Mr & Mrs D Evely

# Averlea Residential Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Averlea Residential Home is a care home providing personal care for up to 14 primarily older people, some of whom may be living with dementia. At the time of the inspection, 12 people lived at the service. The home was on two floors, which were connected by a chair lift. The home had a lounge and dining room for communal use. The service is situated in the small village of Polgooth in Cornwall.

People's experience of using this service and what we found.

The registered manager and provider did not always have clear oversight of the service. Audits, were not completed. The registered manager told us they had not completed any audits since the COVID pandemic.

Staff had not practised fire drills. There were no personal emergency evacuation procedures (PEEPs) in place to inform emergency services of people's needs in the event of an evacuation. No maintenance checks, including checks of fire alarm systems or legionella checks, had been carried out.

No staff training matrix was available, and staff told us they had not received training. No staff supervision record was held and the registered manager informed us they had not completed any supervisions. No records of falls, injuries or accidents had been completed.

People who regularly refused food and fluids did not have appropriate monitoring charts in place. People had not been referred to appropriate professionals, for example, advice had not been sought from dieticians.

There were insufficient staff working with people. Two care staff covered each shift to care for 12 people. On the day of the inspection 1 staff member had only completed 3 shifts previously and so was unlikely to know people well. There was no staff dependency tool used to assess how many staff were needed to keep people safe.

The registered manager spent most of their time during the inspection cooking for the residential home as well as nearly 100 meals for a service they provided in the local community. The staff rotas showed the registered manager had covered 5 kitchen shifts during the week of 3 September 2023 to 9 September 2023. This meant they had not undertaken required management tasks and responsibilities.

We found the registered manager and provider had not sent death or injury notifications to the Care Quality Commission (CQC) as required.

Each person had a file holding a body map. None had been completed to show where people had marks and bruises. No accident forms had been completed.

People had little or no interaction with staff. Our observations showed there were often no staff present during the day in the main lounge area. There were no records of peoples' individual activities and no activity coordinator employed. Staff had not had any up-to-date training in dementia care to help ensure they had the skills to enable people to pass their time in an enjoyable way. One person told us, "I'd like to go out more." While another said, "Not much to do."

There were two televisions in a shared lounge which were angled so people at either end of the room could see a screen. Both televisions were switched on and tuned to different channels. This meant people were unable to hear either television set.

The internal environment needed updating and attention. We had been notified by a relative of a rat infestation. On the day of our inspection, we were informed by the registered manager this infestation had been dealt with. The main area of concern, a bedroom, had been vacated and floorboards removed, and the carpet pulled up waiting for refurbishment.

Other areas of the service required work. The carpets were torn in places and heavily stained. Many areas of the service, including the main dining area and one of the bathrooms, were cluttered. The chairs and other furniture were old, dated, worn and stained.

We found chemical products left around the building which were easily accessible to people and posed a risk. A door separating the dining room and kitchen had a glass panel to allow people entering the dining room to see if there was anyone on the other side. The panel had been covered by notices obstructing the view from the kitchen. On the day of the inspection there was an accident when a member of staff opened this door and made contact with a service user they had been unable to see, who was using a walking aid on the other side, causing them some discomfort.

Medicines audits had not been completed and staff had not had checks of their competency to administer medicines safely. We could not be sure people received their medicines as prescribed as there were gaps in the MARs (Medication Administration Record). No records were available to support the safe administration of external medicines, such as creams and lotions. Some people were prescribed 'as required' pain relief medicines but there was no guidance or protocols in place to help staff make consistent decisions about when these medicines might be needed. Some people were receiving these 'as required' medicines on a regular basis and not 'as required.' The home held medicines that required extra security. No audits of these medicines had taken place and an error was noted on one person's record.

People had not been given the chance to feedback on the care and support they had received. No resident meetings or quality assurance survey had been completed. We observed 1 person being given a choice of food at lunchtime. However, they commented to us that they normally were not offered a choice. One person's records showed they had their food liquidised. There was no record of consent or rationale as to why this happened. People had bed rails and pressure mats in place without any authorisations in place or evidence they had consented to the restriction.

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

Rating at last inspection
The last rating for this service was good (report published 2 April 2020).

Why we inspected
We were prompted to carry out this inspection due to concerns we received about the service, the care

provided, the premises and a vermin infestation.

