John Munroe Group Limited

Mitchell House Nursing Home

Inspection report

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Tel: 01538394270

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mitchell House Nursing Home is a nursing home providing personal and nursing care to seven people living with complex physical and mental health needs. The home had four units all with communal areas and a separate gym and café. The home can support up to 45 people.

People's experience of using this service and what we found
People were not supported by sufficiently trained staff to meet all of their health needs. People were not always supported to receive their medicines as prescribed in a safe way. People's care needs and risks were not all explored within their care files and staff were not always aware of these or how to support people with them. People were not always supported in line with government COVID-19 guidance and best practice. Safeguarding concerns were not reported to the Local Authority as required for further investigation and to reduce future risk. People were not supported by regular staff who knew them well as the home relied upon agency staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People's records were not stored safely to ensure confidentiality. People did not all feel able to raise concerns with the registered manager.

There was a lack of effective and robust quality assurance tools and oversight in place at the service. All concerns we identified were not highlighted by quality assurance tools in place. The registered manager had failed to notify CQC as required following potential safeguarding and police incidents.

People were supported by safely recruited staff. People were supported to eat and drink in line with their needs and preferences. People were supported to maintain their privacy and dignity. People gave positive feedback about the regular staff and told us staff knew them well. People and their relatives overall gave positive feedback about the registered manager. People were supported to have visitors and to access the local community. People had access to healthcare professionals when they required these.

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

Rating at last inspection
This service was registered with us on 05/07/2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about people's risks being managed effectively. A decision was made for us to inspect and examine those risks. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19

and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to peoples' safe care and treatment, capacity and the oversight and governance at the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Mitchell House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was completed by two inspectors.

Service and service type
Mitchell House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with ten members of staff including the provider, registered manager, HR manager, estates manager, head of domestic services, senior care workers, care workers and a nurse. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with further staff at the home and two professionals who regularly visit.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People did not have risk assessments in place to give staff clear guidance to follow on how to support people to mitigate known risks. For example, one person had been involved in thirteen incidents where they had shown distressed behaviours or made threats to staff. Despite this, they had no risk assessment in place in relation to this. This placed the person and those around them at significant risk of harm.

● Where people had risk assessments completed these were not accurate or complete. For example, one person was at risk of self-harm and had recently attempted to end their life whilst at the home. This person's risk assessment stated there was no known risk of self-harm or suicide and not all staff were aware of this incident. Therefore, the provider failed to put actions in place to protect people from known risks to keep them and others safe.

● People's health needs and associated risks were not explored in detail within their risk assessments. For example, one person with a diagnosis of epilepsy had no risk assessment in place giving staff guidance on how to support them to reduce the risk of harm in the event of a seizure. The risk had not been assessed which meant the person was exposed to significant harm.

Using medicines safely

● Medicines were not managed safely and people did not always receive their medicines as prescribed. For example, one person only received half of their prescribed dose of diabetes medicines for six days. This was not identified by the nurses administering the medicine or the registered manager. This placed the person at prolonged risk of harm associated with the poor management of their diabetes from not receiving their medicines and this not being identified in a timely way.

● Staff recorded administering some people's medicines inaccurately. For example, staff had recorded they had given one person their medicines four times on one day when these were only prescribed three times. This meant the person was given an overdose of their prescribed medicines and they were exposed to the harm associated with this.

● When people were prescribed certain medicines staff are required to check and record the amount remaining when giving each dose. Staff had failed to accurately check and record numbers in line with guidance. For example, we found one person had one additional medicine and one person had one medicine unaccounted for. This meant it was unclear if people had received their medicines as prescribed which may have resulted in harm.

Preventing and controlling infection

● COVID-19 guidelines state all professionals visiting a service are required to be double vaccinated, have completed a lateral flow test and have had their temperature taken on arrival to the home. However, on arrival at the home neither inspector was asked for proof of their vaccination status, test result or had their

