Alexandra Care (Leicester) Limited

Dane View Care Home With Nursing

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dane View Care Home with Nursing is a residential care home, providing personal or nursing care to up to 41 people, some of whom are living with dementia care needs. At the time of inspection, 36 people were living at the service.

People's experience of using this service and what we found
People were not always kept safe by the use of an effective safeguarding system and safeguarding incidents were not always reported to the local authority. Risks related to people's health care needs were not well managed and people were at potential risk of harm due to poor health and safety management.

People's prescribed 'as and when' required medicines were not managed safely and there was a lack of guidance for staff. Medicines were not always safely stored, and people were not always supported with their medicines by competent staff.

Staff were not always deployed effectively or responsive to people's needs. The provider did not always ensure staff were suitable for their role by obtaining employment references and certificates of relevant qualifications.

People's privacy and dignity was not always promoted during personal care, support with meals, and by the completion of health and safety checks whilst people slept.

People's needs were not always identified through the effective use of assessment tools and risk assessments did not always consider people's health conditions.

The provider failed to ensure staff were supported through supervision or performance monitoring.

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. People's care plans did not always reflect the outcomes of capacity assessments or authorised deprivation of liberty safeguards and conditions.

The garden and grounds were rarely accessed by people living at the service and activities rarely made use of the available spaces within the service.

People and their relatives raised concerns about the quality of food and the lack of available options. People who required specialist diets were provided with meals appropriate and safe for their needs.

Quality assurance systems were not effective and service oversight was poor. The registered manager

welcomed support and guidance from external professionals, but this was not aways implemented to improve the care people received.

Relatives were not always involved in the planning of their family members' care and feedback indicated there were issues around communication and organisation.

Staff told us the registered manager was approachable and helpful. The registered manager was open and forthcoming throughout the inspection and was aware of their legal responsibilities in relation to duty of candour.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 May 2021).

Why we inspected
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.

We received concerns in relation to end of life care, service management and people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective, and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dane View Care Home with Nursing on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to dignity and respect, consent, safe care and treatment, safeguarding people from abuse and improper treatment, governance, staffing and the employment of fit and proper persons, at this inspection. We have sent the provider 3 warning notices, and 4 requirement notices, to request improvements are made.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Dane View Care Home With Nursing

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 Health and Social Care Act 2008.

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

Inspection team
The inspection was completed by 3 inspectors. 1 inspector was a pharmacist specialist.

Service and service type
Dane View Care Home with Nursing 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The first and second day of the inspection visits to the care service were unannounced. The third inspection visit was announced, and we gave the service approximately 16 hours' notice.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the service on 3 separate dates to complete the inspection. We checked the environment on each site visit.

We spoke with 6 people living at the service and 4 relatives, to gain feedback on their experiences of using the service. We spoke with 12 staff including the registered manager, the clinical lead, care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a selection of records including 10 people's care files and multiple medication records. We looked at 5 staff files in relation to recruitment and reviewed the providers monitoring documents for staff training and supervisions for all staff. A variety of records relating to the management of the service, including policies and procedures were examined.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People were not always kept safe by the use of an effective safeguarding system. Safeguarding concerns were not always recorded and appropriate actions were not always identified to promote safety. For example, injuries sustained as a result of falls were not always reported to the local authority and records were not always completed. This meant people were at risk of harm.
- There was a lack of incident reporting and there was no analysis to look for trends, triggers and root causes to identify measures to prevent reoccurrences and improve safety for people. This meant opportunities to learn lessons went things went wrong were missed.
- Some relatives told us they did not feel their family members were always safe.
- Staff were trained in safeguarding and understood how to identify abuse and report concerns, however, we identified safeguarding incidents that had not been reported to the local authority. This meant the provider failed to keep people safe through a lack of required concern escalation.

The provider failed to protect people from improper treatment and abuse through the use of effect systems and processes. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks related to people's health care needs were not well managed and people were at risk of harm. For example, people were at risk of developing new pressure related injuries and pre-existing wounds were at risk deterioration due to a lack of repositioning and poor wound care management. We raised these concerns with the provider, and they took action to reduce urgent risk. However, these improvements had not been embedded into practice at the time of our inspection. This meant people remained at risk of harm.
- People were at risk of falls. There was a lack of guidance in place for staff to ensure people were supported to mobilise safely. We observed one person being supported by staff in an unsafe manner and found their care plans did not reflect their current needs. We raised these concerns with the provider, and they took action to review this person's documentation and increase staff observations of moving and handling practices. However, further action was required to ensure people's falls risk assessment and care plans were up to date and relevant to people's needs, to ensure safe care.
- People were at potential risk of harm due to poor health and safety management. Uncovered radiators in the main lounge and hair salon were hot to touch, presenting a burn risk to people if they fell or had prolonged contact. We raised this concern with the provider, and they took appropriate action to reduce the risk, however, this was reactive to us raising concerns.

