Woodlands Retirement Residence Limited

Woodlands Retirement Residence

Inspection report

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West Midlands
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Tel: 01384394851

Date of inspection visit:
14 February 2018

Date of publication:
04 June 2018

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?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 14 February 2018. At our previous inspection in December 2016 we had concerns about the quality of care and the management of the service. We found a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider was still in breach of Regulation 17 and we found a further five breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

Woodlands Retirement residence is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates 19 people in one building. At the time of the service 17 people were using the service.

There was a registered manager who was also the registered provider. 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.

The registered manager had not responded and improved the quality of care following our previous inspection and feedback. There was a culture of keeping people safe by restricting their freedom to be independent.

The registered manager did not always follow policies and guidance to ensure people were receiving care that met their individual needs. Staff did not always feel the registered manager was approachable and staff or people were not involved in the running of the home

Risks to people were assessed and lesson learned however actions taken to reduce the risks were restricting people's freedom. There were still insufficient numbers of care staff to maintain people's safety. The registered manager had not recognised and responded to potential safeguarding injuries.

The principles of the Mental Capacity Act 2005 were not being followed to ensure that people were consenting to their care at the service.

People's needs had been assessed however staff did not always have the information they needed to care for people effectively. Staff received training and supervision however they did not feel supported by the registered manager.

The environment was well maintained and nicely presented however consideration to supporting people living with dementia required further action.

People were not always treated with dignity and respect and their right to privacy was not always upheld. People were not always involved in making decisions about their care and support.

People were not all receiving care that was person centred and that met their individual preferences.

People's medicines were safely stored and administered and the infection control procedures in place prevented the spread of infection.

People's nutritional needs were met and they had access to a range of health care agencies when their needs changed or they became unwell.

There was a complaints procedure and people felt able to complain.

People's end of life wishes were noted and when necessary they were cared for to ensure a comfortable and pain free death.

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 safety of the service remains as requires improvement.

Risks to people were assessed and lesson learned however actions taken to reduce the risks were restricting people's freedom.

There were still insufficient numbers of care staff to maintain people's safety.

The registered manager had not recognised and responded to potential safeguarding injuries.

People's medicines were safely stored and administered.

The infection control procedures in place prevented the spread of infection.

New staff were employed through safe recruitment procedures.

Is the service effective?

Requires Improvement

The effectiveness of the service remains as requires improvement.

The principles of the MCA were not being followed to ensure that people were consenting to their care at the service.

People's needs had been assessed however staff did not always have the information they needed to care for people effectively.

Staff received training and supervision however they did not feel supported by the registered manager.

The environment was well maintained and nicely presented however consideration to supporting people living with dementia required further improvement.

People's nutritional needs were met and they had access to a

range of health care agencies when their needs changed or they became unwell.

Is the service caring?

Requires Improvement

The service remains as requires improvement in caring.

People were not always treated with dignity and respect.

People's right to privacy was not always upheld.

People were not always involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

This responsiveness of the service remains as requires improvement.

People were not all receiving care that was person centred and met their individual preferences.

There was a complaints procedure and people felt able to complain.

People' s end of life wishes were noted and when necessary they were cared for to ensure a comfortable and pain free death.

Is the service well-led?

Inadequate

The service was not well led and is now rated Inadequate.

The registered provider had not responded to our feedback in full following our previous inspections to improve the quality of care for people. .

There was a culture of keeping safe by restricting people's freedom to be independent.

The registered manager did not always follow policies and guidance to ensure people were receiving care that met their individual needs.

Staff did not always feel the registered manager was approachable and staff or people were not involved in the running of the home.

Woodlands Retirement Residence

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 checked 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.

This inspection took place on 14 February January 2018. It was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR) which they did. 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 reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We spoke with five people who used the service and observed others care and support. We spoke with one relative, four care staff members and the registered manager.

We looked at the care records for three people who used the service and two staff recruitment files. We looked at the incident/accident reports, rotas and at the systems the provider had in place to monitor and improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we rated the safety of the service as 'requires improvement as we found the registered manager did not have a system in place to ensure there were sufficient staff to meet people's needs and medicines were not always managed safely. At this inspection although we found there had been improvements in the management of medicines we had further concerns about the safety of the service and found there were two breaches of The Health and Social Care Act Regulations (Regulated Activities) Regulations 2014.