temperature taken.
● The registered manager told us all staff vaccinations were checked on recruitment. However, there was no record of these checks. Despite this, staff we spoke with confirmed they had been double vaccinated.
● The registered manager had failed to ensure all staff were tested weekly in line with government guidance. Staff were tested weekly only when they were working on the day tests were completed. This placed people at increased risk of transmission of COVID-19 as this would not have been detected in a timely way.
● People did not have COVID-19 care plans or risk assessments in place which gave staff clear guidance to follow despite people at the service having known health vulnerabilities increasing their risk should they contract COVID-19.
● People were not supported to isolate on admission to the home in line with government guidance. Whilst people at the service had complex needs which may have made isolation detrimental to their wellbeing, the registered manager had failed to complete a risk assessment considering alternative ways to reduce people's risk of transmission of COVID-19.
● Staff were not consistently adhering to personal protective clothing requirements when supporting people with transmissible blood borne viruses. This placed staff at increased risk of transmission of viruses.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● Lessons were not always learned when things went wrong as whilst staff reported accidents and incidents these were not reviewed effectively to ensure actions were taken to reduce the risk of reoccurrence. For example, a person was stating they were going to harm themselves and was speaking with staff about ending their life. Staff completed an incident form to reflect this and the registered manager reviewed this. However, they failed to identify this person had no care plan or risk assessment in place to give staff guidance on how to support them with their mental health needs.

Systems were either not in place or robust enough to ensure people consistently received safe care and treatment. This placed people at harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to have visitors when they wished via a booking system.

Systems and processes to safeguard people from the risk of abuse
● The registered manager failed to provide us with details of all safeguarding concerns and referrals made to the Local Authority Safeguarding team despite us asking for this during our inspection. However, people's notes showed not all potential safeguarding concerns were reported to the Local Authority as required. For example, one person had left the home alone twice and staff had contacted the police. However no incident form had been completed and no referral made to the local safeguarding team. This demonstrated the staff did not recognise the safeguarding issues and did not take action to protect the person from potential harm.
● Staff had completed an incident form following a person telling them they gave men money from their bedroom window. CCTV at the home confirmed two men had come to the person's window and whilst the registered manager informed the police and the person's social worker; no referral was made to the local safeguarding team for further investigation and to protect the person from potential abuse.
● There was also no safeguarding referral made to the local authority following a person attempting to end their life. This showed staff were not equipped to recognise safeguarding concerns, did not report them in a timely manner and had not ensured partner agencies were informed in line with their responsibilities.

Systems were either not in place or robust enough to ensure people were protected from abuse and

improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received mixed feedback about staffing and saw at times people chose not to receive care from agency staff as they wanted support from regular staff who knew them well. One person told us, "I am struggling at the moment, I don't want a wash by someone I don't know."

● People were predominantly supported by agency staff as the home had limited regularly employed staff. As people did not all have care plans and risk assessments in place agency staff were not always clear around peoples' care needs and risks. This placed people at risk of harm. One staff member told us, "I think the detail that is within the care plan is great and extensive but there is a lot of nurses that come into the setting that have only been here a day or two and I don't feel they would be able to grasp each person's background by going through the whole of the plan."

● People were supported by safely recruited staff. The registered manager told us they were in the process of employing additional regular staff and 15 new staff members were due to commence at the service shortly. We will check this on our next inspection.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People did not have capacity assessments and best interest decisions completed to ensure their needs were being met in the least restrictive way and to promote their choices.
- The registered manager had completed DOLS applications for some people at the home. However, they had not completed capacity assessments prior to these applications to consider whether people had capacity and required restrictions placed on them. For example, some people at the service were on one to one staffing, had bed rails in place and crash mats but no capacity assessments which related to these.
- There was CCTV within the home and the provider had failed to ensure people had consented to this. The provider had also failed to complete capacity assessments or best interest decisions for people who may lack capacity in relation to CCTV.

Systems were either not in place or robust enough to ensure people were supported in the least restrictive way. This placed people at risk of harm. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's needs, risks and choices were not included within their care files. This meant staff lacked critical information about the people in their care. This placed them at risk of avoidable harm.
- Care plan reviews failed to adequately review and identify changes in people's needs and care. This

resulted in information about some people's needs being out of date, incomplete and inaccurate.

People's needs were not adequately reflected within their care files to ensure the care provided was informed by their needs and effective. This was a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had access to healthcare services when they needed it. One professional told us, "[Staff] seem to be quite hot on things if they have concerns about a [person] they will call or email just to say can you pop out. They are very timely when we have requested things like bloods or urine."

Staff support: induction, training, skills and experience
● Staff did not always have training to support them to meet people's health needs. For example, people at the service had a diagnosis of diabetes however staff had not received diabetes training. Staff we spoke with did not have sufficient knowledge of how to support people with their diabetes needs should they experience high or low sugar levels. This placed people at risk of not receiving timely care in line with their needs which may have resulted in avoidable harm.
● Staff were also supporting a person with epilepsy without any epilepsy training. Staff we spoke with had limited knowledge about how to support this person in the event of them having seizure. This placed the person at risk of harm.
● We saw other staff training was up to date. For example, staff had received an induction and basic training around moving and handling and health and safety.

