Mrs Sandra Roberts

Little Acre Care Home

Inspection report

82 Skinburness Road, Silloth, Cumbria, CA7 4 QH
Tel: 01697 332105

Date of inspection visit: 17 September 2015
Date of publication: 04/12/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We visited the home on 17 September 2015. The inspection was an unannounced scheduled inspection visit.

Little Acre Care Home is registered to provide accommodation for people who require personal care. The home can accommodate up to 14 older people, some of whom may have mild dementia.

Accommodation is provided on the ground floor of a bungalow style property. All of the rooms are for single occupancy, 13 of the rooms provide en-suite facilities with the remaining room having close access to a communal bathroom.

There is a registered manager in post at the home. 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.

All of the people we spoke to during our visit to the home told us that they were "very happy" with the home and the support they received from staff.

One person said; "I cannot imagine that staff would not be supportive. They are respectful and helpful." Another person told us; "I have never had to complain about anything here. The staff are very, very nice and friendly. I have never seen anyone being unkind here."

Summary of findings

We were also told by a person who had not been at the home for very long; "I have really settled in here. The staff are excellent and very obliging. The food is great and I think I eat too much now."

A relative said; "It is a relief to know that there is someone here to care about my relative. The staff do try to find out about people who live here, what their interests are for example."

When we looked at people's care records, we found that people who used this service were not always involved in decision making and giving consent for their care and treatment. There was little evidence to confirm that decisions had been made in people's best interests because they did not have the capacity to make those decisions themselves. We found that the provider and staff at the home had limited knowledge of the Mental Capacity Act 2005 and the deprivation of liberty safeguards.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service had not been properly supported to make decisions about their care and welfare. You can see what action we told the provider to take at the back of the full version of the report.

This is a breach of Regulation 13: Safeguarding service users from abuse and improper treatment because people who used this service were not protected against the risks of unlawful restrictive practices. You can see what action we told the provider to take at the back of the full version of the report.

We observed that people's medicines had not been managed safely and had not been stored securely. We found that appropriate plans were not in place to help staff effectively manage "when required" medicines, such as pain killers.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of not receiving the right treatment when they needed it. You can see what action we told the provider to take at the back of the full version of the report.

The sample of care records we looked at during our visit did not reflect the current needs of people who used this service. There was insufficient information and guidance available to staff to help ensure they knew how to support and keep people safe.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of receiving unsafe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

We looked at the way in which the provider protected people from the risk of abuse or improper treatment. We found that although there were protocols in place at the home and staff had been trained to recognise signs of abuse, the provider had not dealt with potential allegations appropriately. The provider was not fully aware of their duty to report concerns and incidents.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of harm because the provider did not have effective systems in place and lacked understanding of their responsibilities. You can see what action we told the provider to take at the back of the full version of the report.

We looked at the way in which the provider recruited new staff to the service. We found that the process was not as robust as it should have been. This meant that people who used the service were placed at risk of receiving their care and support from people who may not be suitable.

We have made a recommendation that the service reviews their staff recruitment practices in line with current legislative requirements and good practice guidelines.

On the day of our visit there was little evidence of social or leisure activities available. Individuals did have their own newspapers and magazines and were able to watch TV or listen to their radios. We were told by people that lived at the home that musical entertainers came into the home from time to time and that there was a regular church service at the home.

Summary of findings

We have made a recommendation that the provider finds out more about supporting people with their social and leisure activities, based on current best practice guidance to help ensure people are not left unnecessarily isolated.

Although the provider has started to carry out audits of the service and makes attempts to seek the views of people who use the service, we found that there were some gaps in the process of quality monitoring and service improvement.

We have made a recommendation that the provider seeks further guidance and advice on these aspects of the service to help ensure the service is effectively monitored against current legislation.

During our visit to the home we looked around all areas of the home. The provider had carried out some refurbishment work to the gardens, bathroom, kitchen and laundry areas. This had created a more pleasant environment and improved facilities for people who used this service. We found the home to be clean, tidy and fresh smelling on the day of our visit.

We spoke to people who lived at Little Acre and to some of their friends and relatives. Everyone we spoke to was very complimentary about the home, the staff and the service they received. All of the people we spoke with told us that they “felt safe” and “comfortable” with the staff and managers at the home.

We saw staff supporting some of the people that lived at Little Acre. We noted that staff were very attentive and respectful towards people and provided clear explanations when needed. We saw that staff encouraged people to remain as independent as possible but were on hand if someone did need help or support.