Using medicines safely

● People prescribed 'as and when' required medicines were not managed safely. One person was frequently receiving more than their prescribed dose of their 'as and when' required medicine. The nursing staff and the registered manager had failed to identify this unsafe practice, which put the person at prolonged risk of harm.

● There was a lack of guidance for staff on how to support people with their medicines. Care plans and medicines protocols lacked essential information about people's care needs and the potential side effects of certain medicines. This put people at potential risk of harm as staff did not have access to essential information about people's care.

● People were not always supported with their medicines by competent staff, and we found medicines incidents had occurred. For example, a person's medicines were found on the floor by the inspection team, indicating an unsafe administration. The administrating staff member on duty had not been assessed as competent, despite the provider's policy outlining this as a requirement of the registered manager to ensure safe care. People were exposed to risk of harm as a result of staff not being assessed as competent to administer medicines safely.

● Medicines were not always safely stored. Fridge temperature checks indicated the storage of medicines exceeded the required range, and no mitigating action had been taken by staff. This meant people were at risk of receiving potentially ineffective medicines due to unsafe storage.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. A chair contaminated with faeces had been left in a stair well. Handrails and hand contact surfaces were worn and exposed porous surfaces that were difficult to sanitise effectively. This presented high risk bacterial breeding areas that increased the risk of the spread of infection.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. We found clean clothes and linen were stored next to soiled and dirty washing. This presented a risk of cross-contamination.

● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. The registered manager told us staff were required to use PPE when supporting people during mealtimes. However, we observed staff did not adhere to this requirement, in-creasing the risk of cross contamination of infectious diseases.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. A kitchenette used to prepare food and drink was visibly dirty. This increased the risk of the spread of infectious diseases.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed, due to the concerns related to hygiene and cleanliness.

● We were not assured that the provider was responding effectively to risks and signs of infection. The provider failed to identify shortfalls infection prevention and control and people were at risk of the spread of infection.

● We were not assured that the provider's infection prevention and control (IPC) policy was up to date. The providers policy did not provide sufficient detail to ensure safe levels of cleanliness were maintained or the service environment was adequately monitoring for IPC related risk.

Poor risk management, the unsafe use of medicines, and poor infection prevention and control measures, put people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were sufficient numbers of staff to meet the needs of people at the service, however, staff were not always deployed effectively or responsive to people's needs. For example, we observed one person's call bell to be sounding for over 17 minutes before staff responded. People and their relatives told us they often have to wait for staff. One person told us, "I have to wait for staff all the time. Yesterday I was in continent because I had to wait for support to get to the toilet."

● Staff retention was poor. There had been a high turnover of staff leading up to the inspection. One relative told us, "Over the past year there has been a worrying turnover of staff. Morale is low. High calibre and experienced staff have left or have been dismissed." The provider acknowledged they were experiencing challenges recruiting nursing staff and told us some staff had left the service due to relocating or seeking other employment.

● Staff recruitment processes were not safe. The provider did not always obtain employment references for staff responsible for the delivery of clinical care activity. This meant the provider could not be assured staff had the required experience to fulfil specialist roles safely.

● Full employment histories were not always obtained and gaps in employment histories were not always fully explained. This is a regulatory requirement of all providers.

● The provider did not always obtain certificates of relevant qualifications. This meant the provider could not be assured staff possessed the required skills for the recruited role.

The provider failed to ensure staff had the qualifications, competence, skills and experience necessary for their role. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider completed DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

● People had access to visitors. However, feedback from relatives indicated they often had to wait by the entrance for prolonged periods due to a lack of staff availability.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

- People's privacy and dignity was impaired by the completion of health and safety checks. Radiator temperature checks were completed whilst people were asleep in their private bedrooms. We raised this with the provider, and they told us they would address the issue.
- People described that staff don't always treat them with dignity and respect. One person told us, "Sometimes I feel rushed in the morning and staff can be a bit bossy."
- During mealtimes, people were not always treated with dignity and respect. We observed staff supporting multiple people with their meals at the same time. The registered manager was not aware this poor practice was taking place during the inspection and confirmed staff should only support one person at a time with their meals to promote dignity and safety.
- There was a lack of staff training on dignity and respect. Only 8 out of 46 care staff had completed training in dignity and respect.

