Leonard Cheshire Disability

Dorset Learning Disability Service - 4 Romulus Close

Inspection report

4 Romulus Close
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Date of inspection visit:
12 December 2019
13 December 2019

Date of publication:
18 March 2020

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

About the service
Dorset Learning Disability Service - 4 Romulus Close is a small residential home providing personal care to four people with learning difficulties, autism and mental health needs. At the time of the inspection there were three people living at the service.

People's experience of using this service and what we found
The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. We found some examples of choice and control being restricted.

At the last inspection the service was rated as requires improvement overall. The overall rating as remained as requires improvement, however there has been a deterioration in the rating for four key questions. 'Is the service safe?', 'Is the service effective?' and 'Is the service caring?' have changed from good to requires improvement. The key question 'Is the service well led?' has decreased from requires improvement to inadequate.

We found multiple breaches of regulations. This showed that the provider had been unable to make or sustain the improvements required at the service to ensure people receive safe, effective and high quality care.

People's safety had been placed at risk due to safeguarding not always being given sufficient priority, to ensure people remained safe. For example, when people experienced or were at risk of harm, action was not taken quickly to inform the relevant authorities.

The provider had not assessed and managed risk, which placed people at risk of harm. Some people's nutritional and hydration needs had not been fully assessed when risk occurred. Following one person having an episode of choking, measures had not been taken by the provider to reduce the risk with immediate effect.

There were not always enough staff on duty to meet people's needs safely. However, following our inspection, the provider increased the staffing levels at the service to ensure people's needs could be safely met. Staff knew people well and had developed meaningful relationships with them.

People were not always supported to have maximum choice and control of their lives, and staff did not always support them in the least restrictive way possible, and in their best interests. The policies and systems in the service did not always support this practice. There was no evidence that less restrictive options had been considered when managing people's freedom of movement at the service.

Staff contacted health professionals when required. Staff we spoke with were knowledgeable about the support needs of people they worked with. Staff worked closely with social workers and learning disability nurses.

There was inconsistent management support and lack of governance at the service. This meant there was a risk that systems in place to monitor the quality and safety of the service were ineffective. Following their compliance audit the senior team requested a review of care for all people living at the service.

Following our last inspection, the provider had taken steps to provide information in an accessible format for people. Key policies such as complaints, and care plans were available in an accessible format. Some people using the service were able to sign. Staff informed us they had not received any training in regards sign language, although they were able to understand people well.

People were observed receiving kind and caring support. They had effective caring relationships with staff. Staff could explain how different support worked for different people.

The last rating for this service was requires improvement (published 01 January 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

We identified five breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. We also identified a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations.

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

Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Dorset Learning Disability Service - 4 Romulus Close

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by one inspector.

Service and service type
Dorset Learning Disability Service - 4 Romulus Close 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 did not have a manager registered with the Care Quality Commission.

This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with three people who used the service and two relatives about their experience of the care

provided. We observed people's interaction with staff. We spoke with three staff members, one health professional, the new manager and service manager.

We reviewed a range of records. This included three people's care records and one medication record. We looked at four staff files in relation to recruitment and staff supervision. Records relating to the management of the service.

After the inspection –

We continued to seek clarification from the provider including a telephone call to the regional operations manager to validate evidence found. We asked the provider to send us more information such as staff training details.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to required improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

●There was a risk that people were not supported to transfer safely. For example, one person's care plan was unclear how many staff they needed to transfer. There had been incidents where the person's arm had become trapped in their wheelchair. Staff told us, "We can do the move with one member of staff, but we can position (person's name) so much better with two members of staff". The person's moving, and assistance guidelines stated the person needed two staff to ensure they were in the correct sitting position. We discussed our concerns with the service manager who informed us, "We do need two support workers to assist or they are restricted. This needs to be reassessed". This meant there was a risk that people may not be moved safely which puts them at risk of harm. Following the inspection staffing was increased.

● People were not always supported to eat and drink effectively. Information about people's nutritional needs and preferences was recorded in their care plan. However, when risks occurred, referrals were not always made to appropriate health and social care professionals promptly. For example, one person had a choking episode on 4 December 2019. The incident form had not been reviewed until 11 December 2019. Records showed the person had continued to be given the same food that they had choked on following the choking incident. This meant the risk had remained. On the second day of the inspection we were informed new guidance had been sought from the speech and language team. They advised until a new assessment was completed staff were to stop giving the person the food that had caused them to choke.

Learning lessons when things go wrong

● Lessons were not always learnt, and safety concerns were not consistently identified or addressed quickly enough. The service manager told us a recent provider compliance review had identified that systems need to be improved. The service manager informed us that lessons had not been learnt when things had gone wrong. They told us, " I admit there is improvement needed, but I don't have time, the senior managers are aware that I need time to look at quality improvements and to do spot checks at the services".

