Thomas Owen Care Limited

Thomas Owen House

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection carried out on 10 and 14 July 2014. At the last inspection in November 2013 we found a breach of legal requirements as staff were not properly supported through supervision and appraisal. An action plan was received from the provider which stated they would meet the legal requirements by 22 April 2014. At this inspection we found improvements had not been made with regard to this breach.

Thomas Owen House provides nursing care for up to 39 adults with mental health needs and/or a physical disability. There were 33 people living at the home when we visited. Accommodation is provided in single

Summary of findings

bedrooms, although there is one shared room for two people. There is a variety of communal lounge and dining areas, a hairdressing room, a kitchen, laundry and bathrooms. There are gardens to the rear of the property.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People told us contradictory things about the service they received. While most people were happy, some were not. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas. This included how well equipment and the building were maintained and how the balance between protection and freedom was managed. Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for three people, even though their liberty had been restricted.

People told us there were enough staff to give them the support they needed and this was confirmed in our observations. While staff told us they had received induction and training, the records did not always reflect this. There were no induction records for some staff and records showed many staff had not received refresher training. This meant people could not be confident staff had the skills to meet their needs. People enjoyed the food, but choice and independence in accessing food and drink was not promoted. People's nutrition and hydration needs were not always being met. People were not always receiving the health care support they required as their care was not planned or delivered consistently.

Although people spoke positively about staff, we found caring relationships varied between individual staff members, some of whom were warm, compassionate and caring in their approach. In contrast, others did not engage with people or show empathy.

We saw care was task orientated, rather than centred on people's needs and preferences. There was a wide variety of group activities but no opportunities for people to pursue their own hobbies or go out independently. People we spoke with did not know how to make a complaint.

Leadership and management of the home was poor and there were no systems in place to effectively monitor the quality of the service or drive forward improvements. There had been a lack of action in addressing shortfalls identified at the previous inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe. Although people said they felt safe, we found the way risks were managed limited and restricted people's freedom. People were not involved in decision making and where people lacked capacity, the restrictions amounted to a Deprivation of Liberty Safeguard (DoLS) which had not been authorised.

People who used the service were being put at risk as the premises and equipment were not being maintained.

However, we saw there were sufficient staff to meet people's needs and staff knew how to identify and report abuse correctly.

Is the service effective?

Inadequate

The service was not effective. Staff had not received up-to-date training, induction and support which meant people were at risk from staff who did not have the skills and knowledge to meet their needs.

Although people said they enjoyed the food, choices were limited and people were not always supported to eat and drink enough to maintain their health.

There were inconsistencies in how health care needs were met, which placed people at risk of not receiving the health care support they required.

Is the service caring?

Inadequate

The service was not always caring. Most people told us the staff were great and said staff treated them with kindness and compassion, although a few people told us they were not happy in the home.

Some staff interactions were positive and we saw people benefitted from these good relationships. Other staff lacked compassion and adopted a 'minding' role not initiating or responding to conversation, which meant people were ignored.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. Care plans did not always show the most up-to-date information about people's needs, preferences and risks to their care.

The service told us no complaints had been raised. People were not aware of the complaint process and said they did not know how to raise a complaint. There were a variety of activities for people to participate in as a group to meet their social needs, but no opportunities for people to pursue their own interests or go out independently.

Is the service well-led?

Inadequate

The service was not well led. The manager controlled the service and there were few opportunities for people and staff to be involved in or consulted about decisions which affected their daily lives. Action we had asked the provider to take at the last inspection remained outstanding.

Summary of findings

There were no systems in place to monitor the quality of the service or to drive forward improvement.

Thomas Owen House

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.'

The inspection team consisted of two inspectors, a specialist advisor in mental health and an expert by experience with expertise in mental health. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and contacted the local authority and Healthwatch. The provider completed a Provider Information Return (PIR) and this was returned the day before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 19 people who were living in the home, three care staff, an activity organiser, the deputy manager and the registered manager. We spent time with people in the communal areas observing daily life including the care and support being delivered. We looked at seven people's care records, two recruitment files, the training matrix and 13 staff training records, as well as records relating to the management of the service. We looked round the building and saw some people's bedrooms (with their permission), bathrooms and communal areas.

Is the service safe?

