Galfrie Limited

The Old Hall Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 15 September 2015 and was unannounced.

The Old Hall Residential Home is registered to provide accommodation and personal care for 16 people. The registered provider told us that they normally provide care to 14 people as they no longer regularly use the two double bedrooms for two people. At the time of the inspection, 10 people were using the service.

The Old Hall Residential Home changed its legal entity on the 24 October 2014 but the service, registered manager and owner remained the same. We had previously inspected that location on the 13 February 2013 and the 13 November 2013. The registered manager and the registered provider are the same person and so for the purpose of this report we refer to them as the registered provider.

Summary of findings

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

At this inspection, we found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment that had been undergoing remedial repairs since 2013. People who lived there told us that this was a continued disruption. The environment required further remedial action and improvements in order to make it safe and secure.

Changes were also required to ensure that the building was "dementia friendly" and met the needs of the people who lived there. We made a recommendation to the registered provider that they follow best practice guidelines.

Staff supported people to make choices and where a person lacked capacity, staff were aware that they acted in their "best interest". The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out specific requirements around decision making and restricting a person's liberty. We found that these principles were not always followed which meant that someone's rights may not be protected. We made a recommendation that the registered provider review its decisions in light of the MCA.

The registered provider had in place safe systems for the ordering and storage of medicines. However, staff were not following up to date best practice guidance for the administration of "as required" or "covert" (hidden) medications. We made a recommendation that the registered provider ensure that staff to follow up to date guidelines.

People were happy with the care that they had received. They said that staff were kind, patient, caring and kept them safe. Relatives we spoke to have no concern about the care and felt that the service was good. There was positive interaction between people who used the service and staff and people were treated with dignity and respect. Each person had an accurate record of the care that they required. This meant that staff, who did not know a person well, would be able to provide the right level of care and support.

People told us that they enjoyed the food although there was not always a choice. People who were able eat independently ate well and those who required assistance were supported appropriately.

There were enough staff working on the day of the visit to meet the physical needs of people but staff carried out a variety of other tasks including domestic chores, laundry and cooking and so appeared very busy. This meant that staff often had little time to engage with people apart from when delivering care and areas within the home were unsupervised for long periods of time. We made recommendations that the registered provider review staffing in line with the increasing dependency of people who used the service as well as reviewing the social stimulation provided to them.

Staff who provided care had been through recruitment and selection processes that ensured that they were appropriately skilled to carry out their job roles. However, some staff had started work before the required checks had been carried out which meant that there was a risk that they could have been unsuitable to work in a care setting.

The registered provider did not have a system in place to ensure that they monitored and evaluated the quality, safety and effectiveness of the care and service being provided. They had also failed to report low level safeguarding concerns to the local authority. This meant that they could not always identify potential risks and take steps to make the required improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not completely safe.

People said they felt safe. Staff was aware of the safeguarding process and how to report allegations of abuse.

Staff carried out a variety of tasks in addition to personal care and this meant that some people were without supervision for long periods of time which caused them to be anxious.

The environment required improvement to ensure that people were safe from the risk of harm or acquired infection. Accidents and incidents were recorded but there was no analysis of these occurrences to ensure that lessons were learned and future risk of harm minimised.

People were supported by staff who were of suitable character and skill.

Is the service effective?

Requires improvement

The service was not completely effective.

Staff received training relevant to their job roles but their induction did not meet the required standards of the Care Certificate. Staff received supervision from the registered provider.

Staff took consideration of a person's mental capacity when making decisions about their care but did not always indicate how and why decisions were made in someone's best interest.

People enjoyed their food and were supported to eat and drink.

The service required improvements to the environment to ensure that it specifically met the needs of those persons living with dementia.

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy was maintained and that records about them were kept securely.

Staff had good relationships with people and spoke to them kindly.

The registered provider had not always taken into account the views of people who used the service before making changes that affected them.

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us that staff helped them with the things that they found difficult.

Summary of findings

Accurate and personalised information was available in care files. Advice given by other professionals was transferred into people's care plans for staff to follow

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

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

Is the service well-led?

Requires improvement

The service was not always well led.

People we spoke with and their relatives told us that they had confidence in the registered provider and that they could approach them with any concerns.

The registered provider did not have a system in place to monitor the quality and safety of the service. Policies and best practice guidance were not up to date to ensure that staff had the right information to do the job.

Regular meetings were not held with people who used the service, relatives or staff to ascertain their views and opinions.

The Old Hall Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 September 2015 and was unannounced. This meant that the registered provider did not know that we were coming. The inspection was carried out by an adult social care inspector.