A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed to inadequate.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this report.

Enforcement
At this inspection we have identified breaches in relation to risk and monitoring systems, safeguarding, medicines, infection control and good governance.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.
Details are in our safe findings below.

### Is the service effective?

**Inadequate**

The service was not effective.
Details are in our effective findings below.

### Is the service well-led?

**Inadequate**

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

# Averlea Residential Home

**Detailed findings**

## Background to this inspection

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

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

Inspection team
Two inspectors carried out the site visit of this inspection.

Service and service type
Averlea Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Averlea Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service.

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.

We used all of this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service and 2 relatives about their experience of the care provided. We spoke with 3 members of staff including the registered manager. We received information from 1 professional who had visited the service the day before our inspection and 1 professional after the inspection.

We reviewed a range of records. This included 4 people's care records and 4 people's medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

# Is the service safe?

## Our findings

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

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

Using medicines safely

● Medicines records showed that people may not have always received their medicines as prescribed. People's medicines administration records (MAR) had one or more gaps for regularly prescribed medicines. From these records, it was not always possible to tell whether the person had been given their medicines or not.

● Medicine audits had not been completed, this included auditing of the 'extra security' medicines. Therefore, a recording error had not been picked up. We were unable to check the number of medicines held as there was no record of the number of medicines carried over from the previous month.

● No records were available to support the safe administration of external medicines, such as creams and lotions. MARs had not always been signed to say cream and other external items had been administered.

● When people were prescribed medicines for use 'as required' there were no person-centred protocols available to guide staff when doses might be needed. Staff gave people 'as required' medicines on a daily basis and had not escalated this routine use to the GP to check it was a safe practice. Staff did not record the times 'as required' medicines were administered. This meant it was not possible to tell if they were spaced throughout the day in line with the prescriber's instructions.

● There was no evidence of staff training in the administration and management of medicines and no staff competency checks had taken place.

The provider had failed to ensure the proper and safe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The service did not have effective systems in place to protect people from abuse.

● No information on safeguarding was available in the service to support staff. The registered manager had not raised a safeguarding incident when 1 person hit several staff.

● Staff had not received any training in safeguarding.

The provider had not taken all practicable steps to protect people from risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Records to monitor people's skin integrity had not been completed. For example, each person had a file holding a body map which stated, 'record all bruises and marks.' Each of the body maps was blank although daily notes indicated one person had red marks on the groin area and we observed 1 person with bruised legs and a dressing on their leg. This meant any deterioration in people's skin integrity might be overlooked.

● People's risk assessments were not up to date. No updated risk assessments had been completed for someone who had a pressure mat in place. Daily notes showed this person's call bell had been removed one night but there was no risk assessment in place to support this decision.
● No guidance was in place to support staff with people who had specific health conditions. For example, there was no guidance on the management of catheter care or the monitoring of blood sugar levels to ensure they were within a safe limit. This placed people at risk as staff did not have guidance or training on how to manage people's care safely.
● Emergency plans were not in place outlining the support people would need to evacuate the building in an emergency. Fire drills and checks had not been carried out.

The provider had not assessed or acted on the risks to the health and safety of people receiving care. This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were insufficient numbers of staff on duty to meet people's assessed needs. One person, whose bedroom was on the first floor, had fallen the day before and was still waiting for an ambulance therefore they were being cared for in bed. A second person, also on the first floor was cared for in bed. Both required the attention of 2 staff for any care needs. This meant, while staff were attending to their needs, there would be no one available to respond to requests for support from other people.
● Staff said they worked additional hours to cover any gaps in the rotas. Staff rotas showed that waking night staff had, on occasion, also worked daytime hours when on a waking night shift. This could have impacted on the quality of care provided.
● The registered manager told us they completed care and kitchen shifts most weeks. The registered manager spent most of the day of the inspection cooking for the service and nearly 100 meals for a service they provided in the community. Staff rotas showed the registered manager had covered 5 kitchen shifts during the week of 3 September to 9 September 2023. This meant they were not available to fulfil their role as registered manager.
● There were 2 care staff on duty to support 12 people, 1 of whom had only completed 3 previous shifts. These staff also had additional tasks to complete including, medicine rounds (which sometimes took up to 40 minutes to complete), laundry and coffee and tea rounds. This meant staff could not spend quality time with people or monitor them effectively in order to keep them safe.
● Staff were also having to clean the service. Staff rotas for the week 27 August to 2 September 2023 showed only 1 shift out of 7 had been covered by the employed cleaner. The week of 3 September to 9 September 2023 only 4 cleaning shifts had been covered.