Our findings

Generally we found the service was not safe. Although people we spoke with told us they felt safe in the environment as well as around staff and other people who lived in the home, we observed restrictive practices and found people were not involved in decision making about risks. Risk assessments were not clear and contained minimal detail about the level of risk and how it should be managed.

The manager told us some people displayed behaviour that challenged others. Although we observed staff managed these situations effectively and kept people safe, we found there was a risk averse culture, which meant the focus was on preventing risks rather than supporting people to manage risks safely. This meant there was an imbalance between protection and freedom as people's movements were restricted. Although people could move freely around the communal areas on the ground floor, doors to other areas of the home were kept locked. We saw bedroom doors were locked and the manager told us people were given keys to their rooms only if they asked for them. This meant people who did not have keys were not able to access their rooms without staff assistance. The manager was not able to explain clearly how decisions were made about who had a key to their room. One person told us they felt it was like a prison and another said about the home, " I don't think much of it coz locked up all the time". One person said they had a key to their room but felt they could not keep things private as staff also had a key and went into their room. We saw alarms were fitted to bedroom doors, which the manager told us were triggered when people opened the door. The manager was not able to explain clearly why or when these alarms would be used.

The manager told us three people received one-to-one support continuously throughout their waking hours. The manager told us all three people lacked capacity. We looked at the care records for two of these people and the reason for this level of supervision was not clearly documented and there was no evidence of best interest discussions. We observed the one-to-one support provided was sometimes oppressive with staff either sitting close to or standing over the person and there was limited interaction. We saw staff providing one-to-one support stayed close to people and reacted to any movement, following them if they walked anywhere, asking them what they were doing. When we asked one staff member the reason why people had one-to-one supervision they said it was because the people were 'deemed to cause conflict during waking hours'. We considered people's liberty was being restricted in ways that may amount to a deprivation of liberty and advised the manager to apply to the relevant supervisory body for authorisation. Following the inspection we were notified by the manager that Deprivation of Liberty Safeguards (DoLS) applications had been submitted and two of these had been authorised. The third application was still being considered. This meant that two people had been subject to unlawful control and restraint. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although the manager and deputy manager were aware of the Mental Capacity Act (MCA) 2005 and DoLS, we found they lacked understanding and did not recognise when people were being deprived of their liberty. Mental capacity assessments had not been completed to meet the requirements of the MCA 2005. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Our discussions with the manager showed improvements were required to make sure people were kept safe in the environment and with any equipment that was being used. Although we saw maintenance certificates for some equipment the manager was unable to provide evidence for other equipment. For example, there was no maintenance certificate for one of the chair lifts or the Parker bath (an electronic bath that enables people with limited mobility to bathe safely). A service certificate for the passenger lift and another chair lift listed works to be completed. The manager was unable to confirm if these had been done. The manager told us a gas safety check had been carried out but was unable to provide records to confirm this during the inspection however a certificate was sent to us subsequently.

We observed windows upstairs that opened fully and were not restricted. The manager told us no environmental risk assessments had been completed for the premises. We identified a number of maintenance works during our visit. For example, two of the bathrooms could not be used as they were being used as storage rooms, which the manager told us had been the case for several years. This meant there were only two bathrooms in use for 33 people. The

Is the service safe?

manager told us a maintenance person visited the home daily. The maintenance book showed a list of jobs which were ticked off when completed. We saw no jobs had been 'ticked off' since 22 May 2014 although these were minor jobs there were many listed to be done. These shortfalls meant people were not protected from the risks of unsafe equipment and premises. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with had a good understanding of what constituted abuse and knew the correct action to take if abuse was suspected. They were confident senior staff would respond appropriately to any concerns raised. Staff knew about whistleblowing and who to contact if they felt concerns were not dealt with properly. Staff we spoke with said they had received safeguarding training, however records we reviewed showed eight staff had received no safeguarding training. The manager told us safeguarding training was updated annually, yet records showed thirty-one of the forty-four staff listed had not received training since 2012. We saw safeguarding and whistleblowing policies were available however these were dated 2008. The manager did not have a copy of the West Yorkshire Regional Safeguarding Procedures and was not aware the procedures had been updated last year. The lack of up-to-date training and access to current safeguarding policies meant staff were not fully informed of current practice and guidance which put people at risk.

