Just Global Limited

St Paul's Lodge

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

St Paul's Lodge is registered to provide care and accommodation to a maximum of 21 older people living with dementia. We inspected St Paul's Lodge on 21 and 30 October 2014. There were eighteen people living at the home at the time of the inspection. The first visit was unannounced and the second announced as we had to clarify and seek further information from the registered manager. Our last inspection took place in March 2014 and at that time we found the home was meeting the regulations we looked at.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found systems and processes to keep people safe were inadequate. For example, we found the staff recruitment and selection procedures had not been followed and people had been allowed to start work before all the relevant checks had been made.

Summary of findings

We also found medicines were not managed safely, for example, one person did not start a course of prescribed antibiotics until four days after they had been prescribed.

We saw people had access to a range of NHS services and the input of other healthcare professionals, such as district nurses, GPs and chiropodists was recorded in people's care plans. However, in one person's records we saw there had been a delay of four days in contacting the person's GP about an issue which required medical attention.

People who used the service and their relatives told us the care staff were kind and caring and tried hard to create a warm and relaxed atmosphere. People also told us they enjoyed participating in the activities organised by the activities coordinator and were complimentary about the quality of the meals provided.

We saw the complaints procedure was on display within the home and people who were able told us they knew how to make a complaint. They told us they felt the manager and staff would take their concerns seriously and act accordingly.

However, we found the quality assurance systems were inadequate as many of the shortfalls highlighted in the body of this report relating to people's health, well-being and safety had not been identified by the providers as areas that required improvement.

We also found the service was not meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

We found five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 come into force on 1 April 2015. They replace the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Recruitment and selection procedures designed to keep people safe had not always been correctly followed.

Medicines were not managed safely and appropriately. People did not always receive their medication in a timely manner. For example, we found on one occasion a person had been prescribed an anti-biotic but had not received their medication until four days after it had been prescribed by their GP.

The staff we spoke with knew how to recognise and respond to allegations of possible abuse correctly and were aware of the services whistleblowing policy.

Is the service effective?

Inadequate

The service was not always effective. People who were able told us the way their care, treatment and support was delivered was effective and they received appropriate health care support. However, in one person's records we saw there had been a delay of four days in contacting the person's GP about an issue which required medical attention. This could have resulted in unnecessary discomfort to the person.

We found the location not to be meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

Is the service caring?

Requires Improvement

The service was not always caring. People who were able said the staff were caring and friendly. However, we found the staff at times used institutionalised practices such as serving people cups of tea from a tea pot which still had tea bags in it and to which milk had already been added. This takes away people's independence and freedom of choice.

We also found information about people's preferences and past lives was inconsistent. This information is important when caring for people living with dementia.

The relatives we spoke with told us they were always made to feel welcome when they visited the home and had no concerns about the care, treatment and support provided.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Systems were in place to assess people's needs and we saw evidence people's needs were regularly assessed. However, we found the care plans were not person centred and people's individual needs, preferences and abilities were not always recorded. In addition, there was little evidence to show people who were able were involved in planning their care, treatment and support.

Summary of findings

People told us a range of activities was available and we saw the activities coordinator engaged with people on either a group or individual basis.

Is the service well-led?

Inadequate

The service was not well led. We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust quality assurance systems.

Staff spoke positively about the management at the home and said they were supportive of them.

St Paul's Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out over two days, 21 and 30 October 2014. The first visit on 21 October was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority safeguarding teams. Before our inspections we usually ask the provider to send us provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with eight people who used the service, three relatives, six members of staff, the registered manager and the nominated individual for the service. We looked around the building including a random selection of people's bedrooms, communal bathrooms and toilets and the lounges and dining room.

We observed care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

As part of the inspection process we also spoke with two healthcare professionals who visited the service on a regular basis.

We looked at four people's care records and other records which related to the management of the service such as training records, staff recruitment files and policies and procedures.

Inadequate

Is the service safe?

Our findings

We saw that the provider had staff recruitment and selection procedures in place. They included clear processes designed to ensure that the appropriate checks were carried out before staff began work. The registered manager/provider told us the checks undertaken included a Disclosure and Barring Service (DBS) check, proof of identity, full employment history, training, qualifications and health status. These checks were designed to help the provider to make sure that job applicants were suitable to work with adults at risk.