Risks of harm to people were assessed and lessons were learned following incidents as we saw that the registered manager recorded what action they had taken following an incident. For, example, putting a bed sensor and mattress in place if a person was at risk of falling out of their bed. However we found that people were being supported to remain safe in other ways by restrictions on their freedom. One person who used the service told us: "The staff won't allow you to do things that are dangerous. If I got up and walked they would ask me to sit back down". Another person told us: "The staff make sure I am safe. I can't walk and I don't try as it's not fair on the carers if I fall". Several people required a walking frame to mobilise and we saw that when people were sat down in either the lounge of dining room their frames were routinely taken away from them. We saw one person's risk assessment stated that their walking frame should be removed from them to prevent them from trying to walk. We observed another person whose risk assessment stated they were independently mobile was asked to sit down when they stood up to fetch a blanket for another person. This showed that people's freedom to be independent was being restricted.

We saw some people's risk assessments stated that the night staff should bring them downstairs in the morning and not leave them in their bedrooms due to them being at risk of falling. We found that this practise was happening and people were being routinely woken and brought downstairs for 7.30am. We discussed these concerns with the registered manager who told us that this was to minimise the risk of people falling, however they had not considered people's rights and to being able to freely mobilise as they wished.

Staff we spoke with had received training in the safeguarding processes and understood the signs that a person may have been abused. The registered manager told us that they had no safeguarding incidents and had raised no safeguarding referrals with the local authority. However, we saw that there were occasions when unexplained injuries to people that had been noted and no action had been taken to investigate. These injuries may have been due to abuse or poor care. This meant that people were not always being safeguarded from the risk of abuse.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we had found that the registered manager did not have a system to be able to assess how many care staff were required to meet people's needs safely. At that inspection we found that the registered manager had reduced the care staff from four staff to three staff in the afternoons. Staff we spoke

with told us that there were not enough of them to be able to spend quality time with people. At this inspection the registered manager still had no system to calculate staffing levels and they had now further reduced the numbers of care staff from four staff to three staff in the mornings and increased the domestic staff. We asked the registered manager why they had done this and they told us that now they had more domestic support the care staff had no domestic duties to carry out. However, we observed that there were times during the day that people were who had been assessed as being at high risk of falls were left unsupervised in lounges and dining areas as the care staff were busy in other areas of the home. We saw one person who had been assessed as high risk of falling walking unsupervised along the corridor. This showed that there were insufficient numbers of staff to be able to keep people safe.

We saw that care was task orientated and staff had no time to sit with people as they were continually busy. We saw one person sat at the dining table asking to go to the toilet. The member of staff was already supporting one person to walk to the toilet and there were no other staff available. They asked the person to wait for them to come back instead of offering the person their walking frame which was out of reach and allowing them to take themselves. The person was unable to move until a member of staff brought them their frame.

We saw the numbers and deployment of staff at times had potential to put people at risk. For example, we saw that staff were not always in place to keep people safe and meet their needs. We heard the call bell ringing at one end of the home. All the care staff were at the other end of the home due to the activity that was taking place. When a member of the care staff finally heard the call bell they said: "We can't hear the call bell when we are in that end of the building, I wonder how long it has been ringing?" This showed that the care staff were not deployed safely throughout the home to ensure people's care needs were met in a safe and timely way.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that medicines were stored and administered safely as Improvements had been made to the management of medicines since our last inspection in December 2016. We saw for example that competency checks were undertaken by the registered manager on staff to ensure they were safe to support people with their medicines. Staff told us they had been trained to support people safely with their medicines and we saw audits were completed to checks medicine supplies and records. We saw there were protocols instructing staff as to when to administer 'as required' medication such as pain relief.

We looked at how people were being protected from the spread of infection. We saw that staff used protective equipment such as gloves and aprons when supporting people with their personal care and that there were hand wash available throughout the home. The kitchen was well maintained and had received a five star rating from the environmental health. We found the home was clean and tidy with designated domestic staff.