The home has had two safeguarding incidents in the last twelve months. One had been reported by the home, the other by another agency. Both incidents had been investigated and recorded and reported to the Local Authority and Care Quality Commission (CQC). Disciplinary procedures had been followed and appropriate action was taken.

We observed there were sufficient staff to meet people's needs and keep them safe. People we spoke with told us they felt there were enough staff available to give them the support they needed and no concerns were raised about the staffing levels. One person said, "There's always plenty of staff." Staff we spoke with also felt staffing levels were sufficient to meet people's needs. The manager told us there were two nurse vacancies and their shifts were being covered by agency staff until new staff were recruited. Staff we spoke with and records we saw showed the home followed safe recruitment practices and we found appropriate checks were undertaken before staff began work.

Inadequate

Is the service effective?

Our findings

At our inspection in November 2013 we were concerned at the lack of support provided to staff through formal supervision and appraisal. The provider sent us an action plan outlining the improvements they would make which they said would be in place by April 2014.

At this inspection we found staff were not receiving the induction and training they required to meet people's needs. The manager told us all new staff received induction before starting work. However this was not confirmed in the records we saw, which showed no evidence of induction training. Staff we spoke with said they had shadowed experienced staff when they first started but could not recall induction training they had received. When we discussed this further with the manager she said, "There won't be any recorded evidence of induction, we usually mentor them with other staff."

The manager provided us with a training matrix which she said showed the most up-to-date training staff had received. This showed some staff had not received training updates since 2011. We checked a sample of thirteen staff training records against the training matrix and found four staff had no training records at all. All thirteen staff were on duty and none had received up-to-date moving and handling training or safeguarding training. There was no training and development plan for staff. This meant people were at risk of receiving care from staff who did not have the necessary skills and training to meet their needs. We saw how the lack of training impacted on staff practices when people were being assisted to stand or transfer. Although people who required a hoist were moved safely, others were supported by staff using techniques which placed staff and people they were moving at risk of injury. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Feedback from staff about supervision was mixed; some said they received regular supervision and felt supported, others said supervision was irregular and was limited in what it covered. We saw no supervision records in the staff files we reviewed.

Staff did not always ensure that people were eating and drinking enough to keep them healthy. One person had been assessed by a Speech and Language Therapist (SALT) following a swallowing assessment and we saw they received the liquidised diet and thickened fluids they required. We saw staff assisting this person with their meal calmly and patiently, giving them time to enjoy the meal and chatting with them. However we saw another person had been assessed as nutritionally at risk and had been seen by the dietician who had recommended monitoring their food and fluid intake and weekly weights. Food and fluid charts we saw for this person were incomplete and no charts could be found from 4 July onwards. No weights had been recorded. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people told us the food was good. One person said, "Oh the food is lovely, I really like the meals." Two people said they didn't enjoy the food with one person describing it as 'rubbish'. Some people said the menu was repetitive and did not change from week to week. However our conversation with the cook and the record of meals served did not reflect this. The cook said there was always a choice and alternatives were available. The menu was displayed in the home and we heard people discussing what they were having for lunch. Although the food looked appetising we saw meals were brought to people already plated which meant people had no choice in the components of the meal or portion size. We saw drinks were brought round by staff at specified times throughout the day and people were offered a choice. However there were no facilities for people to make their own drinks and snacks. When we asked staff about this we were told it was not safe for them to do so. Although people were provided with sufficient meals and drinks we found individual choice and control was limited.

We found limited information to show people's health care needs were being met. Although risk assessments were in place for mobility, pressure areas, nutrition and falls these contained minimal information. Review dates were recorded monthly yet these all indicated no change even though some of the assessments we saw dated back to 2009. For example, one person's assessment showed they were at high risk of developing a pressure ulcer, yet there was no information to show how this risk was being managed. Another person's moving and handling plan said they used a 'cocoon' (a system to keep them safe in bed) but staff said this was no longer used as bed rails were in place. One person had diabetes and the care plan showed their blood sugar should be monitored twice a day. There was no further detail about this person's diabetes or what

Inadequate

Is the service effective?