Although care records and risk assessments were not always up to date, the staff we spoke to during our visit were very aware of people’s care and support needs. There was a warm and friendly atmosphere at the home. People living at the home and their visitors commented on this to us. People living at the home at the time of our visit appeared to be compatible. The provider told us that they had made changes to the way in which people were assessed prior to their admission to the home. This included taking into consideration the needs and characters of the people already living at Little Acre.

There are no formal methods of assessing people’s satisfaction with the service. However, when we spoke to people who used the service they told us that they were comfortable in approaching any of the staff or managers in order to discuss concerns, issues or ideas.

We have made a recommendation that the provider seeks guidance about supporting people to express their views on their experience of the service more formally.

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?

Requires improvement

The service was not safe.

People who used this service were not protected against the risks associated with the use and management of medicines. Medicines were not kept securely and there were poor arrangements in place to ensure people received "when required" medicines when they needed them.

Risk assessments and risk management plans were not routinely reviewed and updated as people's needs changed. This placed people at risk of receiving unsafe support.

People who used this service were not protected from abuse or improper treatment. The provider did not have robust staff recruitment processes in place and safeguarding protocols were out of date.

Is the service effective?

Requires improvement

The service was not consistently effective.

People who used this service told us that they were happy with the care and support they received.

The provider and staff had limited understanding of the Deprivation of Liberty Safeguards (DoLs) and the key requirements of the Mental Capacity Act 2005. This meant that people who used this service did not always have their legal and human rights recognised and respected.

The provider had made improvements and adaptations. This meant that the premises were maintained and suitably adapted to meet the needs of the people that used this service.

Is the service caring?

Good

The service was caring.

People who used this service told us that the staff were very supportive. Everyone we spoke with was very happy with the care they received at Little Acre.

People were encouraged to remain independent as much as possible. However, we did see staff providing sensitive care and support when this was requested or needed.

Staff at the home had a good knowledge of the care needs of people who used this service.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

There was evidence of set routines at the home and people had limited access to social and leisure activities.

Care records contained limited information where people had specific and individual needs that required careful monitoring.

People told us that they had never had to complain about the service they received. They said that they felt "comfortable" in addressing any concerns with the providers or staff if this was necessary.

One of the health care professionals we spoke to told us that the staff were "very responsive" to any requests or instructions they left.

Is the service well-led?

The service was not well led.

People who used the service told us that they were happy with the service and that they felt "comfortable" speaking to the staff at the home. Staff also told us that they were able to raise comments and suggestions with the managers at the service.

However, there was no formal processes in place for obtaining the views of people and stakeholders who were involved with the service.

There were gaps in the auditing and governance systems in place at the home and the provider was not familiar with current legislation and regulations. This meant that the health, safety and well-being of people who used this service was compromised.

Requires improvement

Little Acre Care 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 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.

This inspection took place on 17 September 2015 and was unannounced.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, previous inspection reports and action plans that had been submitted by the provider. A notification is information about important events which the service is required to send us by law. Before the inspection, the provider to completed a 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

During the inspection we spoke to four of the people who used the service, three of their relatives and friends. We spoke to two members of staff as well as the registered manager and the provider. We looked at a sample of care records (pathway tracking) belonging to four of the people who used this service and we observed staff supporting people with their day to day needs, in communal areas. We looked at the recruitment records of two recently appointed staff, the staff duty rosters and the staff training records.

Following our inspection of this service we spoke to a member of the community nursing team and staff from the local authority (social workers) provided us with some views on the service.

We asked the provider to send us copies of their policies and procedures in relation to safeguarding, infection control and Deprivation of Liberty safeguards. The provider sent these as requested.

Requires improvement

Is the service safe?

Our findings

During our inspection of this service we spoke to four of the people that lived at Little Acre Care Home and three of their visitors. We spoke to two of the members of staff on duty and the registered persons during our visit too.

People who used this service, who we spoke to, told us that there were "always" enough staff available to help them when needed.

All of the people we spoke with told us that they "felt safe" and "comfortable" with the staff and managers at the home. No one that we spoke to had ever had to raise a concern about the service they received or about the home. People told us that they knew who to speak to if they did have any issues. One person said; "I feel comfortable that I could go and speak to the managers or any of the staff if I had any worries or concerns."

We looked at the way in which people's medicines were managed. We observed the administration of the lunchtime medicines and reviewed people's care plans as well as the medication administration records. We found that people's medicines were not always managed safely. We observed that the medicines trolley was left unattended, open and unlocked during the lunchtime medicines round. We also noted that topical ointments and lotions, although stored in people's own rooms, had not been stored safely and securely.