We saw the registered manager had conducted recruitment checks prior to staff starting work at the service. Reference checks, identify verification and Disclosure and Barring Service (DBS) checks had been completed for the three people whose files we reviewed. DBS checks help providers reduce the risk of employing unsuitable staff. Staff we spoke with confirmed that these checks had been made before they commenced employment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated the provider as 'requires improvement' as staff did not have support through regular supervision or staff meetings. We also found the Mental Capacity Act 2005 was not being consistently implemented to ensure people were not restricted unlawfully. At this inspection we found that there had been improvements in the supervision and training of staff however people were at continued risk of being deprived of their liberty.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that people's mental capacity to agree to their care had not been comprehensively assessed. Although it was noted if people were living with dementia, specific decisions about their care and their ability to consent had not been considered in the assessment process.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that no one who used the service had been assessed as requiring a DoLS or referred as requiring a DoLS authorisation and several people would have been unable to consent to their care at the service due to them living with dementia. We discussed this with the registered manager who told us that this was because no one had asked to leave the service. However, we saw one person's care records showed that they had asked to leave and had been refused. This person had also been stopped from going upstairs on one occasion as staff had blocked their way. The registered manager told us that this was for their own safety; this showed that they had a lack of understanding of the MCA. The principles of the MCA had not been followed to ensure that these decisions were the least restrictive and in their best interests.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that since the last inspection they had received supervision from the registered manager and had staff meetings. However they told us that they did not feel they were always listened to. The minutes of two staff meetings we saw contained an outline of information passed to staff but there was no record of comments, discussions or ideas shared by staff, which indicates that the sharing of best practice was limited.

People's needs were assessed prior to being admitted into the service. However the care plans we looked at did not give staff specific information as to how to provide care dependent on people's individual assessed needs and choices. Some people who used the service due to their mental health needs became anxious or were noted as becoming agitated. We saw that some people had the involvement of a community mental

health nurse to offer advice and support. However, there was limited information as to how to support people when they became anxious dependent on their individual needs. One person's mental health assessment stated '[Person's name] has dementia and gets anxious and agitated. This is controlled by medication'. This showed that best practise guidance was not being followed to ensure people's needs were met effectively.

People told us that they were generally happy with the food they received. One person told us: "The food is plain, nicely cooked. The girls cut it up for me, they are very helpful. Lamb I can't eat or cheese. If lamb is on the menu I ask for everything else that comes with it but not the lamb". We observed lunchtime and saw there was a choice of main meals and desserts. We spoke with the cook who was aware of people's nutritional requirements and we saw an assessment tool that had been implemented to identify people at risk of not eating enough or losing weight. Staff had the support of the external nurse practitioner to check people's weights and monitor the use of prescribed supplements. This ensured referrals could be made to specialist advisors when required such as speech and language therapy when people's swallow was compromised and dieticians when there were concerns regarding people's food intake and weights. The provider had purchased new sit on scales to support this area of care following advice from our previous inspection.

People had access to a range of health care professionals and there was a weekly visit from the senior nurse practitioner linked with the local GP surgery. We saw the necessary referrals were made when people's health care needs changed such as the physiotherapist if a person was having difficulty with their mobility or the district nurse if a person had sore skin. This showed people were supported to remain healthy.

The environment was warm and comfortable and nicely decorated and maintained. There was a garden area which people told us they used in the summer months. One person told us: "It's a pleasure to look out at the lovely gardens here; when the weather is better we go out into the gardens". We saw toilets were raised and the bathrooms were in the process of being adapted to ensure people could access them safely. People's bedrooms were personalised we saw everyone had a call bell in reach of their beds. Many people who used the service were living with dementia and we discussed with the registered manager about good practise guidance in relation to adapting the environment to support people to orientate around the building. For example clear signage of important rooms such as the toilet or people's bedrooms. The registered manager told us that they were currently looking into completing this and had purchased some signage. We were not shown this on the day of the inspection and will look for improvements in this area when we next inspect.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we rated the provider as 'requires improvement' as people's privacy and dignity was not always protected and staff attitude was not always caring. At this inspection we still had concerns that people's dignity was not always being considered.

During the morning in the lounge area we observed a member of the care staff brush four people's hair with the same hairbrush which they carried around in their pocket. Although they asked each person if they wanted their hair brushing they did not wait for a response before brushing their hair. They had also not considered it undignified to use the same hair brush on different people.

We observed a member of staff asking one person to sit down. The person was attempting to help another person who used the service by getting them a blanket as they were cold. When asked to sit down, the person responded by saying: "It's worse than being in the army here". This showed that the person did not feel respected or valued.