We spoke with two recently appointed members of staff who told us the recruitment process was thorough. They told us they had completed an application form, supplied two named referees and attended an interview.

However, when we looked at the staff personnel files we found in two instances the procedure had had not been followed and staff had been allowed to start work before suitable references had been received. In addition, we found one member of staff had been allowed to start work before a satisfactory DBS check had been received. This meant the provider had not followed the correct procedure which might put people at risk of harm.

We found that the registered person had not protected people against the risk of employing staff unsuitable to work in the caring profession. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had staff disciplinary procedures in place. The manager gave us examples of how the disciplinary process had been followed where poor working practices had been identified. They told us staff had been reported to the Disclosure and Barring service when there were concerns about their suitability to work in a care setting.

The provider told us the service had recently experienced staffing difficulties after four members of care staff had left the service's employment and one member of care staff was on long term sick leave. In addition, the registered manager had also been on long term sick leave.

However, they confirmed that staffing levels had been maintained in line with people's needs by the remaining care staff working additional hours and the occasional use of agency staff. The provider said that when agency staff had been used they always endeavoured to employ the same member of staff so that people who used the service received continuity of care, although this had not always been possible.

The staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously. At the time of the inspection the local authority safeguarding unit was waiting for the registered manager/provider to investigate one safeguarding referral which the CQC had also been made aware of.

The provider had a detailed medication policy in place which was referenced to national guidance. However, the senior care staff who were responsible for the safe management of medicines told us they did not have access to national guidance in the home. This meant staff may not be following best practice guidelines. Medicines were stored securely in locked trolley. There were appropriate arrangements in place for the safe management of controlled drugs. There were also suitable arrangements in place for ordering monthly repeat prescriptions.

The amount of each medicine received was recorded and any stock that was carried forward from the previous medication cycle was also recorded which meant the records of medicines in stock were accurate.

Senior staff told us if people refused to take prescribed medicines they were referred back to their GP for a medication review. They told us medicines were not hidden, disguised or crushed so that people did not know they were taking them. No one who used the service was administering their own medicines at the time of the inspection. People had medication care plans in place; however, they did not have any detailed information about the support people required to take their medicines.

We found when medicines were prescribed outside of the monthly cycle they were not always obtained in a timely way. In one person's records we saw they had been prescribed an anti-biotic on 10 October 2014 but the

Inadequate

Is the service safe?

medicines had not been available in the home until 14 October 2014. This meant there was a delay of four days in the person starting their treatment. We asked two of the senior care staff about this and they said they didn't know how it had happened as they were both off duty at the time. We saw no evidence to show that staff had learnt lessons from this incident or put systems in place to reduce the risk of this happening again.

In the medication records of five people we saw they were prescribed a medicine which should be taken 1 hour to 30 minutes before food. There were no arrangements in place for this to happen and the records showed people were given this medicine, along with their other morning medicines at approximately the same time as they had breakfast. This meant there was a risk the medicine would not work effectively. This showed people were not receiving their medicines as prescribed. This was discussed with the registered provider and addressed immediately.

Records for 'as required' and variable dose medicines showed the times and number of tablets administered. There was no guidance in place for the use of "as required" medicine which meant there was a risk this medicine could be given inconsistently. However, senior staff who administered medicines were aware of the precautions that needed to be taken when people were prescribed Paracetamol to be taken 'as required.' There were no other medicines prescribed to be taken 'as required' at the time of the inspection.

The senior care staff told us all the staff who were involved in the administration of medicines had undertaken training. The provider's medication policy stated staff should have a medicines competency assessment every year. The senior carer told us this had not been done. One of the senior carers told us they carried out regular checks on the medication records and stock to make sure they were correct; however, these checks were not recorded. There was no evidence that medication audits were carried out to check that medicines were managed safely and people were protected against the risks associated with medicines.

We found that the registered person had not protected people against the risk of not receiving their medication as prescribed. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The computerised care records system the provider used had a standard set of risk assessments to be carried out for each person, such as falls, pressure sores and moving and handling. The risk assessments were reviewed at set intervals usually every month and were up to date. However, there was more than one risk assessment for some areas of potential risk. For example, there were three different risk assessment tools used to assess the risk of people developing pressure sores. This was time consuming for staff and had the potential to result in contradictory information about people's degree of risk. This was discussed with the manager acknowledged this matter needed to be addressed.

