Mr Paul and Mrs Gloria Crabtree

Park House 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 caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Park House residential care home is a residential care home that provides accommodation and personal care for older people and people living with dementia. The home can accommodate up to 20 people in one building over two floors. At the time of this inspection there were 15 people using the service.

People's experience of using this service and what we found
People and their relatives were generally happy with the care and support they received. However, the combination of inconsistent leadership and ineffective systems which measured the quality and safety of services provided put people at risk. The provider was open about the difficulties the service faced before we came to inspect and recognised the service needed to make significant improvements. During and after the inspection the provider showed they were committed to addressing our concerns and sent a list to the CQC of actions they had planned to take.

Medication systems were in place however, these were not always followed. Risks associated with people's care and support had been identified, however, from records and observations staff were not supporting people in line with their assessments. Therefore, risks were not managed safely. Staff had not had safeguarding training and were not aware of the action they needed to take to protect people from abuse. We identified safeguarding concerns had not been reported appropriately.
People told us they felt safe in the company of staff. However, practices which promoted people's safety were not always followed. For example, staff were not always safely recruited and appropriately supported by the management team to carry out the duties they were employed to perform.

People's needs were not always identified through a robust assessment of needs and care plans lacked detail, which meant staff did not have access to clear information about how to support people safely and meet their needs. People's health and safety risks were not consistently being identified by the service and measures to reduce such risks were not explored or implemented. People's care plans were not being regularly reviewed to ensure they reflected their changing needs. The care plans we saw did not contain advice from health care professionals to ensure people's needs were met.

When staff engaged with people they were mostly kind and caring. However, we observed some staff did not engage when providing support and were task focused. Care was not always planned in a way that promoted people's independence. On the days of our inspection we saw limited activities taking place. We found the home was clean and mostly odour free. Bedrooms had been personalised and communal areas were comfortably furnished. However, some areas of the service were not adapted to meet the needs of people living with dementia.

We have made a recommendation that the service considers current best practice guidance on dementia friendly environments.

Care plans were not person centred and lacked information about people's wishes, preferences and choices. End of life care plans were very sparse and did not contain people's preferences. From the care plans we looked at it was not possible to see if people were involved in their care planning. Staff we spoke with understood people's needs however, did not always follow care plans to ensure they respected their choices. People were not supported to have maximum choice and control of their lives and staff supported did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff had not had the necessary supervision, appraisal and training as is necessary for their role. The provider had a range of audits in place to monitor the service delivery however these were not effective. Action was needed in response to the July 2018 fire risk assessment as issues identified had not been followed up. These actions were completed during and following this inspection. The system for recording complaints was ineffective. The provider did not always submit a notification to the CQC or the local safeguarding authority when an incident or untoward event had occurred.

Rating at last inspection
The last rating for this service was good (published 8 August 2018).

Why we inspected
The inspection was prompted in part due to concerns received from the local authority's' contracts and commissioners which highlighted many concerns about the safety of people using the service. The concerns were considered as part of the inspection. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to safe care and treatment, person centred care, staffing, need for consent, complaints, safeguarding and leadership and oversight at this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore 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 within 6 months 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.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. Since our inspection we have been provided with a detailed action plan form the provider who is

addressing the issues we identified at inspection.

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 safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

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 responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Park House 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 Care Act 2014.

Inspection team
On day one the inspection team consisted of two inspector and an Expert by Experience with experience in dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection continued on day two with two inspectors.

Service and service type
Park House Residential Care Home 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 had a manager registered with the Care Quality Commission. 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.

What we did before the inspection
Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager.

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 six people who used the service and three relatives about their experience of the care provided. We spoke with six members of staff including the acting manager and the administration officer. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. These included three people's care records and multiple medication records. We looked at four 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 reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We asked the registered manager and provider to send us further information in relation to actions they were going to take to address our concerns. We also contacted the fire service and the Local Authority in relation to infection control issues and safeguarding concerns.

Inadequate

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 inadequate.

This meant people were not safe and were at risk of avoidable harm. Whilst most people had positive experiences of the service, there were too many poorly managed risks that put people at risk of harm.