We overheard another member of staff say to a new person who they had not met before when referring to their height: "You are a diddy little thing, aren't you a little thing". This did not consider this person's feelings about their height and was not respectful of the person as an adult.

We also saw a new vinyl chair in the lounge which was covered in plastic. It was being sat on by one person who used the service. We asked the registered manager why there was a plastic cover on the chair and they told us this was because the person deposited 'bodily fluids' on the chair. However, the chair was wipe able and the plastic cover highlighted that the person had an issue with their personal hygiene and would have not been comfortable to sit on for long periods. The registered manager agreed that this was not dignified and assured us they would remove the cover.

We observed the daily routines were embedded and people did not always get to choose what time they got up, had a bath or the times of meals. For example breakfast was at 7.30am and lunch was at 12.00pm. One person told us about getting up: "I think they would have a fit if I said I wanted to get up later. I personally would like to get up later". Although there were meetings for people who used the service these routines had not been discussed and agreed with them.

We also saw there was a restricted visiting notice displayed advising families to avoid mealtimes as this was in people's best interests. However, there was no evidence to support that people living in the home had been consulted about this.

Although some people told us they were able to be independent we saw that people who the staff deemed to be at risk were constantly asked to sit down. People's walking frames were routinely taken away from them to prevent them from mobilising. This did not demonstrate a dignified approach to these people's care and it did not encourage their independence.

People had their own rooms and people who could safely mobilise could access their rooms when they liked. However, we saw examples of where people were stopped from accessing or staying in the privacy of their own room as the registered manager had deemed it unsafe. This meant that people's right to privacy was not always respected.

These issues constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to told us that the staff were kind to them. One person told us: "The staff have been golden to me. They look after me well". Another person told us: "This to me is my home. I like it here, it's a comfortable place". We did observe most interactions between people and the staff that were kind and respectful.

The provider advised that they had advocacy contacts to support people who lacked the capacity to speak up on their own behalf but no one currently used this service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated the provider as 'requires improvement' because people had not been involved in reviewing or planning their care. There was also a lack of stimulation and opportunities for people to engage in activities of interest and hobbies. At this inspection we found that some improvements had been made in relation to activities however further improvements were required.

People had care plans which we saw were regularly reviewed by the registered manager. However the plans lacked detail on how people liked to have their care delivered and their preferences. The reviews of people's care did not involve the person themselves and their views were not gained on the service they were receiving and whether it was meeting their preferences.

We found person centred care was compromised by the routines and task led approach to care. These routines limited the choices available to people and was not always responsive to people's needs as reflected in the lack of choices available as the time people got up, when they ate and when they had a bath. A member of staff told us: "People are got up by the night staff, it's like a routine, and most people are up by 7.00am when I get here".

We saw the registered manager still utilised a bath and bowel book rather than recording people's individual needs in their own personal records. People had a bath or shower on the same day every week. These systems did not support staff to work in a person centred way.

People living with dementia were not having their needs in relation to their dementia met. There was no stimulation offered outside of the one planned activity that took place. People were either asked to sit down if they stood up or when able to walked up and down the corridor. There were no tactile or sensory items available to support people with dementia to feel occupied. Guidance states: Providing appropriate sensory stimulation for Alzheimer's disease and other forms of dementia has been shown in recent studies to decrease agitation and restlessness, as well as improve sleep.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection all apart from two people joined in a group activity of music and movement. A member of staff told us: "We have film afternoons, we have moving to music people come in regularly, some of the residents knit and sew, some of the ladies get great enjoyment from colouring in books and they even ask for them". One person told us: "I go to church and there are two local churches that call in here and conduct services". We discussed whether the registered manager felt that they would be able to respect and meet the needs of people of different cultures, religion and sexual persuasion and they told us they would.

There was a complaints procedure and we saw that this was on show in the lounge area. A relative told us: "I have no complaints and there have been no problems at all, I would know how to make a complaint if I needed to". The registered manager told us that there had been no formal complaints; however given there

was a lack of flexibility and choice the registered manager should seek ways to raise people's expectations and actively encourage people to share their views. This would ensure people feel listened to and valued.

People's end of life wishes were gathered in relation to where they wished to be cared for and any pre planned funeral arrangements. The registered manager told us that they had facilitated some palliative care training for staff. They told us when people were assessed as being at the end of their life they worked with the palliative care team to ensure that people were as comfortable and pain free as they were able to be.

Inadequate

Is the service well-led?

