the service. They continually raised concerns about the quality of the service but these had not been fully addressed.

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

regulatory requirements

•□The registered manager had failed to bring about prompt, sustained and meaningful improvement in the service. Standards had deteriorated since our previous inspection and the registered manager did not inform us they had failed to comply with regulations by the deadline on the action plan they supplied.
•□The registered manager, deputy managers and staff failed to identify risks to people and take action to protect them from harm. There were no clear lines of accountability in the service and responsibility was not taken for the failings that led to people receiving poor care.
•□Whilst the manager had implemented some quality assurance systems following our previous inspection, these had been ineffective in improving the service. Where issues were identified, these had not always been acted on. For example, the registered manager had identified there was a trend in falls occurring between certain times but it was unclear what action they had taken with regards to this.
•□The registered manager, deputy managers and other staff failed to act on concerns we raised in a timely way. This meant that actions were not always taken between our three visits to put in place measures to reduce the risk of people coming to harm.

Continuous learning and improving care

•□Whilst the registered manager had made attempts to implement a more robust quality assurance system, this had been ineffective in improving the service and where issues were identified, these were not always acted on.
•□The provider has a history of non compliance and failing to meet standards and regulations. Despite this, they failed to learn from these experiences and ensure they provided a better service to people living at The Lodge. This meant people continued to receive poor care and experience a poor quality of life.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•□The registered manager told us despite many attempts, people and their relatives chose not to attend meetings. We were satisfied with the attempts they had made, including offering incentives such as attaching meetings to activities such as a tea party.
•□People had previously had an opportunity to feedback their views through a survey. This had not been completed for some time but the registered manager told us they were due to repeat this.
•□Staff meetings had been infrequent and the registered manager said they were poorly attended. This meant it was unclear how the staff team were developed and how key messages were fed back to the staff team.

Working in partnership with others

•□The registered manager had good relationships with other healthcare professionals. One healthcare professional we spoke with made positive comments about the registered manager. However, they also stated that sometimes the service appeared disorganised and chaotic.

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 15 Registration Regulations 2009 Notifications – notices of change<br><br>(1) The registered person must give notice in writing to the Commission, as soon as it is reasonably practicable to do so, if any of the following events takes place or is proposed to take place—<br>(e) where the service provider is a body other than a partnership—<br>(i) a change in the name or address of the body, |

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>1.The care and treatment of service users must—<br>a.be appropriate,<br>b.meet their needs, and<br>c.reflect their preferences.<br><br>2.But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11.<br>3.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;<br>b.designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;<br>c.enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a |

competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;
d.enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible;

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>11.—<br>1.Care and treatment of service users must only be provided with the consent of the relevant person. |

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>1.Care and treatment must be provided in a safe way for service users.<br>2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment;<br>b.doing all that is reasonably practicable to mitigate any such risks; |

**The enforcement action we took:**

Urgent notice to restrict admissions.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>1.Service users must be protected from abuse and improper treatment in accordance with this regulation.<br>2.Systems and processes must be established and operated effectively to prevent abuse of service users. |

3.Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>1.The nutritional and hydration needs of service users must be met.<br>2.Paragraph (1) applies where— a.care or treatment involves—<br>the provision of accommodation by the service provider, or<br>an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or<br>b.the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.<br><br>4.For the purposes of paragraph (1), "nutritional and hydration needs" means— a.receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,<br>b.receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,<br>c.the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and<br>d.if necessary, support for a service user to eat or drink. |

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. |

2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a.assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
b.assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
c.maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

**The enforcement action we took:**

Urgent notice to restrict admissions

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.<br>2.Persons employed by the service provider in the provision of a regulated activity must— a.receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,<br>b.be enabled where appropriate to obtain further qualifications appropriate to the work they perform |

**The enforcement action we took:**

Urgent notice to restrict admissions