The staff told us about medicines with special instructions that needed to be followed. We found that these instructions had been recorded in the person's care plan and we observed staff following them. However, such instructions had not been recorded consistently in all cases and there was poor management of "when required" medicines. Care plans were not in place to help staff recognise when this type of medicine should be administered and how the effects should be monitored and reported if necessary.

This is a breach of Regulation 12: Safe Care and Treatment because medicines were not managed safely.

The records relating to the administration of medicines had been accurately completed and tallied with the amount of medicines in stock. There were suitable arrangements in place for the storage and recording of drugs liable to misuse (controlled drugs) and staff told us that they had undertaken training to help them understand and manage medications safely.

The sample of care records we looked at during our inspection of this service contained some element of risk assessment. We found that the risk assessments did not contain sufficient information, management plans or strategies in order to mitigate such risks. For example; where people had been identified at risk of falling, needing to use equipment and when people displayed behaviours that could become challenging. We cross referenced people's daily notes with their risk assessments and care plans and found that recent, significant events had not been included in the care and risk reviewing process.

This is a breach of Regulation 12: Safe Care and Treatment because the provider had not done everything reasonably practicable to prevent people from receiving unsafe care and treatment.

The staff that we spoke with told us, and their training records confirmed that they had received training to help them recognise and report any suspicions about abusive practices. Staff told us that they knew about the home's "whistleblowing policies" and "would be comfortable in reporting any concerns" to the managers at the home.

All of the people we spoke with (including visitors and people who used the service) told us that they had never witnessed any abusive practices at the home. Everyone we spoke to told us that they knew who to talk to if they worried or concerned about abuse.

We looked at the safeguarding policies and procedures that the provider had in place at the home. We noted that the procedures were out of date and did not reflect current legislation nor did they refer to the local safeguarding protocols.

We looked at the care records and daily notes of four people who used this service. From the information we held about the service and from information we read in people's care records we found that the providers had not always reported safeguarding concerns, accidents and incidents as they are required to do. We spoke to the providers about these matters during our visit to the service. They told us that they were not fully aware of the regulations with regard to reporting incidents at the home.

Requires improvement

Is the service safe?

This is a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. People who used this service were not protected from abuse or improper treatment.

The provider was in the process of recruiting new members of staff at the time of our inspection visit. We looked at the recruitment processes in place. Although application forms had been completed and potential staff had attended for interviews, we found that there were gaps in the recruitment process. The provider did not have robust methods in place to ensure satisfactory checks were made with regards to people's previous employment and conduct. This placed people who used the service at risk of receiving care and treatment from people who may be unsuitable for this role.

We recommend that the service reviews their staff recruitment practices in line with current legislative requirements and good practice guidelines.

We found the home to be clean, tidy and fresh smelling throughout. Housekeepers were employed at the home and cleaning schedules were in place. Waste bins had been replaced with the "hands free" type and contaminated waste had been separated out from general waste.

We noted that staff wore protective clothing when carrying out personal care tasks and disposed of this appropriately. We did speak to the manager of the home with regard to some staff placing people's skin integrity at risk of harm due to sharp or long finger nails.

Requires improvement

Is the service effective?

Our findings

One person told us; "If I have to call for staff to help me, I never have to wait long." Another person said; "I think this is a friendly place. The staff are excellent and very, very nice and obliging." The people we spoke to during our visit told us that they felt that staff were "competent" and knew how to help them with their care needs.

We asked people who lived at Little Acre how they were supported with eating and drinking. One person told us; "We get a very varied diet. The food is great and I think I eat too much. There are always snacks and drinks available and if I don't like something they (the staff) will make me something else."

Another person said; "The cook comes round every day to ask what we want to eat. There is always plenty to eat and drink."

We looked at a sample of four people's care and support records. We found variances in how people were involved in the review and consent with regards to their care and treatment. For example; one person's care plans had been agreed and signed for by their relative on three consecutive occasions. The next four reviews had been agreed and signed for by the person themselves. There was no evidence to support that this person did not have the capacity to make decisions about their care and welfare needs, or whether such decisions had been made on their behalf in their 'best interests'.

Following an incident at the home, the provider had sought the advice of the deprivation of liberty (DoLs) team for one of the people who lived at Little Acre. At that time it had been advised that the provider take no further action other than reporting any changes back to the DoLs team. We looked at this person's records and found that circumstances had changed but had not been reported as required. There was no evidence to confirm that this person lacked capacity to make decisions about their lifestyle or that processes had been put in place to protect this person's "best interests". We noted that this person had been potentially deprived of their liberty unlawfully.