Before the inspection we reviewed the information that we held on the service. We also contacted local commissioners of the service and visiting professionals such as the District Nursing service and Infection control to obtain their views about it.

We spent our time speaking with the people who used the service .We observed care and support in the communal areas, spoke on a one to one basis with five people who used the service and looked at the care records of six people. We also looked at the records that related to how the service was managed and those relating to staff.

Requires improvement

Is the service safe?

Our findings

People who lived at the service said that they felt safe and commented "I feel fine here and the staff keep me safe". Relatives also shared this view with comments such as "My relative is cared for and absolutely safe".

The registered provider had a safeguarding policy in place that staff were aware of. Staff knew what could be seen as abuse and said they would report this to the registered provider. The registered provider did not have an up to date version of the local authority safeguarding policy and protocol.

A relative commented to us, "If I had one concern, it would be that there are times when staff cannot be in the lounge as they are so busy and then no one knows what it happening. Sometimes, I have had to intervene to avoid someone coming to harm". On the day of the inspection we saw that the physical care needs of people who used the service were met by the staff on duty. We did, however, observe that in addition to providing personal care, staff undertook domestic chores such as cleaning, laundry, meal and drink preparation and washing up. A number of people also required the assistance of two staff for personal care. This meant that for periods of the day, communal areas and those bedrooms where people stayed for long periods were unsupervised. We observed that one person needed a lot of guidance and support and when staff were not available to direct them they sought this from other service users who were not always patient with them.

We recommend that the registered provider continuously review staffing levels to be able to adapt and respond to the changing needs, dependency and circumstances of people using the service.

Accidents and incidents were recorded appropriately and changes made to care plans if it was felt that steps could be put in place to minimise future incidents to that individual. However, the registered provider did not have a mechanism in place to analyse accidents and incidents in terms of wider themes and trends. This meant that the registered provider would not be aware if adjustments were needed to the premises, equipment or staff practices as the result of similar occurrences.

The registered provider must employ staff that care suitable to work in a care setting. We looked at three recruitment files to see if the required checks had been made. The applications contained full employment histories and satisfactory written references had been received. There were no interview notes on file to demonstrate why that person was deemed suitable for the position. However, two staff employed in 2004 and 2010 commenced work prior to the required checks being returned from the disclosure and barring service (DBS). The most recent staff member had started after their checks had been returned. The registered provider told us that they were aware of the need to carry out an adult first check and that staff needed to work under supervision until the required checks had come through. There was no risk assessment in place to evidence this had taken place. We advised the registered provider of the requirement to carry out a written risk assessment in such circumstances.

We looked at the medication administration records (MARs) for five people who lived in the home. Medicines, including controlled drugs, were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. The registered provider told us that they had a good relationship with the local pharmacy. Medication administration records (MARs) were clear and accurate and it showed that people had been given their medicines correctly by checking the current stock against those records. Care staff supported people to take their medicines in a variety of ways that met their individual needs and preferences. We saw that staff explained to people what medicines they were taking and why. Medication was administered throughout the day as some people needed medicines before or after food.

Care plans were not in place for people's prescribed medicines that only needed to be taken 'when required'. This meant that there was no information to enable care staff to administer these medicines consistently. One person was given their medicines covertly; i.e. hidden in food or drink and given without the person's knowledge or consent. There was no information with the MARs to show care staff which medicines were to be given covertly and no information in the care plans or the MARs detailing exactly how and in what circumstances they should be given. It was not possible to see from records which medicines had been given covertly and which had been given with the

Requires improvement

Is the service safe?

person's knowledge and consent. It was recorded that "The GP has made the decision to discontinue some and to crush the remainder and to give chocolate afterwards". The pharmacist had not been consulted to ensure medication was safe to be administered in that way. We found that, for this person, their care plan indicated that medications were to be crushed but a staff member told us that they gave them hidden in food. Arrangements for giving medicines in this way had not been made in accordance with the Mental Capacity Act 2005 and current NICE guidance.

We recommend that the registered provider review its management of medicines in line with current guidance such as that published by National Institute for Health and Care Excellence: Managing medicines in care homes.

