Mrs Mary Crook

Southernhay Residential Home

Inspection report

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Date of inspection visit: 17 and 22 June 2015
Date of publication: 21/09/2015

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

Southernhay Residential Home is registered to provide accommodation and personal care for up to 20 people living with dementia. Nursing care is provided by the local community nursing team.

The home is managed by the registered provider. Therefore, it does not need to have a registered manager. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider was available throughout our inspection visit.

At the last inspection carried out on 2 December 2013, we found the provider was not meeting the regulations in relation to records and quality assurance. Following the

Summary of findings

inspection the provider sent us an action plan telling us about the improvements they were going to make. They told us they would make these improvements by the middle of March 2014. During this inspection in June 2015 we found that the provider had not taken sufficient action in relation to the concerns previously identified.

The service was not well-led. There was no quality assurance system in place. As a result the provider had not found a number of concerns identified during this inspection. We found concerns in relation to mental capacity assessments, Deprivation of Liberty Safeguards, care plans, medicine management, risk management, and staff recruitment and training.

People who lived in the home were not always safe. People's medicines were not always well managed. Although staff had signed to confirm they had administered medicines, it was not possible to check whether medicines had been given because of poor accounting and record keeping. Safe staff recruitment practices were not always followed to ensure staff were suitable to work with people who lived in the home.

Risks to people were not always assessed, identified, and managed. For example, one upstairs bedroom window opened wide over a roof which may have placed people at risk of falling from a height. Disposable razors, denture cleansing tablets, and an anti-bacterial spray were observed in bathrooms which may have placed people at risk of injury or harm. After the inspection, the provider confirmed that the window had been restricted. There was no personal emergency evacuation plan in place for each person that told staff how to safely assist them in the event of a fire. The premises were not maintained appropriately to ensure people were kept safe.

People did not always benefit from support from staff who had up-to-date training. Although staff had not completed training we saw most staff had skills to meet peoples needs.

People were not always treated with dignity and respect. Staff were not always aware of their responsibilities. For example, one person was at risk of choking. The care plan had not been updated to give staff information on how to support this person. Some staff were not aware they needed to stay with the person whilst they were eating, and were unsure what to do if the person did choke. Staff had not been given information about people's personal histories. This meant staff did not have important information which could help them to understand and respond to each person's dementia care needs in a caring and compassionate way. Most staff were kind and caring, showing patience when supporting people. Some staff showed skill when encouraging people and distracting them to relieve distress. For example, when one person showed signs of distress, a member of staff reassured them. The person responded by saying "You're lovely".

The provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. There were no mental capacity assessments in people's care plans. It was not clear how people's care and treatment was carried out in their best interests where they lacked capacity to make decisions about their care themselves. The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Most people's freedom to leave the premises or move around the home was restricted without the protection of a legal authorisation to do so under the Deprivation of Liberty Safeguards. The provider had not made application for authorisations for people to be deprived of their liberty.

People who lived in the home had some degree of dementia. The environment was not suitably adapted for people living with dementia. People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. During our Short Observational Framework for Inspection (SOFI), several people showed signs of boredom and frustration.

People were at risk of receiving inconsistent care. Care plans were confusing with information in different places. People's care plans did not accurately reflect their care needs. As a result, staff did not have the information available to help them to deliver consistent and appropriate person centred care based on the person's needs and preferences.

The registered provider was visible in the service but was not aware of their legal responsibilities, such as the requirement to let the CQC know about the events that took place in the home. For example, one person had been seriously injured. The provider did not have a copy of the new Regulations which came into force on 1 April 2015. They downloaded these from the internet during our inspection.

Summary of findings

The provider had recently arranged for a senior member of staff to take on extra responsibilities so they would be able to make the required improvements. The staff member had enrolled on the Level 5 Diploma in Leadership and Management. During our inspection, a new quality assurance system was delivered to the home.

Since the inspection, the provider has spoken with the local authority quality monitoring team. The team are visiting the home to support the provider to make improvements to quality and safety for people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider’s registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

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.

People were not always protected from the risk of harm because risks were not identified and managed.

It was not possible for staff to evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health.

Safe staff recruitment practices were not always followed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not followed the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. Most people were being deprived of their liberty without the protection of a legal authorisation to do so.

Staff had not received up-to-date training to ensure they had the knowledge and skills to meet people's needs effectively.