The provider had failed to ensure sufficient, qualified staff were available to provide consistent care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service before new staff started work.

Learning lessons when things go wrong
● There was no evidence the service reflected and learnt from issues and incidents when things went wrong. There were no systems to record and report incidents or concerns. When things went wrong no reviews or investigations were carried out. This increased the risk of reoccurrence.
● Where changes in people's needs or conditions were identified, prompt and appropriate referrals to

external professionals had not been made. For example, a person had not been referred to the dietician team for support in managing their dietary needs.

Systems and processes were not in place to ensure the service was continually evaluated and improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. We had reports the service had a rat infestation. The registered manager told us the rat infestation had been dealt with.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home.

Inadequate

# Is the service effective?

## Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●One person had recently started receiving a respite service at the home and a second person was receiving day care. There were no care plans in place for these people. This meant staff did not have sufficient information to meet their needs.
● Assessments of people's individual needs did not always include sufficient detail to enable staff to provide person centred care.
● People's care was not being provided in line with national guidance and the law.

The provider had not ensured a complete and contemporaneous record was held in respect of each person. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff training was not up to date. We requested the staff training records, but none were made available. Staff had not received recent training to ensure they had the relevant skills and knowledge to support people. Staff files contained training certificates. None of the files we reviewed contained a certificate dated later than 2019.
● A member of staff told us they had worked at the service for approximately 15 months. They told us they had received training at their previous place of work, but this had not been updated since starting employment at Averlea.
● Staff were not offered formal supervision sessions. There was no opportunity for staff to highlight any gaps in their knowledge or identify training needs.

The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as necessary to enable them to carry out their roles.. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us they were arranging for all staff to complete on-line training.
● Staff told us they were well supported by the registered manager who was available for support if they needed it.

Supporting people to eat and drink enough to maintain a balanced diet
● One person had been identified as being at risk due to poor intake of food and fluids. There were no food

and fluid records in place to enable staff to monitor their intake and identify any increased risk.
● The inspection was carried out during a heat wave. People did not have access to drinks throughout the day. We observed 1 person being given a choice of food at lunchtime. However, they commented to us that they normally were not offered a choice.

The failure to effectively monitor people's food and fluid put people at risk of harm. This contributed to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The service was based in an older style property and was in need of updating. The décor was tired and carpets were stained and worn. In some areas there were malodours.
● A bathroom on the first floor was being used to store equipment. There was no panel on the side of the bath leaving pipe work exposed. A toilet on the same floor had no hand washing facilities. On the base of the toilet there was a wooden toilet raiser which was rotting. The shelf over the radiator was worn.
● The dining room was cluttered and was also being used as a storeroom for food stuff, medicines and a space for files. This did not create a relaxed environment for eating in.
● A door separating the dining room and kitchen had a glass panel to allow people entering the dining room to see if there was anyone on the other side. The panel had been covered by notices obstructing the view from the kitchen. On the day of the inspection there was an accident when a member of staff opened this door making contact with a person they had been unable to see, who was using a walking aid on the other side, and caused them some discomfort.
● There were two televisions in a shared lounge which were angled so people at either end of the room could see a screen. Both televisions were switched on and tuned to different channels. This meant people were unable to hear either television set.

The failure to keep the premises properly maintained and suitable for use was a breach of regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was not working in line with the legal requirements of the MCA. There were some restrictions in place to keep people safe. For example, the front door was locked with a keypad code which people did not have access to. Some people had bed rails and pressure mats so staff would be aware if they got out of bed.
● There were no mental capacity assessments in place although staff told us some people did not have

capacity due to their health conditions. No DoLS applications had been submitted to authorise any restrictions on people's liberty.
● One person sometimes had their meals liquidised. It was unclear why this was done as 2 different explanations were given. This decision had not been taken with advice from SALT or any other external professionals. Daily notes indicated the person had not consented to this practice and objected to it.