The registered provider shared with us an infection control audit that had been carried out by the Infection, prevention and control team from the Cheshire and Wirral Partnership NHS Foundation Trust on 28 November 2014. Failings with the service had been highlighted and they had sent the registered provider a number of action requirements. The registered provider had not completed an action plan following this audit in order to monitor and evidence their improvements. On this inspection, we found that little progress had been made with the recommendations from the Infection control team. There were holes visible in walls that needed repair, wires were exposed in the sun room, some carpets were threadbare, celling lights shades were missing in a number of rooms, and bathroom sealant needed replacement. Improvements had still not been completed to the laundry and sluice areas. Some areas of the home, chairs and tables were not visibly clean or were damaged, surfaces were dirty and dusty and bed bumpers were stained. There were no cleaning schedules or written standards in place.

We found that one en-suite had a very loose toilet seat and brought this to the attention of the registered manager. There was electrical equipment stored in a bedroom (which was in use) and this could pose a risk if someone living with dementia had access to this. The registered provider said that repairs had been carried out in the room and the person had "Forgotten to remove" the items. The window restrictors in three of the upstairs bedrooms were insufficient as the main window opened in excess of 100mm. We brought this to the attention of the registered provider.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014 because the premises were not completely safe and people were not protected from the risk of infection.

Cheshire Fire and Rescue had issued a Fire Enforcement notice in March 2014 that has now been complied with. There was an up to date Fire Risk Assessment, training and drills had taken place and equipment had been upgraded and tested. We did note that it was the personal choice of some people who lived at the home to keep their bedroom door open but these were propped open and did not have a "self-closing" facility. This could pose a risk in the event of a fire.

Requires improvement

Is the service effective?

Our findings

People were satisfied with the meals provided and felt that there was "Enough to eat and drink" and "The meals are sufficient". There was a set menu for each meal that staff said was based upon the preferences of the people who lived there. Meal times were relaxed and provided people with an opportunity to chat. The dining table was arranged with place mats, cutlery, napkins and condiments. People were offered a choice as to where to sit. Care plans also reflected preferred place such as "At the table with friends" or "Tends to like to sit apart from others as can get unsettled if disturbed whilst eating".

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had an understanding of the basic principles but had not always put this into practice.

We found that eight of the people who lived at The Old Hall were under constant supervision as they were not able to leave unattended or had their liberty restricted in some way. Doors into and within the building were only accessible with a fob. Those people with the mental capacity to use a fob were provided with one to allow them to move freely within the building. Where, due to the requirement for close supervision, people could not move freely, the registered provider had made a number of applications to the supervisory body in order to ensure that any actions taken were in line with the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations are building specific and cannot be transferred to a different care home. If a person is moved permanently to a new home the authorisation must end. On the day of the inspection we spoke to the registered provider about a person who was deprived of their liberty and had been subject to a DoLS in another setting. A new DoLS application had not been made and the registered provider was not aware that is was not transferable. We asked the registered provider to make an application as a matter of priority. Where there was a restriction or deprivation of liberty identified, records did not demonstrate why it was required or whether staff had considered the least restrictive options. For example, there was nothing in the documentation to state what had been considered (where someone lacked capacity), to keep a person safe, before the use of bedrails.

We recommend that the registered provider review the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that all forms of restriction and restraint are given due consideration.

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, whether to take medication or how to keep themselves safe. People's mental capacity had been taken into consideration when planning their care and staff were able to tell us that sometimes they made a decision in a person's "best interest". Care plans indicated that staff "should protect and act in a person's best interest and act as their advocate". However, for complex and significant decisions, a formal mental capacity assessment had not taken place and there was no evidence as to why a particular decision had been reached. A number of people did not have access to a call bell as it was 'It was not considered safe' or because 'They cannot use one'. Although other measures such as pressure mats had been put in place there was no mental capacity assessment, risk assessment or best interest decision around its removal. Where it was deemed appropriate to administer covert medication staff had sought the opinion of the persons' family and GP but did not demonstrate that a mental capacity assessment had been carried out or why a 'best interest decision' was made to give medication this way.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment must only be provided with the consent of the relevant person. Where a person lacks capacity staff must act in accordance with the requirements of the MCA 2005.

The provider had responded to changes in the business market and told us they wanted to offer a more specialist service for people who were living with dementia. They had not given any consideration of best practice guidance as to how to make to people's 'living spaces' more supportive and accessible. No changes had been made to colour,

Requires improvement

Is the service effective?

lighting, bathrooms, fixtures and fittings or signage. There were very few items about for people to touch, pick up and encourage interest or discussion for people living with dementia. This meant that the environment did not fully meet the needs of people living with dementia.

We recommend that the registered provider take account of national best practice to ensure that the environment is suitable for the service provided.