Assessing risk, safety monitoring and management
- Risks to people's health and wellbeing were not safely managed.
- Risks associated with people's care and support had been identified. However, we found these were not followed, putting people at risk of harm. For example, one person had a detailed assessment completed by the physio which stated that on occasions the person would need the support of the hoist to be moved, this had not been updated or reflected in the care plan. We also found the hoist would not fit in the lift which meant the person could not safely be supported at the service.
- Staff we spoke with could tell us about the risks associated with people's care. However, the documentation staff completed lacked detail and was not reviewed to assess if risks were managed. For example, one person who was at risk of falls had a mobility care plan in place for staff to follow. However, following a number of falls, the care records had not been updated to reflect this.
- Equipment used by the service was not always fit for purpose or suitably well maintained. For example, when checking equipment during the inspection we found the hoist had not been checked at the required intervals. We spoke to the manager about this and on the second day of the inspection the necessary safety checks had been completed.
- Staff had not had moving and handling training.
- Risks in relation to fire safety had not always been safely managed. In July 2018, a fire risk assessment was completed which identified several actions which required immediate attention. We checked and found these actions had not been carried out.
- Staff had not had adequate fire safety training.
- People did not have personal evacuation plans in place (PEEP). These contain information about people's mobility and any communication problems that might make evacuation from the building difficult.
- A fire register was kept at the front door for care staff and residents to indicate when they had left the building. However, this did not contain accurate and up to date information about the people who were living at the service. Due to the nature of these concerns we raised these issues with South Yorkshire Fire and Rescue who conducted an onsite visit the following day to ensure the home was safe.
- The provider did not have a management plan to follow in the event of an emergency such as a power failure, gas leak or flooding.

We found no evidence that people had been harmed. However, the provider's failure to assess the risks to the health and safety of all people receiving care or treatment and to do all that is reasonably practicable to

mitigate any such risks placed people at an increased 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.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have an effective system in place to safeguard people from abuse of harm.
● The provider had failed to report safeguarding concerns to the appropriate agencies. During the inspection we raised four safeguarding concerns with the manager. The provider had failed to recognise these safeguarding concerns. Following the inspection we contacted the local authority to see that the notifications had been submitted.
● Staff training records showed staff had not received up to date safeguarding training.
● The provider did not have oversight or awareness of these concerns which meant people could be at risk of harm.

This was a breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices were not always followed as the required checks had not been undertaken on staff before they started work.
● The provider did not have a system in place to work out the number of suitably qualified and competent staff to meet peoples care and treatment needs.
● Following our inspection, we asked the provider to clarify how staffing numbers were calculated based on people's dependency and if the layout of the building was taken in to consideration. We received this information but the information we received was conflicting.

We found no evidence that people had been harmed however, the provider had failed to operate effective recruitment procedures to ensure all persons employed were suitable for the purposes of carrying on a regulated activity. This placed people at an increased risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Systems to manage medicines were not safe. The medication policy, and staff training required attention.
● Staff training in the safe management of medicines had not been kept up to date. We asked the provider to take immediate action to ensure staff had an assessment of their competence to administer medicines.
● The provider's policies and procedures were not in line with current legislation or best practice guidance.
● We found some areas of the providers system for the storage of medicines required attention. For example, the fridge for storing medicines was stored in an unlocked room on the floor. We raised these concerns with the manager and found they took immediate action to address the concerns.
● Records identified incidents of missed medication that had not been reported to the appropriate authorities and staff were not always following the procedures to ensure people's safety. For example, records showed one person had not had a sufficient supply of the medicines they needed. The provider had asked the person to complete a complaint form, but no other action had been taken.
● Stock sheets did not record carried over amounts on the medication administration record (MAR), so it was not possible to determine how many were in stock to evidence medicines were given as prescribed.
● Protocols were not in place for when people were prescribed medicines to be given as and when required. Staff were also not recording if the medicine when given had been effective so were unable to review effectively.

We found no evidence that people had been harmed however, the provider had failed to ensure the proper and safe management of medicines. This placed people at an increased risk of medicine-related harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were not always protected by the risk and spread of infection.
- The home had undertaken audits however there was no action plan to support the audits. For example, there were cleaning schedules in place. However, there was no clear record of frequency of cleaning, or who was responsible for what.
- There were only sinks for hand hygiene in the bathrooms. Limited sinks had liquid soap and paper towels in the bathrooms and bars of soap and towels were in all the rooms. This could cause a risk of cross infection as the towels will be used by different carers
- Slings that were used to hoist people were stored in a cupboard located next to the cat litter trays. The slings were covered in cat excrement and were not safe to use.