The environment was not suitably adapted for people living with dementia to ensure the best possible outcomes.

People's nutritional needs were not always well managed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was not always respected. People were not always treated with dignity and respect. There was little interaction between some staff and people when they provided support.

Other staff were kind and caring, giving reassurance to people to relieve distress.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were risk of inconsistent care because the care plans had not been updated after reviews were held.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

People and their relatives had access to the complaints procedure. Staff knew to look for facial expressions and changes in behaviour to tell if a person was unhappy.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

We found a number of issues during our visit which had not been identified by the provider. Systems were not in place to ensure people received safe, high quality care.

The provider had not addressed breaches of regulations relating to quality assurance and records found during our last inspection.

Records were not accurate or kept-up-date.

Southernhay Residential Home

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 was 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.

One adult social care inspector carried out this unannounced inspection on 17 June and 22 June 2015.

On the day of our visit, 18 people were using the service. We used a range of different methods to help us understand people's experience.

We spent time observing care and used the Short Observational Framework for inspection (SOFI). This gives us a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with one person and one relative. We spoke with the provider and four staff.

We looked at three care plans, medication records, staff files, audits, policies and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The service was not safe.

Risks to people were not always assessed and managed to ensure they received appropriate care and support. One person's care plan contained information that they could get agitated and restless. Daily records showed they had hit a member of staff. Staff said the person could be quite aggressive and tried to scratch, hit, and punch them. The provider had recently sought support from the mental health team. However, the care plan had not been reviewed to include information about the triggers that could result in these behaviours, which would help staff to support this person in a safe proactive way, or how staff should support this person if they were in a distressed state.

Risks were not always managed to ensure people were kept safe. For example, one person had been assessed by the speech and language therapist. The advice was to ensure the person was given full supervision when eating due to the risk of them choking. Staff told us when this person had their meal they would go in and out of this person's bedroom. This person was left alone for over ten minutes at lunchtime without staff checking them. Although, monthly reviews in the care plan showed this person was at risk of choking, there was no risk assessment which gave staff information on how to reduce the risk of choking and what to do if the person did choke.

People's medicines were not always well managed. Entries on the MAR sheet which had been hand written were not always signed by two members of staff to ensure the correct information had been recorded. Although staff had signed to confirm they had administered medicines, it was not possible to check whether medicines management was accurate. This was because records relating to the medicines in stock, were not accurate. Not all medicines held in stock had been recorded. When medicines had been carried forward from the previous months supply, these had not been recorded. Therefore, it was not possible to evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health.

We found a prescribed cream in one person's bathroom that had passed its expiry date of September 2014. This meant that this person was exposed to risks associated with the administration of creams that had potentially ceased to be effective following expiry of the 'use by' date.

Risks to people were not always assessed. For example, one upstairs bedroom window opened wide over a roof. As some people had dementia they could have climbed through this window and fallen from a height. Disposable razors, denture cleansing tablets, and an anti-bacterial spray were seen in bathrooms which may have placed people at risk of injury or harm. After the inspection, the provider confirmed that the window had been restricted.

There was an emergency plan in place in the event of the fire alarm sounding. However, there was no personal emergency evacuation plan for each person that told staff how to safely assist them in the event of a fire.

The premises were not always maintained appropriately. Several toilets had carpets which smelt of urine. We observed mould on the bottom of bath mats. The material on a commode was ripped. This may have placed people at risk of infection. The provider told us there was no building maintenance and renewal plan in place. The gas safety check had expired. A service visit had been booked for 1 July 2015.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks had been carried out in relation to fire, water, electrical installation, stairlifts and hoists.

Safe recruitment practices were not always followed. For example, where a staff member had been previously employed to carry out care work with vulnerable adults, the provider had not sought a reference from their most recent employer. After the inspection, the provider made contact with the employer and obtained a reference. In January 2015, we received information that a staff member had been employed without the appropriate criminal record checks being in place. The provider had told us they would use an agency to check criminal records so this did not happen again. Staff files showed these checks were now carried out before staff started working in the home.