The provider failed to ensure people's dignity and respect was protected. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's needs were not always adequately assessed. Admission assessments did not always sufficiently explore people's needs and risk assessments did always reflect their needs accurately. This placed people at potential risk of harm.
- The provider had not ensured key information about people's health was present in their care plans. Information contained in people's care plans was not clear and some information was contradictory. This placed people at risk of not having their needs met.
- Admission assessments considered people's individual characteristics such as disabilities, personal choices, and religious and cultural beliefs.

Staff support: induction, training, skills and experience

- People were not supported by suitably trained staff to meet their needs. The provider's staff training matrix showed only 1 out of 46 care staff had completed training on palliative care; only 2 out of 46 care staff had completed training on continence care; and 22 out of 46 care staff had completed training on pressure area care. People were at immediate risk of harm as staff did not have the skills and knowledge required to

deliver safe care.
● One relative told us, "I do not feel the staff have proper training or the necessary guidance and support to deal with some of the residents."
● Staff inductions were not always fully completed or suitable for the role. For example, inductions did not consider responsibilities related to the safe delivery of clinical care. This meant staff were not always aware of their roles and responsibilities.
● People were not always supported by competent staff. Staff administering medicines had not been assessed as competent and we identified medicines errors. This put people at risk of harm as the provider could not be assured staff had the required skills and knowledge to ensure safe medicine practices.
● The provider failed to ensure staff were supported through supervision or performance monitoring. Some staff had not received managerial supervision or spot checks. This meant the provider could not be assured that staff performance was safe.

The provider failed to ensure staff were appropriately trained and competent. Staff did not receive suitable inductions or support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained in Equality and Diversity and demonstrated knowledge in this area. Staff understood what was important to people and had knowledge on their personal wishes and choices.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider was not working within the MCA principles. People who received their medicines covertly, as instructed by a medical professional, had not been identified to lack capacity through an MCA. This meant their right and ability to consent to treatment had not been considered. Moreover, best interest decisions had not fully considered least restrictive practices.
● People's care plans did not always reflect the outcomes of capacity assessments or authorised deprivation of liberty safeguards and conditions. This meant staff did not have access to relevant guidance on how to support people in relation to consent and where authorised restrictions were placed on people's lives.
● One relative told us the wrong health condition had been recorded as the cause of their family members cognitive impairment within their DoLS assessment. This meant the provider was unable to assess and meet their needs effectively.

● Not all staff were trained in MCA or DoLs, and some staff lack knowledge in this area.

The provider failed to act in accordance with The Mental Capacity Act 2005, when people were unable to give consent due to a lack of capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care

● Advice from health care professionals was not always reflected in the care people received. Guidance from the Tissue Viability Team in relation to wound management was not always followed by care staff, and there was a lack of intervention from the management and clinical leadership team. We raised these concerns with the provider, and they provided us with an action plan detailing their intentions to improve people's care.

● Records showed there were sometimes delays in escalating health concerns to health care professionals. This led to delays in obtaining required guidance and support to keep people safe.

● The local authority provided feedback indicating they had not been made aware by the provider of some concerns related to people's care. This prevented the local authority from completing required assessments to ensure people's safety.

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

● We saw people being given a choice of meals. However, people and their relatives raised concerns about the quality of food and the lack of options given. One relative told us, "The quality of food is very poor and there is no choice. [Person] is bored of having sandwiches every day and doesn't eat them." Another relative told us, "Some meals contain strange combinations of foods."

● There was no menu available for people and they did not know what the meal options were for the day.

● People who required specialist diets due to swallowing difficulties, were provided with meals appropriate and safe for their needs. Staff understood people's specialist dietary requirements and knew how to access this information in people's care plans if needed.

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

● The service environment was not utilised to its full potential. The garden and grounds were rarely accessed by people living at the service and activities rarely made use of the available spaces within the service. One relative told us, "The lack of activities is a problem. There is no weekly schedule of activities, whatever appears to be on the boards. The lovely former chapel is rarely put to use." One person living at the service told us, "Activities don't happen very often. We have the television on but that's about the limit."

● The service was well decorated throughout, although there was a lack of personalisation in some areas including people's private bedrooms.