Our findings

At our last inspection we identified that there was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered manager did not have effective auditing systems in place to monitor and improve the quality and safety of the service. At this inspection we found there was a continuing breach of this regulation and a further four breaches of regulations.

There was an inconsistency in the experiences people had living in the home. People who were physically able to mobilise and who had the mental capacity to make decisions for themselves experienced more choice and autonomy, whereas people who were living with dementia or who were at high risk of falls were restricted to maintain their safety. One person told us: "I make my choices; I do have family members that help me. I am not bossed about by anybody". Yet we observed that other people were restricted by routines the registered manager and staff had put in place seemingly to keep people safe. The registered manager had not recognised that these routines affected the quality of life for some people who used the service.

Staff had training to guide their practice in respect of people having choices and their decisions being respected, however the registered manager was not ensuring these principles were put into practice. The routines that were in place impacted upon staff's capacity to provide a more person centred approach to care. There were some institutionalised practices around dignity and respect and a lack of people being involved in their care or making decisions. We had previously shared these concerns with the registered manager in December 2016 and again in August 2017 however these practises continued and the quality of care had not improved. This showed that the registered manager was not responding to our feedback to improve the quality of care for people.

There was little evidence to support the view that the registered manager promoted a set of values amongst the staff team and ensured people received 'good' care. When we fed back our findings in relation to the member of staff using the same hairbrush the registered manager told us that they knew who that would be. This showed that the registered manager had not acted to prevent this practise from taking place and ensure people received dignified care.

At our last inspection in we identified concerns about staffing levels. At this inspection we saw the registered manager had still not implemented a dependency tool to assess the safe level of staff required to meet people's needs. Since the last inspection there had been a reduction in care staff in the mornings and an increase in domestic staff. The registered manager told us that the standard of cleanliness had not been an issue prior to the increase in domestic so it was unclear why care staff had been reduced and domestic staff increased.

We saw that the registered manager completed maintenance checks of the building including checking of the safety of any commodes that were in use. We found three commodes which were in use that were unsafe as the rubber bungs had come off and this created a hazard as if the leg of the commode ended up on a person's foot this would cause an injury. This meant that this maintenance check was ineffective as the registered manager had not identified these faults.

We found that people's daily care records were poorly maintained on pieces of paper. The sheets of paper were not dated or numbered and were often loose in the records file. A person's daily record could have easily gone missing as they were not being secured safely in the file. These daily records were not audited for their content and this meant that the registered manager was not ensuring the safe keeping of people's records and checking that people were receiving the care they required.

The registered manager reviewed people's care plans regularly but this did not include asking the person themselves if they were happy with the quality of care they were receiving. There were resident meetings but these did not evidence that people were asked their views on the service they received and whether any improvements could be made.

There was a task based culture in the home. People's care was not tailored to their individual needs and disproportionate restrictions were placed upon people in an attempt to maintain their safety. Neither the registered manager or care staff recognised that people's dignity and privacy was not being upheld in the home. The registered manager who was also the provider had not updated their knowledge related to best practice guidelines in supporting older people or people living with dementia. As a result of this people experienced care in a way that did not meet their individual needs. People's feedback about the care they received was not sought or valued by the registered manager or the staff providing their care.

These issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not feel valued or that they had the opportunity to contribute to the development of the service. Staff we spoke with told us that they felt the registered manager was unapproachable. They told us that there had been occasions where they had been spoken to inappropriately in front of other staff. We were unable to clarify this however we did see minutes of staff meetings which only documented comments made by the registered manager and did not note any feedback from staff.

The registered manager mostly worked with other agencies to deliver care. For example, on the day of the inspection they were liaising with a health professional about the changing needs of one person who used the service. However, they had not liaised with the local authority in relation to some people who may have been being deprived of their liberty by not being able to consent to their care and they were not following good practise guidance in relation to supporting people living with dementia. This meant people were not always receiving good quality care that met their individual needs.

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care that was person centred and reflective of their individual preferences.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and their right to privacy upheld.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA 2005 were not being followed to ensure people's mental capacity was assessed.

The enforcement action we took:

We issued a warning notice.

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 People were not always safeguarded from inappropriate care and restrictions on their freedom.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the quality of the service were ineffective.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There insufficient numbers of care staff to keep people safe.

The enforcement action we took:

We issued a warning notice.