Systems were in place to ensure people were protected from abuse. Staff were able to tell us how they would recognise possible signs of abuse. Staff knew how to raise

Inadequate

Is the service safe?

concerns about abuse and poor practice with the manager. They felt the manager would listen to their concerns and respond to these. Staff were aware of the external agencies they could contact with their concerns. The safeguarding policies did not contain information about who staff could go to outside of the home. The provider confirmed they would add contact details for the external agencies. During our inspection, we observed an incident of poor practice. This was reported to the Local Authority safeguarding team. The provider carried out an investigation and put training in place for the staff member between our visits.

Although staff were busy on the days of our inspection, they attended to people's needs. People received care and support in a timely manner. On the first day, the provider was on duty with three care staff, maintenance staff, and a domestic. On the second day, the staffing levels had increased. The provider was on duty with four care staff, maintenance staff, a domestic, and a cook. The rota showed normal staffing levels were four care staff, the registered manager, cook, domestic and maintenance staff.

The provider and staff told us they had been short staffed recently but felt there had been enough staff on duty to meet people's care needs. We looked at past rotas. The provider told us the rotas did not accurately reflect the number of staff on duty and there had been more than recorded. Due to the inaccurate recording we could not be sure people benefitted from enough staff at all times. The provider was interviewing and recruiting new staff to ensure there were enough staff at all times. However, there was no system in place to assess whether staffing levels were sufficient to meet people's individual needs and keep them safe.

Accidents and incidents were monitored to minimise the risk of reoccurrence. For example, one person had fallen five times in a two month period. The provider had looked at the falls and found they had all taken place in the person's bedroom. The person had moved to another bedroom where staff were able to monitor them more closely. The falls had reduced as a result.

Inadequate

Is the service effective?

Our findings

The home was not effective.

The provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. The Mental Capacity Act (2005) (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision can be made involving people who know the person well and other professionals, where relevant. The provider had a copy of the Code of Practice. Our observations showed some people may not have capacity to make decisions. However staff had not incorporated this into the planning of their care. There were no mental capacity assessments in people's care plans. Therefore, it was not clear how people's care and treatment was carried out in their best interests, or whether they had the capacity to consent to care or refuse this. There was no recorded evidence of discussions with families. Nine out of eleven staff had not completed training in the MCA. Some staff did not have a good understanding of the principles and codes of conduct associated with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The front door was locked and people were unable to leave the home. No one was seen to try to leave the home. Staff told us they would stop people if they did try to leave. The provider was aware of changes to DoLS due to a supreme court judgment, and the need to make an application to the local DoLS team but had not made the applications. People were being deprived of their liberty without the protection of a legal authorisation to do so. Two DoLS applications had been made. Both applications had been authorised. There was evidence each person's best interests had been properly considered and the authorisations were being followed.

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

Staff had not received training to ensure they had the knowledge and skills to meet people's needs effectively. Staff told us their training was not up-to-date and that staff absences had meant they did not have time to complete updates. The provider confirmed that training needed to be updated if it was not on the training records. Individual training records were not easy to understand and showed gaps in a number of areas. For example, out of a total of eleven staff, eight had not completed safeguarding training. Six had not completed first aid training. Five had not completed dementia training. Seven had not completed food hygiene training. Nine had not completed infection control training. Three had not completed moving and handling training. One staff member was also employed at another home. The provider told us they had completed their training but there was no evidence to confirm this. Several staff told us they had completed first aid training but were not sure what to do if one person choked. Although staff had not completed training we saw most staff had skills to meet peoples needs. Staff had not received an annual appraisal to discuss their training and development needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us staff would be attending the falls prevention training organised by the fracture liaison service.

We saw records that showed staff had received regular supervision. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues.

People's nutritional needs were not always well managed. Several people needed a soft diet. Food was pureed together, rather than each food in the meal being pureed separately. This meant the food looked unattractive and the individual flavours were lost. The provider confirmed they were aware the foods should have been pureed individually but acknowledged it hadn't been on the day of our inspection. People were not given a choice of meal at lunchtime. Staff told us they would find an alternative if a person did not want the meal on offer. Staff encouraged one person to eat some more food. They didn't want any more so staff took the plate away before returning with a banana, biscuits, and a pudding which the person started to eat. People were encouraged to drink fluids. For example, staff sat with several people and supported them to have a drink. They explained what the type of drink, checked the person was alright, and encouraged them to drink more.

Inadequate

Is the service effective?

People's weights were recorded regularly. However, where one person had lost weight there was no written plan of how this was being managed and reviewed. Where people were at risk of losing weight, the cook prepared enriched foods, which included adding cream and butter to them. Staff regularly offered people drinks.