Adapting service, design, decoration to meet people's needs
● People and their relatives gave mixed feedback about the environment. One relative told us, "The room's a bit clinical." However, one person spoke with us about how pleased he was with the facilities in the home including the gym.
● Despite this, the environment was specifically designed to meet the needs of the people who they were supporting. There were multiple communal areas, a gym and outside space which people had access to.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs and how they were to be met were recorded within people's care files. For example, one person required support whilst eating and this was documented within their care plan.
● People gave positive feedback about the food. One person told us, "I can have scrambled egg and garlic, they'll cook whatever you want here."
● People's special dietary requirements adhered to and staff could tell us who required a diabetic diet. Where people required support to monitor their diet and fluid intake and weight, staff were supporting them with this and documenting it within their care files.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People told us and records confirmed limited involvement of people and where they wished, their relatives being supported to make decisions regarding their care. However, the registered manager told us they were working with people to formulate their care plans. We will check this at our next inspection.
- Information was displayed in communal areas about accessing external health professionals and community organisations for people to use if they wished to.

Respecting and promoting people's privacy, dignity and independence
- People's right to confidentiality was not always respected as people's records were left unattended within communal areas.
- People were supported to maintain their privacy. For example, staff closed doors and curtains whilst providing personal care.
- People were encouraged to choose what they wished to do during the day to encourage their independence. One staff member told us, "We take people shopping and to do things they like, it's their choice."

Ensuring people are well treated and supported; respecting equality and diversity
- People gave mixed feedback about the differences in approach of the regular staff and the agency staff. One person told us, "A lot of staff that are not understanding. Communicating my previous history to the agency staff who don't speak English is a bit of an issue." However, they also told us about the regular staff, "The staff here can't do enough for us. This is a place I'd like to spend the rest of my life."
- Relatives gave positive feedback about the staff. One relative told us, "Well [all staff] I have come across have been absolutely lovely."
- Staff were knowledgeable about people's likes and dislikes and during our inspection we observed positive interactions between people and staff.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement: This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The registered manager was unable to show us any compliments or complaints they had received despite us requesting this during the inspection. This meant we could not check whether the service had received feedback and how they acted upon this.
- Not all people we spoke with felt able to raise concerns they had about the service. For example, one person told us they had raised concerns before and felt their place at the home was at risk because of this. On review of documentation we confirmed the registered manager had advised a person they may not be able to meet their needs moving forward should they continue to have negative feedback.
- The provider had a compliments and complaints policy in place and relatives told us they felt able to raise concerns.

We recommend the provider implements a robust system to record, monitor and response to complaints. We have reported on the lack of an adequate system in well led.

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

- People's needs were not all explored within their care files. This placed people at risk of not receiving support in line with their needs. For example, one person's care plans did not contain sufficient information around their continence care needs.
- People's preferences were included within their care plans and staff knew people's likes and dislikes. One relative told us, "[Staff] ask about [person's name's] likes and dislikes. I said they like music and the next time I went they had fitted a music player and that seemed to give [person's name] a lift."
- People, and where appropriate their relatives were not yet involved in the planning of their care. The registered manager told us they planned to implement this following our inspection. We will check this on our next visit.

End of life care and support

- People did not have end of life care plans in place which explored their wishes and preferences. Whilst no one at the service was receiving end of life care this placed people at risk of not receiving care in line with their wishes at the end of their lives.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability,

impairment or sensory loss and in some circumstances to their carers.

● People had communication care plans which explored how they could be supported to communicate. For example, one person's care plan advised staff to repeat back what they have said to a person to support their understanding.

●Staff understood people's communication needs and we observed staff communicating with people in line with their communication care plans.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to have visitors within the home. One relative told us, "When I take my mom in who has dementia to visit [person's name] staff offer us drinks and refreshments."