Staff received training relevant to their jobs such as safeguarding and moving and handling. New staff undertook an induction programme of training and shadowing an experienced staff member. The current induction programme for staff did not meet the requirements of the Care Certificate. This is an identified set of standards for new health and social care workers. It is expected that registered providers should follow the Care Certificate standards to assess the competence of workers. We asked the registered provider to ensure that they review the induction programme to ensure that it follows the Care Certificate standards.

Staff told us that they received supervision and were able to seek support at any time. We saw that staff had last received supervision in May 2015. The registered provider also worked alongside the staff during the week and also at night which gave them the opportunity to provide direct guidance and support.

Requires improvement

Is the service caring?

Our findings

People who used the service made comment such as “I like the staff and they are very kind”, “I have no grumbles, I am well looked after”. Relatives and professionals who visited the service echoed this view and told us “The staff are so kind, they treat everyone like family”, and “The staff are always very kind and patient”.

Not all of the people who lived at the service were happy with the changes being made to their home in terms of the environment and the service user group. One person said “This place had been like a building site”. They explained that the owner does “Lots of the work himself and so it takes forever and never gets finished” and that “It has been a nuisance as it creates noise and dust”. Another person expressed concern that they had not been consulted about the decision to offer a home to people living with dementia, that they no longer had anyone to talk to and were “Upset and frightened” by the illness and some of the associated behaviours. They said that they now “Spend more and more time” in their bedroom.

There was a good rapport and relationship between people who used the service and the staff. Conversations took place that indicated that staff knew people well and were able to talk to them about their families, interests and things that worried them. One person did not feel well following lunch but could not express why. Staff took the time to talk to them and to try to understand how they were feeling. Another person was anxious about the whereabouts of a family member and staff were patient and kind and responded appropriately to their repetitive questions when they were able. However, there were times of the day when staff were not around to give this support and the person was distressed. This also impacted on the other people in the service.

People were treated with dignity and respect .Staff assisted someone who was eating with their fingers in a light-hearted way “You are having great fun with that food, but shall I just help you a little bit so that your food doesn’t go cold?” Staff were discrete in encouraging people to use aprons where there was an identified need. Staff asked “Would you like to have an apron as it will help protect your nice clothes if you accidently spill something on them”. Staff provided support where it was required and some people had adaptive utensils to aid their independence.

When personal care or medication were required, staff spoke kindly explained what they were going to be doing and why. There was a feeling of warmth, and genuine care displayed by staff. Staff knocked on people's doors before entering and kept them closed whilst personal care was undertaken. Staff were discreet when encouraging people to go to the toilet and this meant that their privacy was respected.

On the day of the inspection, music played quietly in the background in the morning whilst people had a cup of tea and got ready for the day. Staff asked people if they had a preference as to listening to music or watching the TV at numerous points throughout the day.

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

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

Requires improvement

Is the service responsive?

Our findings

People who used the service could not recall involvement in the writing or reviewing of their care plans. One relative confirmed that they had been involved in discussions at the point of admission about care that was required. People did not sign or consent to their own care plans where they had the capacity to do so. We looked at five care plans and saw that none were signed by the staff member that had completed them. The registered provider told us that she had spent a long time writing care plans as she was aware that they are required but stated that "No one reads them as we are a small home and all the staff get to know the people well".

From our observations and discussions with staff, it was evident that they knew the people using the service well and told us that any changes are always discussed in handover. The care plans we looked at were personalised in that they told us someone's likes, dislikes or personal preferences such as "Give [name] an explanation of what you are going to be doing. Allow [name] to sit at the wash basin and hand [name] a warm flannel as they are able to wash their face". Care plans also focused on things that a person could do for themselves and staff said that "It is important to help people to do things for themselves where they are able". Care Plans were reviewed monthly but some of the care plans had been written in 2012. We spoke with the registered provider about the importance of ensuring that care plans themselves and not just the reviews reflect current need. Where specific risks were identified, assessments were in place to highlight the risks and to provide guidance for staff. A person who lived at the home had a medical condition that could be transmitted from person to person. There was a care plan in place and information for staff as to how to provide care whilst minimising the risk of cross infection. One person who used the service exhibited behaviours that challenged staff and others. Their care plan had reference to the things that calm and settle them such as "engage [name] in things that interest them such as reading her favourite [name] magazine."

Skin care and the weights of people were regularly monitored using recognised risk assessment tools such as the Waterlow (for pressure prevention) and MUST (Malnutrition Universal Screening Tool) for weight. Where concerns had been identified, referrals had been made to the appropriate professionals for assessment and guidance. A visiting professional confirmed that appropriate referrals were made and that staff were responsive to any instructions given.