The environment was not suitably adapted for people living with dementia. For example, some areas had large mirrors. This could be difficult for people living with dementia to understand. There was nothing for people to pick up and handle throughout the home. This type of stimulation can improve mood, encourage people to talk with others and take part in daily activities. People had access to the garden with support from staff and the provider had planned to develop a seating area outside.

People were supported to access health care services. People had seen professionals including GP, district nurse, and specialists. There was no system in place to show people's healthcare needs had been assessed and monitored. Staff took appropriate action to prevent pressure sores.For example, staff knew to elevate one person's heels and were seen to reposition the person after they moved. However, the person had developed a pressure sore on their heel. The service had made a referral to the district nurse team who were attending.

We recommend the provider researches and implements guidance for supporting people with dementia in an enabling environment.

Requires Improvement

Is the service caring?

Our findings

The home was not always caring.

The quality of interactions between staff and people were variable. People's privacy was not always respected. For example, a member of staff entered one person's bedroom without knocking on the door as a way of seeking permission to enter, or letting the person, if they were not able to respond, know they were entering. The person was eating their lunch. The member of staff did not say anything to the person and switched the vacuum cleaner on.

People were not always treated with dignity and respect. For example, two members of staff stood in front of people whilst supporting them to eat. This did not promote an enjoyable experience and may have been intimidating for the person. There was very little interaction between staff and people. One member of staff gave instructions such as "food is here, open your mouth then" and "swallow". The person responded by putting their hands up and trying to stop the staff member assisting them. After this incident, another member of staff took over and assisted the person to eat. The person knew this member of staff. As a result, the person looked calmer. However, the member of staff still stood in over them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent 30 minutes carrying out a Short Observational Framework for Inspection (SOFI) observing people in the lounge. Some interactions were good and showed staff respected people at the home. For example, when staff stopped and spoke with people this lifted the person's mood. One person asked where the toilet was. The staff member responded kindly saying "Come on, I'll show you" and gently took the person's hand. However, some people did not have as many interactions as others.

Some interactions showed care staff were kind and caring. One person commented that staff had been very good and attentive to their needs. Staff sat down next to a person when assisting with their food and chatted to the person. Staff were patient when supporting people to mobilise, allowing people time without rushing them. Staff explained they would help one person to stand. They gave the person a choice of walking or using the wheelchair. The person chose to walk. Staff respected their choice, encouraged their independence, and supported the person to walk.

Some staff showed patience and skill when encouraging people. Staff successfully used distraction techniques as a way of relieving people's distress. For example, when one person showed signs of distress, a member of staff reassured them. The person responded by saying "You're lovely". The staff member offered to go for a walk with the person.

Two of the bedrooms in the home were shared by two people. Staff said that a privacy screen was in place and was pulled across when personal care was carried out. During our inspection, one person spilt a drink on their trousers. Staff supported them to go to their bedroom and change into dry clothes.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of not receiving care that met their needs. Care plans were confusing and information was not easily accessible. Each care plan had a section which showed monthly reviews had been carried out. The information in the monthly reviews had not been used to update the main section in the care plan. This meant people's care plans did not accurately reflect their care needs. For example, one person's mobility had deteriorated. The review carried out in March 2015 stated the person now needed full assistance with personal care. There was no detailed information so that staff knew how to deliver consistent and appropriate person centred care based on the person's needs and preferences. There was no evidence that people or their representatives had been involved in writing and reviewing the care plan.

Care plans did not give information about how each person's dementia impacted on their day to day life or how to care for people with more complex needs in an individualised way. Care plans did not contain detailed information in relation to each person's communication needs.

Staff did not always know people's personal histories. Each care plan contained a section where staff could record a profile to enable them to learn about the life of the person and their interests. The profiles we looked at were all blank. This meant staff did not have important information which could help them to understand and respond to each person's dementia care needs in a caring and compassionate way.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. The provider had not used information about the person's life, the work they had done, and their interests to develop individual ways of stimulating and occupying people. During our Short Observational Framework for Inspection (SOFI), several people showed signs of boredom and frustration. For example, one person paced up and down the lounge. Another person kept standing up and then sitting down. A third person was fiddling with their hands and showing signs of distress.