We found systems were either not in place or robust enough to demonstrate risks to people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The service did not always ensure that there were enough staff on duty to ensure people's safety. One person needed someone to sit with them whilst they were eating; another required two staff to support with

moving and assisting. One relative told us, "There is never enough staff on duty, there used to be four people living there, when one left they cut the staffing back". Another raised concerns that when only one member of staff was on duty they did not feel people living at the service could be supported safely.

●Staff rotas for the last four weeks showed staff worked alone from either 6 or 7pm, until new staff came on duty the next day. Staff told us "Shifts were long", and it was difficult to support people on their own.

● Staff lone worked during the evenings, two people were reported as being intolerant of each other on occasions. One member of staff told us, "We have to keep an eye on them when they are in the same room, it's difficult when there is only one of us on duty. We can't be in two places at once". This meant there was a risk that effective outcomes were not being sought for people who used the service. Following the inspection, the provider told us they had increased the staffing levels.

● Staff files showed that appropriate records including checks from the disclosure and barring service (DBS) and references were in place. However, we reviewed two recruitment files and found both files had gaps in employment history. This meant there was a risk that unsuitable staff may be recruited as a result. The service manager took immediate action to rectify the errors.

The provider's failure to ensure there were enough, suitably qualified staff was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

●Safeguarding was not always given sufficient priority, to ensure people remained safe. For example, when people experienced or were at risk of harm, action was not taken quickly to inform the relevant authorities.

● The service had policies and procedures to guide staff how to keep people safe, for example the recording of accident and incidents. Staff told us, "We complete accident and incident forms and put them on the desk. Sometimes they are there a while before the manager picks them up."

● Staff were able to demonstrate the process to take if they were concerned in regard to abuse.

Systems in place were not operated effectively to ensure people were safe. This was a breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People received their medicines safely from competent staff. All staff who administered medicines undertook training and a competency check before they took responsibility for people's medicines administration.

● Some people were prescribed medicines, such as pain relief, on an as required basis. There were no protocols in place to tell staff when these medicines should be administered. The service manager told us they would action this with immediate effect.

Preventing and controlling infection

●Staff had access to personal protective equipment (PPE) and knew how and when to use this.

●Staff completed the cleaning of the service and the cleaning rota guided them to ensure all area of the service were kept clean. Staff were using an electronic system to record when they had completed cleaning tasks.

●Staff received food hygiene training and correct procedures were followed where food was prepared and stored.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received the appropriate training in regards their understanding of restraint. People did not always have freedom of movement around their home. On one occasion, one person was restricted behind a kitchen door. Staff told us this was to keep them safe whilst the front door was open. There was no evidence that less restrictive options had been considered. We discussed our concerns with the service manager who informed us restrictive practices around the service was being reviewed by the provider, following their recent internal compliance audit. We informed the local authority of our concern with regard to the restrictive practice.
- Staff had not received all the training they needed to provide safe and effective care. Staff did not have adequate training in the use of physical intervention. This had resulted in them using techniques they had not been trained in to manage people's behaviours whilst out in the community.

The restriction of freedom of movement was a breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they did not always feel supported at work. Comments included, "We seem to be left to get on with it. We don't receive regular supervisions." " I don't know when I last had a supervision, it was a while ago. We are all feeling pretty unsupported by the management team". One member of staff had not received supervision since January 2018. The service manager told us, "We have a new manager in position. We will ensure we review our supervision process, to ensure action is taken to get supervisions back on track".

The provider's failure to ensure staff received appropriate support in regards supervision and appraisal was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff monitored people's weight, and when they were at risk of losing weight or needs changed they sought the advice of professionals which they acted on.
- People received the support they required to eat their meals. One person needed staff to sit and support them with a 'two plate system'. We observed staff sitting with the person supporting them to eat slowly by putting small amounts on their plate, and then adding more when required from the other plate. Another

person required physical assistance to eat their meal, at lunch time we saw they received full support in a dignified way.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

●People at the service were living with a learning disability or autism, which affected their ability to make some decisions about their care and support. Mental capacity assessments and best interest paperwork were in place. However, staff told us one person had not been able to have their holiday this year as a best interest meeting had not taken place. One support worker told us, "(Person's name) missed their holiday, they (managers) said it needs to have a best interest meeting. They never had the meeting, so (person's name) never had their holiday".
● Some people had conditions on the DoLS. Some of the DoLS needed to be reviewed and updated as conditions were out of date. For example, one person's conditions were linked to medicine that the person no longer required.
● Staff had completed some previous training about DoLS but needed refresher training about the MCA as they lacked some knowledge in this area.
●Staff sought people's consent before providing care. Staff were overheard on numerous occasions asking people for their consent, for example to enter their room.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider conducted an assessment of people's needs, so staff knew how to support them.
● Staff we spoke with were knowledgeable about the support needs of people they worked with.
Care plans contained information about health conditions and appointments with professionals.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives.
● People had access to a range of health and social care professionals, including social work and learning disability team, to achieve the best outcomes for people. One staff member told us they worked closely with social workers and learning disability nurses. They said, "We have good working relationships with the GP and other health professionals".
● People had various specialist professionals involved in their care and support, and all the information was detailed in the support plans and staff were made aware of any changes.