We found that another person had bed rails in place. There was no risk assessments to identify and confirm that this was the safest and least restrictive practice. There were no assessments to confirm whether this person had the capacity to make decisions about the use of this type of equipment or whether it was in their best interest to use it. In fact their daily notes recorded at least two occasions where the person had tried to climb over the bed rails, placing themselves at risk of harm or injury. We spoke to the provider about this matter at the time of our inspection because urgent action needed to be taken to ensure the safety of this person. The provider told us that this person had used bed rails prior to moving into the home and so they "assumed they were appropriate."

We found that the provider and their staff had limited knowledge of the requirements of the Mental Capacity Act 2005 and the specific requirements of the deprivation of liberty safeguards.

This is a breach of Regulation 11: Need for consent because people had not been effectively involved in decision making processes. Where people may not have been able to make an informed decision, the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005.

This is a breach of Regulation 13: Safeguarding service users from abuse and improper treatment because people who used this service were not protected against the risks of unlawful restrictive practices.

The staff we spoke to told us about the training they had received to help them undertake their duties safely and effectively. We noted from staff training records that a variety of topics had been included in the staff training plans/records. We found that the staff training provided included; first aid, moving and handling, fire evacuation and some basic training with regards the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff told us, and we noted from their records, that staff received supervision on a regular basis and were able to discuss their work and training needs with the managers at the home.

A visitor to the home told us that they thought the food provided and the portion sizes were "reasonable." People who used the service told us that they were able to choose from two meal options at lunch time and tea time each day. One person told us that they needed to drink plenty of fluids each day and that the staff "know this very well, they are always coming in to make sure my water jug is topped up with fresh water."

Requires improvement

Is the service effective?

We observed the serving of the lunch time meal. We noted that people were given choices regarding what they would like to eat and where they would like to eat their meal. Most people sat in the dining room, which provided a pleasant and sociable setting. Some people preferred to eat in the privacy of their own rooms. In either case, staff were on hand to provide support and encouragement where this was needed.

The sample of care records we looked at included assessments of people's nutritional needs. Where necessary, body weights had been monitored to help ensure people maintained a healthy body weight and identify when the advice of health care professional might be needed.

We looked around all areas of the home during our visit. We found that the provider had carried out extensive improvements to the facilities at Little Acre Care Home. The laundry and systems in place to reduce the risk of cross contamination had improved, with further improvements planned for.

A new wet room had been created in place of the old shower room. People we spoke with told us how pleased they were with this particular improvement. The kitchen at the home had also been replaced recently.

Good

Is the service caring?

Our findings

Everyone we spoke to during our visit to Little Acre Care Home told us that they were "very happy" with the care and support they or their relative received.

People who used the service made the following comments:

"I can't imagine that the staff here would not be supportive. I have found them to be respectful and helpful."

"Everyone is very friendly here, I have never seen anyone being unkind and I can't imagine staff being this way. I am very happy here and everything is grand."

"They (staff) are very tactful and respectful when helping me with my personal needs."

One of the relatives we spoke with told us "It is a relief to know that there is someone here to care."

We spoke to some of the health care professionals that visit the home on a regular basis. They told us that there were no issues with regard staff at the home following their instructions or advice. They said "Staff seem to understand and follow any treatment plans or advice we give. They are quite good at contacting us and making appropriate requests for visits".

We observed staff working with people who used this service during our visit to the home. We noted that staff spoke in a kind and friendly manner to people. Visitors to the home and people who lived at the home commented positively on this approach.

We noted that people were encouraged to remain independent as much as possible. This was particularly noticeable when people were moving around the home and at lunchtime. Although staff were on hand to help when needed, they did not intervene unnecessarily.

Where people did need help, for example with mobility, staff provided explanations of the processes involved and this helped to reduce any anxieties the person had.

The sample of care records we looked at clearly identified the things people needed support with and the things they could do for themselves. However, some of these records were out of date and did not always reflect current needs and risks. We spoke to some of the staff on duty about people's care needs. They were able to give us a good overview of the needs of the people they were supporting and the actions they would take to help them.

We found that detailed care plans had been developed to help staff support people with their skin care needs and that there was good liaison with community nurses in this respect.

We observed the administration of the medicines at lunchtime. We noted that people who needed eye drops or inhalers administered received these in the privacy of their own room rather than in a communal area.

At the time of our visit there was no one at the home receiving end of life care. The provider told us that there were arrangements in place to provide this level of care when needed, including support from community nurses and doctors.

Requires improvement

Is the service responsive?

Our findings

All of the people we spoke to during our inspection of this service confirmed that they had never had to make a complaint about the home or the support they received.

One person told us; "The staff are very friendly here and I know the owner and manager. If I had a problem I would tell them." Another person said; "I have had no complaints. If I had I would tell the owner or the manager. I feel very comfortable about going to speak to them about anything."