The registered provider had ensured that people had an air mattress to minimise the risk of developing a pressure area where required. However, there were no instructions for staff as to how to correctly set the pressure. This meant that a person could be at risk of further skin damage from lying on a mattress that was too hard or soft. Staff told us that they go by "The feel" of the mattress. It is essential that staff are aware of the correct pressure for both lying and sitting and that there is a process in place to review this as a person's weight increases or decreases. We brought this to the attention of the registered provider and asked that they review the use of pressure mattresses as a matter of priority.

Two people had food prepared so that it was soft or pureed. The medical background and care plans did not reflect why this decision had been made and by whom. We spoke to the registered provider who said that staff had made these decisions following difficulties that the people had with swallowing. We asked the registered provider to seek a medical assessment and professional opinion for these persons as a matter of priority as to make this decision was not within the scope of their qualification.

There was no one employed specifically to provide social stimulation and activities for people living at the home. The registered provider said that funds were not available for this but we discussed how some of the most beneficial activities can be simple, everyday tasks such as setting the table for a meal or folding clothes. Staff were busy throughout the day, care and interaction was "task" orientated and staff did not have the time to encourage people to help them. This meant that people did not have much social stimulation throughout the day and so staff did not maximise choice and control.

We made a recommendation that the registered provider review best practice guidelines and research around social stimulation as people living with dementia needed meaningful and enjoyable activities to live well. This can also help to reduce behavioural symptoms such as agitation, restlessness and aggression.

Requires improvement

Is the service responsive?

People who used the service and their relatives told us that they knew how to make a complaint and would be confident in it being resolved. There were no complaints outstanding at the time of this inspection. The registered provider had a complaints process that directed people as to how to make a complaint and people were aware of it.

Requires improvement

Is the service well-led?

Our findings

The registered provider was also the registered manager and therefore had an active role within the service. People who used the service, relatives and visiting professionals felt that they had confidence in the registered provider and felt able to approach them with concerns.

The registered provider told us that they have "Moved towards offering care to those living with dementia as it reflects market demand and the financial rewards are greater". However, this had been done without consideration or discussion with people who lived at the service and the impact that this might have upon them. This meant that the registered provider had failed to encourage feedback and to seek the opinions of people who used the service. The registered provider had also not considered fully considered the implications of the providing care for those living with dementia care as it will require a revision of staffing levels, training and the environment.

The registered provider did not have robust systems in place to monitor the quality and the safety of the service that they delivered. There were no formal audits carried out to assess compliance with record keeping, infection control, medication management etc. This meant that the registered provider was not able to identify where the quality and safety of a person was being compromised.

For example: the registered provider had failed to record any audit on how well medicines were handled although she told us that she checked all medicines themselves on a monthly basis. The infection control team were not able to establish when items had been cleaned as the registered provider did not carry out their own infection control audit or cleaning schedules. They had highlighted shortfalls in practice and recommended that audit systems were set up. The registered provider had not completed an action plan or audit systems in order to minimise the risk to people who lived at the service, staff and others. It is essential to have a robust system of audit in place in order to identify concerns and make the necessary improvements.

The registered provider told us that they held regular meetings with staff, relatives and people who used the service to seek their opinions. Neither staff, people who used the service or visitors could recall any recent meetings. The registered provider was not able to provide us on the day of the inspection with copies of minutes of the meetings or the surveys carried out. We asked the registered provider to provide these following the inspection but they did not do so.

This was a breach of Regulation 17 of the health and social care act 2008 (Regulated Activities) Regulations 2014 because registered providers must assess and monitor the quality and safety of the service in order to mitigate any risks. They must also seek and act on feedback from people who use the service.

The registered provider had policies and procedures in place in order to reflect the requirements of the business and also to direct staff in their day to day work. These needed revising and updating in order to reflect current legislation, policy and best practice in order to ensure that staff had up to date knowledge in order for them to provide effective and safe care. For example, we found that the medication policy available to staff was the "The administration and control of medicines in care homes and children services: 2003".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How this regulation was not being met: Care and treatment was not always provided with the consent of the relevant person. Where a person lacked capacity staff did not always act in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How this regulation was not being met: The registered providers failed to assess and monitor the quality and safety of the service in order to mitigate any risks. They did not also seek or act on feedback from people how used the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How this regulation was not being met: The premises were not completely safe or well maintained. People were not protected from the risk of infection.

The enforcement action we took:
We issued a warning notice and told the registered provider to complete the required actions by 31 January 2016.