We looked around the premises and found since the last inspection some new furniture had been purchased and general improvements made to the environment. However, some areas of the home would benefit from decorating and refurbishment and the manager confirmed this work would be completed as part of a rolling programme of refurbishment.

We saw the equipment used to assist people such as the stair lift from the ground to first floor and hoists were serviced in line with the manufacturers' guidelines. However, the registered manager told us the stair lift from the lower ground floor to the ground floor was not operational at the time of the inspection. The registered manager confirmed the bedroom accommodation on the lower ground floor was not being used and said the stair lift would be repaired before the rooms were occupied.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation is used to protect people who may have their liberty restricted to keep them safe but are not able to make informed decisions on their own.

The care plans we looked at did not include information about people's capacity to make decisions. In one person's records we saw a care plan called 'cognition (memory)' dated 18 July 2014 stated 'Try to ensure (the person's name) does not leave the home.' There was no information to show that a Deprivation of Liberty Safeguards authorisation application had been made or was in place. This meant the provider was not able to demonstrate they were acting in accordance with the principles of the Mental capacity Act 2005 (MCA).

People had medication care plans in place. However, they did not have any information about people's capacity to consent to taking their medicines. There was no evidence to show best interest decisions had been made on behalf of people who lacked the capacity to give informed consent to taking medicines.

We saw people's bedroom doors were locked during the day. A senior care assistant told us this was to stop other people who lived in the home going into people's rooms and interfering with their belongings. They told us some people had keys to their rooms which meant they could go to their rooms whenever they wanted. However, we saw when people lacked the capacity to make a decision about this there was no information in their care plans to show when, how and by whom the decision had been made.

We spoke with the senior care staff about the above concerns and they told us they had done training on the Mental Capacity Act and DoLS. They told us none of the people who used the service and who lacked the capacity to give informed consent to being there had DoLS in place. We spoke with the manager who told us this matter would be addressed.

We found that the registered person had not protected people against the risk of not acting within the provision of the Mental Capacity Act 2015. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff told us they always asked people's consent before they provided any personal care or treatment and continued to talk to people while they assisted them so they understood what was happening. The staff told us restraint was never used as people responded well to other diversionary techniques if they exhibited behaviour which challenged. We observed the interaction between care staff and people who used the service. We saw care staff asked permission from the person who used the service acted in accordance with their wishes. This meant people's rights were protected because staff understood the need for people to give consent to care and treatment.

There was evidence that people's nutritional status was assessed and people's weights were checked at least once a month. Information about people's dietary needs and preferences was recorded in their care plans. People living in the home told us the food was good, one person said, "I always enjoy the food, I don't have a lot but I enjoy it."

We found the lunchtime meal was a social event with the majority of people sitting together on one long table in the dining room. We saw people were offered a choice of meals and the activities coordinator had their meal with them and prompted people to eat their meal discreetly when required. However, we saw there were no plate guards available which made eating their meal independently difficult for one person.

We spoke with the cook and it was apparent they had a good understanding of people's dietary needs and encouraged them to eat a nutritious and well balanced diet. They told us they worked from a four week menu which was changed seasonally. They confirmed that people who used the service had input into menu planning through the meetings they had with the manager and people were always offered different choice if they did not like what was on the menu. The cook told us it was not common practice to provide people with a daily menu. This meant people were unaware of the meals prepared until they actually arrived in the dining room. However, on the second day of the inspection this matter had been rectified and we saw menus were available to people from early morning.

Inadequate

Is the service effective?

The registered manager told us they were in the process of introducing a new comprehensive induction programme which took into account recognised standards within the care sector and was relevant to their workplace and their roles. We were told following induction training new members of staff always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. This was confirmed by the staff we spoke with.

The registered manager told us that following their induction training additional mandatory training was also completed by staff. They confirmed this training was either provided in-house, by e-learning or by an external training provider.

The care staff we spoke with had mixed feelings about the standard of training provided through E-Learning. The majority felt they learnt and understood more by attending a training course and preferred this type of learning. Prior to the inspection we had also received concerns from an anonymous source that the training provided through e-learning was poor and did not always equip staff to carry out their roles effectively. This was discussed with the registered manager who confirmed they were looking at providing more class room based training in the future to address this matter.