● There was lots of information and guidance notices available for staff in the staff only areas of the service.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Quality assurance systems were not effective. For example, care file audits did not always identify missing or incorrect information in people's care plans, infection prevention and control audits did not highlight potential risk and medicines audits did not identify repeated medicine errors. This meant shortfalls in care were not identified and were exposed people to further risk of harm and poor-quality care. Opportunities to improve people's care were missed.
- The clinical leadership team were not always aware of their role and responsibilities at the service. There was a lack of oversight of clinical care from the clinical leadership team, and they were not supported to understand their roles and responsibilities in this area. This led to people being at prolonged risk of harm due to being exposed to ongoing unsafe care practices.
- The registered manager failed to maintain effective service oversight. The system in place to monitor deprivation of liberty safeguards applications and approvals was not up to date. There was no oversight of staff competency assessments, and the registered manager did not maintain effective oversight of call bell response times or clinical care activity. The lack of effective oversight systems and processes meant short falls in care practices were not identified and people were exposed to prolonged poor care and potential risk of harm.
- There was a lack of oversight from the providers to support the registered manager. The providers engaged with the registered manager on a regular basis to provide support. However, there was no system or process in place to maintain provider level oversight of the service and provide valuable feedback to support the registered manager to develop and improve.
- Oversight of staff deployment was not effective. Staff were not always deployed effectively and were not always responsive to people's needs. There were a lack of systems and processes in place to ensure the management team-maintained oversight of staff deployment. We raised these concerns with the registered manager, and they implemented a new managerial daily walk around to improve oversight of staff deployment.

Working in partnership with others; Continuous learning and improving care

- The registered manager welcomed support and guidance from external professionals, but this was not aways implemented effectively to improve the care people received. During the inspection, there were scheduled meetings and visits from health care professionals to better understand the needs of people at the service and improve quality of care. However, learning had not always been embedded into practice. For

example, information and guidance from the tissue viability team was not always reflected in the care people received, due to a lack of quality assurance and effective managerial oversight. This people were exposed to risk of harm.

● Prior to the inspection, the registered manager had sought engagement from the Care Quality Commission to support their review of an incident. Discussions highlighted concerns in relation to the oversight of clinical care. However, no follow up action had been taken to improve oversight of clinical care and we found people were consequently at risk of avoidable harm during our inspection. The registered manager had failed to take appropriate action to ensure people received safe care.

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

● Relatives were not always involved in the planning of their family members' care. One family member told us, "I have just been made aware, not by Dane View, that there should be a care plan in place for [relative]. I do not know if this exists and have obviously not been involved with it." Another family member told us, "They did an assessment with my [relative] when they first came here but there's been nothing since." This meant the provider could not be assured the care people received was appropriate.

● People using the service were not always aware of how to raise a complaint and said staff were often too busy. One person told us, "Sometimes I get enough time, sometimes I get none. It depends how busy they [staff] are with other people. I don't know how to raise a complaint about this."

● Feedback from relatives of people using the service indicated there were issues around communication and organisation. One relative expressed difficulty arranging hospital transportation for their relative due to poor communication. They also explained there were errors in some of their relative's documentation leading to staff having incorrect guidance about their relative's health conditions.

Systems and processes were not effective at monitoring and improving the quality and safety of the service. The provider did not always seek or act on feedback from relevant persons. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff told us the registered manager was approachable and helpful. One staff member told us, "The registered manager is good, she listens if I need to say something." Another staff member told us, "I find working with [registered manager] good. She is open to suggestions; I feel comfortable raising concerns."

● Staff were not always given opportunity to raise concerns during supervision, however, regular team meetings took place. One staff member told us, "We have team meetings when I can raise concerns."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and the provider were open and forthcoming throughout the inspection. They engaged with the inspection team and were receptive to feedback.

● The registered manager was not always compliant with their legal responsibilities in relation to duty of candour. For example, the absence of an effective incident recording and reporting procedure resulted in some incidents not being reported to the relevant authorities.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people's dignity and respect was protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with The Mental Capacity Act 2005, when people were unable to give consent due to a lack of capacity.

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 The provider failed to protect people from improper treatment and abuse through the use of effect systems and processes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff had the qualifications, competence, skills and experience necessary for their role.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Poor risk management, the unsafe use of medicines, and poor infection prevention and control measures, put people at risk of harm.

The enforcement action we took:

Issued Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective at monitoring and improving the quality and safety of the service. The provider did not always seek or act on feedback from relevant persons.

The enforcement action we took:

Issued Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were appropriately trained and competent. Staff did not receive suitable inductions or support.

The enforcement action we took:

Issued Warning Notice