action should be taken if the person became hypo or hyperglycaemic. Although the care plan had been reviewed monthly no one had seen this information was missing. This put the person at risk if they did develop high or low blood sugars. Another person had a Do Not Attempt Resuscitation (DNAR) form in their care file. The manager told us the DNAR had been agreed when the person was in hospital and no longer applied. She said she had limited experience with these forms and did not know what to do. The manager said she had discussed the DNAR with the person's relative and asked them to sort it out. The manager told us there was another person in the home who also had a DNAR which was similar. We advised the manager they needed to contact both people's GP. This situation put both people at risk of not receiving life saving treatment from staff if they did collapse. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was limited information in the records to show that people had regular access to GPs, opticians, dentists and other healthcare professionals. We saw evidence to show some people had input from the tissue viability nurse, the dietician, SALT and GPs, however for other people there was no information recorded.

Inadequate

Is the service caring?

Our findings

Although the deputy manager said care plans were discussed with people, we found no evidence of this in the records we reviewed and people we spoke with said they had not been involved in their care planning. One person who lived in the home said they felt people were not listened to. We found people's views were not actively sought by staff, people's choice and control over their care was limited and independence was not promoted. Although staff told us there were regular residents' meetings, people we spoke with felt they were not involved in decisions about the home. The manager told us satisfaction surveys were not used. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received mixed feedback from people who used the service, but most people we spoke with said staff were 'great' and described them as kind and compassionate. They said staff treated them with respect. One person described the staff as 'so-so' and said some were kind. Another person said, "I'm very happy, staff treat me well." A further person said, "I'm well looked after." Two people expressed dissatisfaction with the service. One person said, "I don't like this place I'm not happy here at all" and another person said, "I hate it here."

We saw some staff interacted with people well and had developed good relationships. For example, we saw activity staff chatted with people and encouraged them to join in with different activities. People were laughing and singing and staff involved people who were hesitant about joining in by pulling up a chair and asking people to join them. We saw some care staff took every opportunity to talk with people, listened to what they had to say and showed a genuine interest. We saw these staff treated people with dignity and respect.

In contrast, we saw several instances where staff ignored people and did not listen to them. For example, we saw three staff members providing one-to-one support. Interaction was limited and when staff did speak to the person they did not listen to the response or respond to any conversation the person tried to initiate. We saw other staff who walked past people without acknowledging them. The only interactions for some people were when staff were carrying out a task such as assisting people to mobilise and then conversation was limited to instructions. We found the manager's approach to people was changeable and saw with some people she was relaxed and friendly but with others was quite dismissive.

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with people who have complex needs.

Inadequate

Is the service responsive?

Our findings

The manager told us no complaints had been received in the last 12 months. We asked the deputy manager how people were informed about the complaints procedure. They said the complaints procedure was not displayed in the home and if people wanted to know about the procedure they could ask staff for a copy. People we spoke with were not aware of the complaints process and said they did not know how to make a complaint. People said if they had a complaint they would speak to staff or the manager. This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the care plans we saw required updating. People's choices and views were not reflected and there was no evidence to show how people had been involved in decisions about their care. The manager told us people who used the service did not have the cognitive ability to make informed decisions and this comment reflected the ethos of the service in failing to recognise people's individual needs or abilities. For example, we saw toiletries and cigarettes were bought collectively, which meant people had no choice or control in selecting their own. We saw cigarettes were kept in the office and single cigarettes were given out by staff to people on a group basis at regular timed intervals. The manager told us some people kept their own cigarettes and other people's were locked up in the office. There was nothing in the care records to show how or who had been involved in making these decisions. When we asked the manager she told us she had made the decision and it had not been discussed with people. She said the cigarettes were rationed as otherwise some people would smoke their day's allowance within an hour.

In another example, we saw a person had been moved from one bedroom to another. The manager said this had been her decision as she felt it was necessary to protect the person. We spoke with the person who said they had been given no choice in the move and the records we saw did not explain why this action had been taken or show how a best interest decision had been made. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans contained basic information which focused mainly on people's health care needs and provided little information about people's preferences or personal history. For example, the care plan for one person who had one-to-one support gave no information about what the person enjoyed doing and stated 'staff to explore how to make the most of time'. When we spoke with this person they were able to tell us about their interests yet none of this was reflected in their records and they told us no one had spoken with them about their care plan. They said they were bored and there was nothing much for them to do.