We looked at the training matrix and although we found several gaps in the training provided to individual members of staff the manager confirmed that they had already started to address this. For example, we saw training on safeguarding vulnerable adults, the Mental Capacity Act, tissue viability and care planning had been arranged to be facilitated by an external training provider in November and December 2014.

We saw people living in the home had access to a range of NHS services and the input of other healthcare professionals, such as district nurses, GPs and chiropodists was recorded in people's care plans. However, in one person's records we saw there had been a delay of four days in contacting the person's GP about an issue which required medical attention. The records showed a concern had been identified on 6 October 2014 but the person's GP had not been contacted until 10 October 2014. We asked the senior care worker about this and they said they had not been aware of the delay until we brought it to their attention. The records showed that although the concern had been recorded in the person's daily notes on 6 October 2014 it had not been handed over to the next shift to be followed up.

We found that the registered person had not protected people against the risk of not receiving prompt medical attention. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of the inspection we spoke with one healthcare professional who told us they did not have concerns about the care provided but felt communication could be improved. For example, by letting them know when new people moved into the home. Following the inspection we spoke with a second healthcare professional who told us that although they had observed some good care practices staff did at times not respond effectively to meet people's basic needs.

Requires Improvement

Is the service caring?

Our findings

Feedback from people who used the service and their relatives about the attitude of staff was good. One person told us, "I am well looked after and the staff are really nice." The relatives of another person told when they realised their relative required residential care they had looked around a number of other homes before choosing St Paul's Lodge. They said they had chosen the home because the staff had been friendly and informative during their initial visit and the there was a warm and relaxed atmosphere.

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence. For example by encouraging them to make choices about how they spent their time at the home and always asking them for their consent before assisting with their personal care needs. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people and people were provided with the opportunity to make decisions about their daily lives.

However, we found the staff's knowledge and understanding of giving people the opportunity to make choices was not always put in to practice. For example, at breakfast we found the care staff were serving people cups of tea from a tea pot which still had tea bags in it and to which milk had already been added. The tea looked as if it had been made for some time and was therefore very strong. We were told by the care staff that this was common practice and milk was always added to the tea before it was served. This is institutionalised practice which takes away people's basic rights to decide how they want to take their drink.

We saw people's personal information held on the computer was password protected. However, we found confidential records and reports relating to both people who used the service and staff had been left on the office desk in the lounge area. This meant unauthorised people had access to people's confidential information.

We looked at four people's care records and found there was no information about their past lives and the recording of information about people's preferences was inconsistent. Information about people's past lives is particularly important when caring for people living with dementia because it can help staff to understand why people behave in a certain way and how best to support them.

There was no information about advocacy services displayed in the home. The senior care staff told us none of the people who lived in the home had an advocate at the time of the inspection. However, they said some people had been supported by advocates in the past.

The manager told us there were no visiting restrictions and family and friends were encouraged to visit their relatives anytime. The relatives we spoke with told us they were always made to feel welcome when they visited the home and offered a drink and light refreshment. One visitor said, "I enjoy visiting; the staff are friendly and keep me informed of any changes in my relatives general health and wellbeing." Another visitor said, "I visit at different times during the day and I have always received a warm welcome."

Requires Improvement

Is the service responsive?

Our findings

We saw that people's needs were assessed before they moved in St Paul's Lodge. The registered manager had recently introduced a new, more detailed, format for the pre admission assessments. However, we found it did not include a section for information about people's past lives.

People had care plans in place. However, in most cases they were generalised and did not include information about people's individual needs, preferences and abilities. For example, two people's care plans which related to personal hygiene stated "offer daily, bath, shower or wash" but did not say what people preferred. This meant there was a risk people would not receive care which met their individual preferences.

Another person's care plan said they should have a pressure mat on the floor to alert staff when they got out of bed because they were at risk of falling. When we looked in their bedroom there was no pressure mat in place. We asked one of the senior care workers about this and they said it had been ordered but not delivered. There was no information in the care plan to show what actions staff should take to reduce the risk in the interim period.

We found that the registered person had not protected people against the risk of not receiving appropriate care and support. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In three of the four care plans we looked at there was no evidence that people who used the service or those acting on their behalf had been involved in developing and reviewing their care plans. This meant there was a risk care was not planned and delivered to take account of people's individual needs.