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

● People had their rooms personalised and were encouraged to have their own belongings in their rooms, which reflected their personal interest and preferences.
● The communal areas and outside areas of the service were in need of refreshment and updating.
● Where necessary, appropriate aids and equipment were in place to meet people's needs, including specialised seating and ceiling track hoists.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's independence was restricted due to sharing transport with other services run by the provider. Staff told us this limited their ability to take people out. Comments included, "There are only two vehicles that can support wheelchairs, this limits our access." "The big issue is the bus, we used to have our own bus, now we have to wait until it's free. This is a problem between the houses as everyone wants it, Particually at this time of year."
- People were treated with dignity and respect. Staff spoke with people in a friendly but polite manner. One relative told us, "Yes I am sure they are all respected. The staff all seem fine, they talk to me when they need to. There is another manager, but I have not met her yet".
- Personal records were kept securely.

Ensuring people are well treated and supported; respecting equality and diversity

- Although people were not always able to tell us they felt well supported we observed caring and kind interactions throughout the inspection. People had effective caring relationships with staff who provided their care and support. Staff could explain how different support worked for different people.
- People told us they 'Liked staff and thought they were kind'. Although some people were unable to voice this, they smiled and gave us a 'thumbs up'.
- Throughout the inspection we observed a positive and inclusive culture at the service, and heard staff supporting people with a kind and respectful manner in their approach. They responded to people's differing needs, by touch, tone of voice and eye to eye contact.
- A social care professional who had contact with the service confirmed that staff were "Friendly and approachable."

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

- Staff understood people's communication needs, where people were not able to verbally communicate their choices or emotions. Although staff had not received sign language training, they were well informed about people's non-verbal communication methods.
- People's cultural and spiritual needs were respected. Staff encouraged people to receive visitors in a way that reflected their own wishes and culture, including time spent in privacy.
- The service supported people to maintain relationships with friends and family. Relatives told us they could visit their loved one when they wished.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as require improvement, because the provider was not meeting the requirements of the Accessible Information Standards (AIS). At this inspection the rating for this key question has remained the same.

This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers. The provider was not meeting these standards.

●Following our last inspection, the provider had taken steps to provide information in an accessible format for people, however improvements were still required. People had sensory impairments or were living with autism, which meant it was important for them to have structure to their day. One person's care plan informed us it was important for them to have information which informed them what day it was, and what the events of the day were. We noted their communication board did not have the correct planned events in place. Staff told us they did not have all the correct photos to use on the board. They said, "If they are going out we just put the photo of the bus, we don't have all the specific photos".
●Some people using the service were able to use sign language. Staff informed us they had not received any training in using sign language, although they were able to understand people well, through their body language and approach. The service manager informed us, gaps in their training programme had been noted, for example communication, moving and assisting and behaviour support. They informed us staff would be accessing training early 2020.
● Improvements were required in regards how the communication needs of different people were met. For example, at our last inspection one person's communication aid was not working. We found at this inspection the aid was still not fixed. This meant the person's ability to communicate their needs were still restricted.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
●People had set days where they were supported with activities however, we observed that if people were not on one of their planned activities they had limited opportunities to participate in any other activities. One person was often directed back to their room to play their keyboard, others sat in the dining room with staff or alone in the lounge watching TV. Staff told us they were limited to what they could do with people due to the lack of transport and sufficient staffing levels.

This meant improvements were required in how people's sensory and communications needs were met. This was a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's relatives told us that they felt involved in their loved one's care. However, this was not always reflected within the care planning process, and there was no evidence that reviews had taken place. The provider had identified that information was out of date in their care records and were in the process of updating all their care plans in a format that people could easily understand.

Improving care quality in response to complaints or concerns,

● A complaints policy was available, however there was no evidence of complaints or how these had been dealt with. The service manager told us they had received a complaint from a relative that had been resolved.

●Relatives told us that they felt confident in raising any concerns or complaints.

● The provider had evidence of easy read formats for complaints, however these were not noted around the home where they would be accessible to people and their visitors.

End of life care and support

● There was nobody receiving end of life care at the time of the inspection.