The failure to act in accordance with the MCA meant people were deprived of their liberty without legal authority. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● There were no records to show staff were monitoring people's specific health needs such as weight, nutrition and hydration or people's skin health. This placed people at risk.
●People were not always supported to maintain good health, nor were referred to appropriate health professionals as required.
● Information to ensure staff understood and could support people with their health needs was not available. One person was living with a stoma, while another had a catheter in place. There was no information for staff about this or guidance on how to meet people's needs.

The failure to protect people from identified risk was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager said she had a good working relationship with the local surgery and district nurse team.
● Feedback from an external professional did not raise any concerns about the service.

Inadequate

# Is the service well-led?

## Our findings

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

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

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

- The registered manager and provider had no oversight of the service. The registered manager confirmed they covered kitchen and care shifts 3 or 4 times weekly. Therefore, they had no capacity to complete managerial duties such as oversight of the care files, completing audits or arranging staff training or supervision.
- There were no records of the registered manager or provider undertaking any audits to monitor the quality and safety of the service. Consequently, there had been a failure to identify or act on the concerns found during the inspection.
- The registered manager and provider had failed to report any deaths or injuries to service users to CQC as required by law.
- Not all accident or incidents were recorded and no analysis of accidents and incidents had been carried out to highlight any patterns or trends.
- Staff working at the service had received no training and no supervision. There was no assurance that staff had the appropriate skills and training for their role.
- Fire equipment checks and practice evacuations were not up to date. PEEPS (Personal Emergency Evacuation Procedures) were not available to emergency services in the event of an emergency evacuation. After our inspection, the fire service visited the premises. They issued the provider with an Enforcement Notice.

The provider's governance systems were ineffective in monitoring and improving the service people received. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Continuous learning and improving care

- There was limited evidence of the provider's ability to drive improvement in the service. No feedback or analysis of accidents, incidents, and safeguarding had been undertaken to promote learning and improve care.
- Governance systems were not being used effectively in the service to identify areas that needed improving.

- The provider had failed to ensure the safety and quality of the environment had been regularly assessed and monitored. Audits on the environment were not being carried out. The areas for improvement described in the effective section of this report had not been identified.

● There was inadequate oversight of people's changing needs, the care provided and people's care records.

● There were no audits of daily notes, care plans or body maps, therefore it had not been identified that body maps, which were used by the district nurse team to review people's general health conditions, did not contain up to date information.
● Policies and procedures were not available to support staff in their practice.

The provider had failed to establish satisfactory governance arrangements. This contributed to the breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider's systems failed to ensure that people received person-centred care to meet their needs.
● People did not always receive good outcomes. People' comments included, "Not much to do" and "I'd like to go out more."
● Staff had used disrespectful language to describe people or what people had done when recording daily notes. This indicated a disrespectful approach to people.
● There was a general air of neglect and the impact of this on people's emotional well-being had not been considered.

The provider's governance systems were ineffective in improving the service people received. This contributed to the 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
● There was no evidence available to demonstrate people's and relatives' views on performance of the service had been sought.
●There were no formal opportunities for staff to provide feedback, for example, staff meetings and staff supervision had not been taking place.

The provider had failed to seek and act on feedback in order to improve the service. This was contributed to the breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● We contacted some professionals for feedback about their experience of working with the service. We received feedback from 1 professional and no issues were noted.
● The registered manager told us they were not a member of any manager forums or similar.

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
● Relatives told us the registered manager communicated well with them and kept them up to date with any changes in their family member's 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 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had failed to ensure the premises used by people is properly maintained.<br><br>This was a breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 15 (1. e) |

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to act in accordance with the MCA. This meant people were deprived of their liberty without legal authority. The provider must ensure that care and treatment must only be provided with the consent of the relevant person.<br><br>This was a breach of Regulation 11 (need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 11 (1) |

**The enforcement action we took:**

We issued a Warning Notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured the proper and safe use of medicines.<br><br>This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 12 (2. g)<br><br>The provider had not assessed the risks to the health and safety of people receiving care<br><br>This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 12 (2. a) |

**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<br><br>The provider must assess, monitor and improve the quality and safety of the services provided.<br><br>This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 2 (a) |

**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<br><br>The provider had failed to ensure sufficient employed qualified staff were available to provide consistent care.<br><br>This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 18 (1)<br><br>The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform.<br><br>This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Regulation 18 (2. a) |

**The enforcement action we took:**

We issued a Warning Notice.