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

On the first day of our inspection, the television was on all day in the lounge but not everyone in the room was watching it. Some people took part in ball games during the afternoon. Daily records indicated people spent their days relaxing and sleeping in the lounge and watching television. Staff told us people enjoyed the visiting musical entertainment and poetry which was held once a month.

People and their relatives had access to the complaints procedure. The service had not received any complaints in the past twelve months. A relative told us "I'm more than happy". Staff knew to look for facial expressions and changes in behaviour to tell if a person was unhappy.

We recommend the provider researches and implements guidance in relation to engaging people with dementia.

Inadequate

Is the service well-led?

Our findings

The service is not required to have a registered manager as the provider manages the home. The provider was visible in the service but records showed they were not aware of their legal responsibilities. For example, they had not submitted notifications in relation to a serious injury and the approved DOLs applications.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have a copy of the Regulations which came into force on 1 April 2015. They downloaded these from the internet during our inspection.

At the previous inspection carried out in December 2013, we identified the provider was not meeting the regulations in relation to quality assurance and records. The provider sent us an action plan which said they would take action to meet the regulations by March 2014.

At this inspection, we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. We discussed this with the provider who told us they had not been able to complete the action required due to staff illness. There was no quality assurance system in place. This meant the provider had not found the concerns we identified during our inspection. There was no effective staff training system. We found concerns in relation to care plans, staff training, mental capacity assessments, Deprivation of Liberty Safeguards, medicine management and risk management.

Records relating to people's care were not well organised or reviewed appropriately. A number of records were not accurate or kept up-to-date. This included care plans and risk assessments. There was no effective staff training system in place. Therefore, it was not clear when staff had last completed training. The Medication Administration Record (MAR) sheets were not completed correctly. For example, staff had not used the coding system identified on the form. Therefore, when people had not received their medicines, it was not possible to tell why this had happened.

Staff were not always aware of their responsibilities. A new member of staff didn't understand that they should be working on the floor. They joined two other care staff who were having a break. The provider was supervising one part of the lounge. However, the other part of the lounge was not supervised and people in this area were showing some signs of distress.

The home provided support to people living with dementia. The arrangements in relation to activities and the environment did not reflect current guidance.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider felt confident that the staff member who had recently taken on extra responsibilities would be able to make the required improvements. The staff member had enrolled on the Level 5 Diploma in Leadership and Management. A new quality assurance system which links to the fundamental standards had already been ordered and was delivered during our inspection. The staff member had recently attended the local care forum to learn more about current best practice.

Since the inspection, the local authority quality monitoring team have begun visiting the home to support the provider to make improvements to quality and safety for people.

The provider worked in the home alongside staff. Staff told us they found the provider approachable. They said "We talk all the time"; "They're really easy to talk to" and "If I'm worried about anything, it's sorted straight away". Staff were able to make suggestions to improve the service. For example, one member of staff had recently made a suggestion about looking to offer a better variety of activities that were more individually suited to people. The provider had asked them to research some ideas.

The provider had sought feedback from relatives recently. These asked for their views of the support provided. A total of four completed questionnaires had been received at the time of the inspection. All of the responses were positive and there were no suggestions for improvement. One relative said "We couldn't be more happy with the care and attention".

The service had received a food hygiene visit in March 2015. They had been awarded a rating of five. This was the highest rating and showed the service maintained very good hygiene.

The service had taken part in the local health trust's pressure ulcer prevention project. The provider told us they

Inadequate

Is the service well-led?

had been chosen to take part in the project. The service had received health care visitors from Denmark to come and discuss the project and share good practice in how to prevent pressure ulcers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not carried out assessments or designed care and treatment to make sure each person received appropriate person-centred care.** Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not treated with dignity and respect at all times.** Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People and those lawfully acting on their behalf had not given consent before care and treatment was provided.** Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were deprived of their liberty without lawful authority.** Regulation 13 (5)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission of a serious injury or the outcome of DoLS applications. Regulation 18(4B)(c) and 18(5)(g)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive appropriate training and appraisal to enable them to carry out their duties. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 Systems did not enable the registered person to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:
Warning notice

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 not always assessed risks to people's health and safety or made adjustments to make sure the risks were minimised. The premises and were not suitable for purpose to ensure people were kept safe. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. Regulation 12 (1) (2)(a)(b)(d)(g)

The enforcement action we took:
Warning notice