● People were supported to access their local community. For example, people told us and we saw they had planned trips to local shopping centres to support people to complete their Christmas shopping and to access the local park.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider and registered manager had failed to ensure there were adequate and effective quality assurance tools in place to identify where improvements were required at the service and ensure actions were taken in a timely way. For example, the registered manager had not been aware of any of the concerns we identified at this inspection prior to our visit. This placed people at risk of harm.
- Quality assurance tools in relation to medicines were not effective and had not identified the concerns we found during the inspection. For example, the registered manager told us people's medicines were checked by the night nurses, but was unable to provide us with any record of these checks. The registered manager also told us they had no oversight of medicines. At this inspection we found multiple concerns in relation to people not having protocols in place for as required medicines, stock checks of controlled drugs not being accurate and people not receiving their medicines as prescribed. Ineffective oversight of medicines placed people at prolonged risk of harm.
- Quality assurance tools had not identified where people's care records did not consistently contain accurate, up to date or detailed guidance for staff to follow. At this inspection we found multiple concerns in relation to people's care plans. For example, there was insufficient information around people's health and mental health needs, risks and behaviours. This placed people and those around them at risk of not receiving care and support in line with their needs and associated risks.
- The provider and registered manager had failed to ensure people were consistently supported in the least restrictive way and that documentation reflected this. For example, people did not have capacity assessments and best interests decisions completed where these were required and the registered manager appeared unclear on their role and responsibilities in relation to the Mental Capacity Act.
- The provider and registered manager had failed to ensure all potential safeguarding concerns had been reported to the local safeguarding team for investigation and to mitigate future risks to people.
- The provider and registered manager had failed to ensure concerns we identified around infection control were identified and action was taken in a timely way. For example, where an environmental audit had been completed by domestic staff, the registered manager had not reviewed this and ensured actions required had been completed. The audit stated no daily cleaning schedules were in place when completed October 2021, this was still the case during our inspection.
- The provider and registered manager had failed to ensure staff had sufficient knowledge and training to meet the needs of people they were supporting. For example, staff were supporting one person with epilepsy and did not have training in relation to this. This had not been identified prior to our inspection and placed this person at risk of harm.

● We raised our concerns with the provider and registered manager during and following the inspection to ensure immediate risks to people's safety were mitigated. Whilst the registered manager had taken some action to reduce people's risks and staff's knowledge of these and people's needs this was not sufficient and we continued to have concerns around quality and oversight within the home and staff's knowledge of the needs of the people they were supporting.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● As reported in 'responsive' people did not always feel able to raise concerns with the registered manager.
● Feedback questionnaires had not yet been set to people and their relatives as the service had only been open since September 2021.

Quality assurance tools were not effective or adequate to identify where areas of improvement were required and to ensure improvements were embedded at the service. This placed people at significant risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to notify us where potential safeguarding concerns had occurred within the service, as they had not identified these and where contact had been made with the police.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had informed people's relatives of incidents within the home. However, not all incidents in relation to medicines management had been identified prior to our inspection. As the provider and registered manager had failed to identify all potential incidents, they had not informed people all their relatives of these. This meant the provider and registered manager had not met the requirements of duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People gave positive feedback about the registered manager. One person told us, "I could tell them if I was worried about something and yeah they probably would do something about it." Another person told us, "[The registered manager] is a laugh and real and pleasant."
●Relatives gave mixed feedback about the home and stated that communication could be challenging at times. One relative told us, "I try and call at the weekend to ask how [my relative] is or to say I am coming in but no-one ever answers. I rang several times at the weekend and I got nothing." Another relative told us, "Mitchell House feels permanent to me for [my relative], I think the [registered manager] has played a big role in the way I feel. The contact I have had with them has given me reassurance."
● The provider and registered manager have acknowledged improvements are required at the home and are working with us, the Local Authority and the local commissioning team to make these improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity was not assessed as required and best interests decisions completed to ensure people were consistently supported in the least restrictive way.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not have care plans and risk assessments in place that gave sufficient guidance to meet their needs and mitigate the associated risks. Staff were not adequately knowledgable or trained in people's specific health care needs such as epilepsy. Government guidance around COVID-19 was not being followed. Medicines were not being managed safely.

The enforcement action we took:

We asked for urgent improvements to be made at the home and an action plan to be sent to us weekly of these improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not referred to the local safeguarding team for investigation.

The enforcement action we took:

We asked for urgent improvements to be made and the provider to send us an action plan weekly of improvements they had made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance tools were not in place or effective to ensure sufficient oversight at the service. All concerns identified during the inspection had not been identified prior to our visit therefore timely improvements had not been made.

The enforcement action we took:

We asked for urgent improvements to be made and the provider to send us an action plan weekly of improvements they had made.