The service employed an activities organiser who worked five days a week. They provided a varied programme of social activities for people. During the inspection we observed the activities organiser interacted with people in a caring and compassionate way both individually and in groups.

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. We looked at the complaints register and saw that two complaints had been received since the last inspection. Both complaints had been dealt with correctly and within the timescales set out in the complaints procedure.

The people who were able told us they had no complaints about the service but knew who they should complain to. The relatives of two people who used the service told us they were aware of the complaints procedures and would not hesitate to make a formal complaint if necessary. One person told us they had spoken with the manager about one aspect of their relative's care they were not entirely happy about and action had been taken immediately to address the matter.

Inadequate

Is the service well-led?

Our findings

Prior to the inspection the registered manager had been on sick leave for about seven weeks. In their absence the deputy manager supported by the provider had managed the home on a day to day basis. The registered manager had not returned to work on the first day of the inspection but was on duty the second day. However, although we were aware the registered manager was on sick leave the providers were unaware they were required to officially notify us of this.

We found there was a lack of robust quality assurance and audit processes. The problems we found during the inspection and highlighted in the body of this report had not been identified by the registered manager or provider prior to our visit.

For example, there were no medication audits undertaken by the provider and we found significant problems with the way peoples medicines were managed. We found the recruitment and selection procedure for newly appointed staff was not always being followed which meant people deemed unsuitable to work with adults at risk might be employed.

The service was providing care to people living with dementia but did not have the right processes in place to make sure they were working in accordance with the legal requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. This meant the rights of people who lacked capacity were not promoted and protected.

People's health care needs were not always identified and acted on in a timely way which risked people experiencing discomfort and had to potential to risk people's health deteriorating.

During the inspection we witnessed institutionalised practices which the registered manager and provider were unaware of such as serving people cups of tea from a tea pot which still had tea bags in it and to which milk had already been added. This compromised people's basic right to make choices about how they wanted to take their drink.

We found confidential records and reports relating to both people who used the service and staff had been left on the office desk in the lounge area. This showed the provider had not taken appropriate measures to protect confidential information.

This showed us the provider did not have effective systems in place to assess and monitor the quality of the services provided or to identify, assess and manage risks to safety and well-being of people who used the service.

We found that the registered person had not protected people against the risk of not operating an effective quality assurance monitoring system. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they carried out health and safety audits and checked the staff training matrix and supervision schedules on a routine basis to make sure they provided accurate and up to date information. However, they acknowledged that in their absence some of the audits and quality assurance checks had not been completely as thoroughly as they should have been hence the reason we had found some shortfalls in the service.

We saw staff meetings were held about every three months to make sure staff were kept up to date with any changes to policies and procedures. In addition, we saw evidence the providers visited the service on a regular basis and carried out internal audits which should have made sure the registered manager and senior staff team were working effectively and in people's best interest. However, it was evident during the inspection that shortfalls in the service had not been identified or addressed as part of this process.

The registered manager told us people who used the service, their relatives and other healthcare professionals were involved in the quality assurance process. They told us as part of this process survey questionnaires were sent out to people on at least an annual basis to obtain their views and opinions of the service provided.

We saw the results of the last survey carried out in the May of 2014. We saw only five questionnaires had been returned from the relatives of people who used the service. They

Inadequate

Is the service well-led?

showed overall people were satisfied with the quality of care and facilities provided by the service. Comments included, “My mum is very happy and loves it here” and “Comfortable home and lovely food.”

In addition, we saw three questionnaires had been received from healthcare professionals involved in people’s care and treatment. All the questionnaires showed they were happy with the standard of care, support and treatment provided by the management and staff.

The registered manager told us the information received was collated and action was taken to address any suggestions made to improve the service or concerns raised. However, the registered manager confirmed the information from the May 2014 survey had not been collated at time of the report. This demonstrated to us that people who used the service and their representatives were asked for their views about their care and treatment.

The staff we spoke with told us they were well supported by the manager and senior staff team and enjoyed working at St Paul’s Lodge.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not act within the provision of the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have suitable arrangements in place to regularly assess and monitor the quality of the services provided and to identify, assess and manage risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not have suitable arrangements in place to ensure people who used the service received their medicines as prescribed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had failed to ensure that recruitment and selection procedures designed to keep people safe had been correctly followed.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered provider did not have suitable systems in place to ensure people who used the service received prompt medical attention.