We found no evidence that people had been harmed. However, the provider's failure to assess the risks to the health and safety of all people receiving care or treatment and to do all that is reasonably practicable to mitigate any such risks placed people at an increased risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Accident forms were in place to record accidents and incidents.
- There was no record of trends and patterns and how incidents could be used as lessons learned to minimise future events occurring of a similar nature.

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 the last inspection this key question was rated as good. At this inspection this key question deteriorated 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
● Although the quality of assessments and people's care plans needed improvement, most people and their relatives told us the standard of care they received was good. People had assessments of their needs completed but these were not detailed and did not give staff guidance about how to manage risk. We spoke to the manager about this concern and they agreed that the care records needed reviewing and updating as a matter of urgency.
This was a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008(Regulated Activities 2014.

Staff support: induction, training, skills and experience
●The provider failed to ensure staff received appropriate training, supervision and appraisals. They also failed to ensure staff were suitably skilled and experienced for their role.
●The provider did not have an accurate and up to date list of people working at the service.
● The provider could not always determine when a staff member's training was due for renewal because there was no oversight of staff training.
● We found nine staff had not had an assessment of their competence to safely administer medicines, there were only three records of staff who had completed moving and handling training and no records of any staff completing training in the Mental Capacity Act 2005.

We found no evidence that people had been harmed however, the provider had failed to ensure all staff had 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. This 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
● People were supported to eat and drink enough to maintain a balanced diet. However, we looked at records of people's fluid intake and saw these did not include how much fluid people needed on a daily basis. One person's care record said they were on a food and fluid chart but there were no charts in place. We spoke to staff and they said the person was no longer on food and fluid charts, but this had not been updated in their care plan.
● We spoke with people about the quality of meals they received. One person said, "The food is really good." Another person told us, "Its homemade food and very good." We received mixed feedback from relatives.

Comments included, "The only thing that my [relative] has really complained about to me is the food. It's not really a complaint either, she just says its good food but very plain and gets a bit boring" and "The food is magnificent. All [relative] wants is good English food and that is what they serve, no complaints there at all."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to health care professionals when required.
● We looked at care plans and saw that when healthcare advice had been given, however, this was not always followed.

Adapting service, design, decoration to meet people's needs.'
● The service was not appropriately decorated or designed to meet people's needs.
● There was a lack of signage to help people navigate around the home and some bedroom doors were blank which did not assist people in locating their bedroom.
● People's bedrooms were personalised to their individual choices and tastes. However, communal spaces were cluttered and difficult to navigate around.
We recommend that the service consider the NICE guidelines "Dementia" supporting people with dementia and their carer's in health and social care.

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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Capacity and consent were not consistently recorded.
● Where people lacked capacity, we found there were no decision specific capacity assessments or best interest records recorded in the care records. For example, one person had been assessed as requiring a sensor mat, however there was no record of a mental capacity assessment (MCA) or best interest decision supporting this restriction.
● The provider's system for monitoring DoLS was ineffective because it was not accurate and up to date.

We found no evidence that people had been harmed however, the provider had failed to establish robust processes to ensure valid consent was always obtained and the principles of the MCA were not consistently adhered to. This meant people's legal rights were at risk of not being upheld. This was a breach of

regulation11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Ensuring people are well treated and supported; respecting equality and diversity
● Equality was promoted within the service and staff knew how to support the cultural needs of people from different ethnic and religious backgrounds.

Supporting people to express their views and be involved in making decisions about their care
● Care plan documentation did not reflect that people had been involved in creating and updating them.
● Surveys had been completed by people using the service, but these had not been reviewed or analysed to help improve service delivery

Respecting and promoting people's privacy, dignity and independence
● People's privacy and dignity was not always upheld.
● We found peoples confidential information was left out in public areas which meant other people could access them.
● We found a number of bedroom doors had holes in them which meant people did not have the privacy they needed.
● We spoke with people who used the service and their relatives. One relative said, "The staff try their best with my relative, but they do seem to be rushed at times and a couple more staff wouldn't go amiss. It's not conducive to good care if you don't have enough people to administer it." Comments from people using the service included, "There's not enough staff, waiting for the toilet is a nightmare, I pee myself now because it's easier. You can be waiting three quarters of an hour" and "The only kind of complaint I've got is that sometimes the buzzers go on and on and on at night. Mind you, if they've buzzed and no one has come to help them, then they are going to keep on buzzing it."
● We found there were enough staff to provide basic care, but limited time was available to engage with people. We observed staff interacting positively with people during our inspection. The provider did not have a staffing assessment tool to determine the level of staffing needed in the home. This meant we could not be assured that there were enough staff on duty to safely meet people's needs.
●Staff treated people with kindness and we heard people having a laugh and a joke with staff.