● Two people had end of life care plans in place, however, further work was required to make them person centred, as the plans had been written many years ago at a different service. The service manager told us that they would ensure they reviewed their end of life care plans and make them personalised.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. This was because the systems to monitor and improve the quality of the service were not effective. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- During our inspection of Dorset Learning Disability Service - 4 Romulus Close , we found significant shortfalls in the way the service was governed. There had been a lack of effective leadership and management. There had been no oversight into the daily lives of people living at the service to ensure that their needs were being met.

- At our last inspection we found systems to monitor and improve the quality of the service were not effective. We found at this inspection the concerns remained.
- The management of the service had been inconsistent, and the culture created did not always support the delivery of high-quality, person-centred care. There was little focus on reducing restriction and promoting people's basic rights. Many of the risks found throughout our inspection, such as restrictions around the service and unsafe staffing levels, had been overlooked by the management team as they had become accepted as part of the culture of the service.
- The service had not had a registered manager in position since 27 September 2019. Staff told us they did not have any senior support at the service. They told us morale was low and they felt isolated. Comments included, "We are just left to get on with it, morale is low". "We need more support and managers to listen to us". "We need better communication". The service manager told us, "I admit this service has suffered because it has had poor management recently. This will improve now following our compliance visits and the appointment of a new manager".
- Feedback to staff was not effective and they were not clear about some of the guidance to follow . For example, one staff member told us, "We need to use mechanical restraint to keep (name) safe when out in the community. I have never received training on the use."

The provider did not always operate effective systems and processes to make sure they assessed and monitored the service. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●The provider had not sought regular feedback from people and their families and people had not received regular reviews of their experience of care. Relatives told us they had been asked in the past about their views but not for a long time.
●Staff had opportunity to complete feedback forms on their experience of working at the service. Staff feedback leaflets were available in the staff sleeping in room, with stamped address envelopes. We reviewed some comments and found them to be negative. There was no evidence of action taken by the provider to address the comments.
● Prior to our inspection the provider had completed their own compliance inspection which identified areas of concern found during our inspection. The provider had taken action to address the concerns identified. They had ensured two senior managers would have regular oversight of the service and support the new manager. The regional operations manager told us, "Quality issues have been identified following our internal audit, measures are being taken to address the concerns identified".
●Following the inspection, the service manager informed us, staffing levels had been increased to two staff each evening. Two new SALT Assessments were in place. They told us " Staff were now very clear what they should do and how they should support people". They also informed us they would be seeking guidance and clarity in regards the use of restraint and ensuring behaviour support plans were in place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider had failed to ensure the service met regulatory requirements. At this inspection we identified six breaches of the regulations.
● The registered manager had left the service in September 2019. There is a requirement that providers need to inform the Care Quality Commission when a registered person is absent. The Care Quality Commission had not been informed the registered manager had left, and a new manager was in post. The new manager was currently on induction and would have the responsibility of managing two services.

This failure to notify us of the absence of the registered manager is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations.

● The service had clear lines of organisation and staff were clear about their roles and responsibilities, however felt that they lacked regular support from the provider. One member of staff told us, "It has been a tough time with the lack of managers. I am now feeling that we have a manager in place we are hoping that things will get better".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The registered manager understood the requirements of duty of candour that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm.

Continuous learning and improving care
●The service manager and regional operations manager were open with us about areas of the service which required improvement and had begun to make some changes at the service. For example, the management team had begun to update all the care plans ensuring they were all in easy read format.

Working in partnership with others
● The local authority had completed an audit of the service in February 2019, which found similar concerns identified at our last inspection in January 2019. They told us they had planned to review the progress in regards their action plan at the same time as our inspection. They informed us they would continue to work

closely with the service.

●The service worked well with other organisations. They had good relationships with local healthcare services for example, local GP's, advocacy and occupational therapists.

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 15 Registration Regulations 2009 Notifications – notices of change Regulation 15 HSCA Regulation 2009 Notice of change. The provider failed to notify the Care Quality Commission of the absence of a registered manager

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems in place to ensure people received person centred care were not fully effective.

The enforcement action we took:

To impose conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure risks had been assessed and safety measures put in place to keep people safe from harm.

The enforcement action we took:

To impose conditions on the providers registration

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 Regulation 13 HSCA RA Regulations 2014 Safeguarding Systems in place were not operated effectively to ensure people were safe. The provider had not regularly monitored and reviewed the approach to use of restraint and restrictive practices.

The enforcement action we took:

To impose conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance System in place were not effective to ensure the governance systems and processes established to ensure compliance with the requirements of the regulations were being operated effectively.

The enforcement action we took:

To impose a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems in place to ensure people received person centred care were not fully effective.

The enforcement action we took:

To impose conditions on the providers registration