A health care professional that we spoke with commented; "We have no problems with the service and things have improved. The staff are very responsive to requests and instructions."

Everyone told us that staff were very responsive to their needs and that they "didn't have to wait long" if they called for assistance.

The sample of care records we looked at provided some evidence that care and support was provided around people's individual needs. There were aspects that needed to be improved on. For example, where people had specific conditions or behaviours that needed careful monitoring and where people had used equipment to help keep them safe. Care plans recorded people's interests and hobbies but this had not been done with any consistency and some contained more detailed information that others.

We observed, and people told us that there were set routines in place at the home. We saw from records that there were set days and times for people to bathe or shower and people all came for meals at the same time.

People we spoke to confirmed this was the process. One person told us; "There is a kind of rota for the shower. I don't think it is strict and I think staff would help me have one on a different day if I asked, but I haven't asked".

On the day of our visit to the home there were limited activities available. Some people watched TV or listened to the radio in their own rooms or the communal areas. We noted that people were able to have their favourite newspaper and magazines delivered to the home if they wished.

A visitor to the home told us that staff "do try to find out what people's interests are." We noted that there were regular religious services and musical entertainers at the home. People could choose whether to attend or not. People told us that they were able to go out if they wanted to with families and friends. Others said that they preferred to stay in their own rooms but did go into the communal areas "if there was something on" that they were interested in.

We recommend that the provider finds out more about supporting people with their social and leisure activities, based on current best practice guidance to help ensure people are not left unnecessarily isolated.

The provider told us that they had reviewed the way in which pre-admission assessments were carried out. This meant that the provider took into account the impact new admissions may have had on people already using the service.

The service had a complaints process in place and this was accessible to people who used the service and visitors to the home. The provider had not received any complaints about the service they provided at Little Acre.

Requires improvement

Is the service well-led?

Our findings

People who used the service and their visitors told us that they were very happy with the service. No one that we spoke to during the inspection of this service raised any concerns with us. People commented on the "family atmosphere" at Little Acre and people told us that they were "kept up to date" with any issues that might affect their relatives.

We checked the information we held about this service and compared this with the events and incidents that had been recorded at the home. We found evidence in the sample of records we looked at during our inspection visit, of five matters that should have been reported to CQC, two of which should also have been referred to the local authority. The provider told us at the time of the inspection that they were not familiar with the requirements of this regulation.

This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009 because the provider had failed to notify CQC of incidents occurring at the home as specified in this regulation. We are dealing with this matter separately.

There were gaps in the auditing and governance systems in place, which meant that the safety and well-being of people using this service was compromised. For example: risk assessments were not reviewed as needs changed; mental capacity assessments and records of the decision making processes when obtaining consent had not been maintained; and there was little evidence that appropriate legal processes had been followed.

We recommend that the service seek advice and guidance with regards to their governance and auditing practice to make sure their service is monitored effectively against current regulations and legislation.

The service has a registered manager in place.

We found that records relating to staff and people who used this service had been kept securely in order to maintain confidentiality.

Staff discussed and showed us the process in place for auditing and checking that medicines were accounted for safely at the home.

We found that equipment such as hoists and fire fighting equipment had been regularly inspected and serviced. The provider carried out visual audits of the premises and where necessary, improvements to the environment were made. We noted that major improvements to the home had been made, making it a more pleasant and hygienic environment for the people that lived and worked there.

Although there were no formal processes in place for people to comment on how the service was run or how improvements could be made, we found that people were able to make comments. People using the service told us that they felt comfortable in approaching any of the staff or the managers in order to discuss issues, concerns or ideas. People told us that they were confident that they would be listened to and actions would be taken.

Staff told us that the manager frequently held staff meetings and that the provider operated an "open door" policy. Staff told us that they were encouraged to make suggestions as to how the service could improve.

We recommend that the service seek advice and guidance from a reputable source about supporting people to express their views about the quality of services they experience.

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent How the regulation was not being met: People who use services had not been effectively involved in decision making processes. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. How the regulation was not being met: People who use services were not protected against the risks associated with unsafe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. How the regulation was not being met: People who use services were not protected against the risks of receiving unsafe care and treatment. Regulation 12 (2)(a)(b)

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014. Safeguarding service user from abuse and improper treatment. How the regulation was not being met: People who use services were not protected against the risks of abuse and improper treatment because effective systems were not in operation. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014. Safeguarding service user from abuse and improper treatment. How the regulation was not being met: People who use services were deprived of their liberty. Regulation 13(5

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.