Inadequate

Is the service responsive?

Our findings

Our findings - Is the service responsive? = Inadequate

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not always receive person-centred care which met their needs and preferences.
- The care records did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences.
- There was some inconsistency in the records as one person's mobility care plan was not very detailed or clear. For example, one person's records stated that the person needed/ does not need the rotunda to support transfers. Another person's care records said they mobilised with the support of a zimmer frame and no assistance, whilst staff said the person's needs had deteriorated, and they now needed assistance to mobilise.
- Monthly reviews of people's care plans were not always done.
- People were provided with a basic range of activities. We saw staff assisted to meet people's social needs, although there were some extended periods when there was a lack of interaction and activities available for people.

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 service identified people's information and communication needs by assessing them.
- People's communication needs were identified, recorded and highlighted in care plans.
- The service did not have a policy on accessible information and had not had training on the Accessible Information Standard.

This was a further breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008(Regulated Activities 2014.

Improving care quality in response to complaints or concerns

- The system for managing complaints was ineffective.
- Complaints were recorded, but these were not always investigated and responded to appropriately
- The complaints procedure on display in the home, however this information was out of date.

All the above evidence shows a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● People's choices for their end of life care had not always been considered and were not clearly recorded, communicated or kept under review. We spoke with the manager and they told us there were currently people at the home receiving end of life care. The manager told us they would look at the care plans for these people in more depth to ensure their needs and preferences were included.

This was a further breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008(Regulated Activities 2014.

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 good. At this inspection this key question has now deteriorated to inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; and how the provider understands and acts on their duty of candour responsibility to be open and honest with people when something goes wrong

- At the time of our inspection the registered manager had resigned from their position a week before we visited, the provider had appointed an interim manager.
- There had been no dependency tool, used to assess there were enough staff available to provide support.
- There was a lack of monitoring of daily care records to ensure people received support from appropriate staff in line with their assessed needs and risks.
- Records were not always accurate and had not been updated to reflect a change in people's needs.
- Accident and incident audits were in place and completed monthly. However, accident and incidents had not always been recorded these had not been analysed to ensure any trends and patterns could be identified to prevent reoccurrence.
- Medication audits had not identified the concerns we found with the management of people's medicines. For example, the medication audit was recorded in March 2019 and had not identified concerns regarding stock control or PRN protocols.
- Staff had not received sufficient induction, training and supervision support.
- At this inspection we found the most recent rating for the home was not on display. It is a legal requirement to ensure the most recent rating is on display and to inform the CQC of notifiable events.

All the above evidence shows a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, as the provider had failed to report all notifiable incidents to the CQC this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009; Notification of other incidents.

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

- The provider did not promote a person-centred culture that ensured people achieved good outcomes.
- People were at risk of receiving poor care because the risks to their safety and wellbeing were not mitigated to protect them from harm.

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

● There was a lack of evidence to show how people and their representatives had been involved in care planning.
● Quality surveys completed were kept in a file but not analysed.

Continuous learning and improving care
●The service worked with other professionals such as health care workers. The provider ensured that appropriate support was obtained as required. However, guidance obtained was not always followed.
●There was a lack of effective governance systems in place to monitor the service and mitigate risks to people. For example; quality assurance audits had not identified the concerns with staff training, supervision and appraisal, the management of risk and the safe management of medicines raised at this inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk.
All the above evidence shows a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● Following the inspection, we found the management team engaging with the local authority to access further training and guidance.

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 18 Registration Regulations 2009 Notifications of other incidents The provider was not submitting the necessary notifications as required by the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care which met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not working in compliance with the MCA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines. This placed people at an increased risk of medicine-related harm. The provider did not have effective systems in place to manger risk effectively.

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 The provider did not always refer safeguarding concerns to the appropriate bodies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for dealing with complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have effective recruitment systems and processes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have access to the right support, training supervision and appraisal as is necessary for their role.

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 17 HSCA RA Regulations 2014 Good governance Good governance as Legal requirements were not met and management oversight was not evident over key aspects of the service.

The enforcement action we took:

Warning Notice