There was a varied activity programme displayed and we saw some people were involved in a range of activities such as swimming, yoga, singing and board games. We saw people who participated in these activities enjoyed them and one person told us how much they looked forward to going swimming. However, we found activities were provided predominately on a group basis and there was no provision for people to pursue their own hobbies or go out independently. One person said they were unable to go out and staff did not support them to do so. We saw for some people in the lounge and conservatory there was little stimulation or activity. Although staff were present interactions were limited and staff reacted only when people started to get up or move around.

Inadequate

Is the service well-led?

Our findings

We found the service was not well-led. There were no effective systems in place to monitor the quality of the service or drive forward improvements. We found the home was poorly organised and although staff responded to people's needs as they arose this was reactive rather than proactive and planned.

We were concerned that the manager, who is a registered nurse and has been in post for many years, was unable to provide us with explanations as to why things had happened or evidence to support the decisions she had made. We found the provider information return (PIR) the manager had completed prior to the inspection contained limited information some of which was incorrect. For example, the PIR stated three deaths in the last 12 months had resulted in coroner involvement. When we explored this with the manager we were told no deaths had been referred to the coroner and this was an error. Similarly the information provided with regard to staff training was not confirmed by the training records we saw at the inspection.

The three deaths that had occurred had not been notified to the Care Quality Commission as legally required. The manager was unable to give a reason why notifications had not been made. This is a breach of Regulation 16 Health and Social Care Act 2008 (Registration Regulations) Regulations 2010.

We saw accident reports were filed in people's individual care files. The manager told us there were no systems in place to audit and review accident or incident reports. This meant themes and trends were not identified and placed people at risk of repeated incidents as actions were not identified or lessons learnt. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us she audited the care plans and when we asked to see copies of the audits she said there were no records. We found issues in the care records had not been picked up. For example, in two people's daily notes we found information about other people's care had been documented. People's care plans were not personalised and did not reflect their current care. Reviews were recorded monthly but comprised mainly of statements stating no change. We asked to see copies of any other audits taken to monitor the quality of the service and the manager told us there were none.

The manager told us the provider carried out monthly visits to the service and we asked to see copies of these reports. Initially we were told these were kept in head office and could not be accessed; after further enquiries the manager advised the provider had not carried out any visits to the service since last summer.

The manager told us staff meetings were usually carried out every three months. We asked to see minutes from the last meeting. The manager was not able to provide these and told us a meeting had not been held for several months. The deputy manager told us the last staff meeting was last year.

There was not an open and inclusive atmosphere and people were not encouraged or involved in developing the service. The office door was kept locked even when staff were in the office. The manager told us this was to keep people out as if she left the door open people kept coming in for cigarettes. We saw when people entered the office they were swiftly escorted out by staff.

There were limited opportunities for people to be involved in a meaningful way in decisions about the home and their daily lives. There were no formal systems in place to gain the views of people who used the service, relatives or health care professionals. When we asked the manager about this they told us satisfaction surveys were not used and there were no other systems in place to gain this information. People we spoke with told us they had never been asked for feedback about the service.

We asked the manager about any improvements that had been made or were planned to the service. She told us some areas of the home had been refurbished and the service was looking to recruit two nurses. The PIR asked what improvements the service planned to introduce to make the service better led and the response given was the service was planning to set up a qualified staff meeting every two months. No other information was provided.

We found management lacked understanding of the principles of good quality assurance which meant best practice was not recognised or developed to move the service forward and improve outcomes for people.

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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure each service user received care that was appropriate and safe Regulation 9 (1)(a)(b)(I)(ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not protected service users and others against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15(1)(c)(i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure that people's dignity and independence were maintained as far as practicable, or to enable service users to make, or participate in making, decisions about their care.** **People were not always treated with consideration and respect or provided with opportunities to promote their autonomy, independence and community involvement. Regulation 17 (1)(a)(b) (2)(a)(h)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place to bring the complaints system to the attention of service users. Regulation 19 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not protect service users from the risks of inadequate nutrition and dehydration by providing support to enable service users to eat and drink sufficient amounts for their needs. Regulation 14 (1)(a)

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not have suitable arrangements in place to safeguard service users against the risk of abuse as they had not protected service users from the unlawful use of any control or restraint. Regulation 11 (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to people. Regulation 23 (1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 10 (1)(a)(b)(2)(v)**