A Kilkenny

Belper Views Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Belper Views Residential Care Home is a care home that provides personal care for up to 25 people, some of whom are living with dementia. At the time of the inspection there were 23 people using the service. The accommodation is split across two floors. The ground floor provides communal space with two lounges, a dining area, conservatory and level access to a secure gardens There are bedrooms, toilets and bathing facilities on both floors.

People's experience of using this service:
The overall rating for the service is inadequate and the service will be placed in special measures.

Services in special measures 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. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

After the last inspection the provider had developed an action plan, however we found that the actions agreed to be completed by the provider and registered manager had not been done.
There was a lack of leadership, coordination and oversight which failed to drive the necessary improvement. We saw that audits had not been used to consider how the safety for people could be improved and risks reduced or mitigated. The rating from the last inspection was not displayed.

Staff did not receive the support they required to ensure they were competent in their roles. When they completed training, their knowledge was not checked to see if they understood how to implement their learning. Staff were not always responsive to people's needs and we saw that the communal areas were frequently unsupervised. Lessons had not been learnt to drive improvements.

People were not safe and staff were not aware of how to raise concerns and we saw incidents which had

occurred had not been reported. People's risks had not been considered and measures put in place to reduce the risks.

Medicines were not managed safely. People had not always received their prescribed medicines, and stocks had not been regularly checked to ensure it was stored in accordance with guidance. When staff administered the medicine, they did not follow the national guidance and we saw this placed people at risk of not receiving their medicines.

People were not protected from the risk of infection. Measures were not in place to ensure cleaning schedules had been followed, to maintain cleanliness and hygiene at the home. People's needs and choices had not been considered.

People are not supported to have maximum choice and control of their lives and staff had not supported them in the least restrictive way possible; the policies and systems in the service did not supported this practice.

People enjoyed the meals, however they did not always receive the support they required during the meal period. When people required support with their nutrition this had not been considered or a referral made to a health care professional for direction.

When people required support with their health care, referrals had not been made in a timely way to support people's immediate or ongoing needs. This meant effective partnership working had not been developed for people's care when needed..

The home had not considered people's view when they embarked on a refurbishment of the home. No questionnaire or meeting had been held for people to comment on their care or the environment they lived in. People's dignity was not always respected, we saw that staff did not always have the time to spend meaningful time with them.

People had not received a pre- assessment before they commenced their care at the home. There was not always care plans in place which detailed the care people required and their preferences.
Consideration had not been made in respect of information access or aspects of people's equality or cultural needs. When people required support for their care at the end of their lives, this was not reflected in the care plans or the support which was available.

There had been no complaints made about the service since our last inspection, however there was no information to inform people how they could raise any concerns. When significant events had occurred at the home, notifications had not been completed to inform us of the event and the action which had been taken, to help us check people's care at the service.

When staff were recruited this was done in line with current guidelines, obtaining two references and a police check. This ensures staff are safe to work with people.

Rating at last inspection: Rated as Requires Improvement, report published 25 July 2018

Why we inspected: This was a planned inspection based on the rating at the last inspection which was Requires Improvement. At this inspection we found the service had deteriorated to Inadequate and we have placed the home in special measures.

Enforcement We found eight breaches in regulatory requirements. You can see the action we asked the provider to take at the end of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. We have restricted admissions to the home and placed conditions on the home to support us to continue to monitor the progress being made.

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not 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**

Belper Views Residential Home

Detailed findings

Background to this inspection

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

Inspection team:
One inspection manager, an inspector and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.
Service and service type: Belper Views Residential is a care home. People in care homes receive accommodation and personal care. 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:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority, clinical commissioning group (CCG) and other professionals who work with the service. We assessed the information we require providers to send us at least once annually to provide some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection we spoke with four people and two relatives to ask about their experience of the care provided. Some people were unable to tell us about their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We spoke with three members of care staff, the cook and the registered manager. We spoke with the provider who was also present for the feedback we gave at the end of our inspection. After the inspection we spoke with two external health care professionals.

We reviewed a range of records. This included five people's care plans and daily logs, in addition to medicine records. We also reviewed the process used for staff recruitment, various records in relation to training and supervision of staff, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely; Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

- People's medicines were not managed safely. Staff did not follow nationally recognised guidance for medicines administration and we saw errors in the medicine administration records (MARs).
- We saw that some people had not received their medicines as prescribed and other people's medicines had been dispensed from the packaging, however there was no MAR to record they had received it.
- When staff administered medicines, they did not observe whether people had taken them before signing the MAR to show this. We observed one person disposing of their medicine in a tissue, which had not been seen by the staff.
- Medicines were not stored safely. For example, medicine was left unattended on top of the medicines trolley, which was in the office with the door wedged open.
- The medicines fridge did not have a lock on the door to keep medicines secure and no temperature checks had been completed so that medicine was stored at the required temperature. Topical Creams had not been recorded on the MAR and there was no record to show whether staff had applied these to people's skin, as prescribed.
- People were placed at risk of avoidable harm because risk assessments were not always completed. There was no guidance for staff to follow..
- Some people were at risk of sore skin from any prolonged body pressure . There were no risk assessments in place related to this and we saw that people were left in the same position for long periods, placing them at increased risk.For example, we observed one person sat in the same position for eight hours and another person lay in their bed all day, There was no turn charts to ensure the person changed position to reduce the pressure.
- Some people required support with specialist equipment to help them to move safely. There was no plan to provide staff with guidance. We saw staff supporting people with equipment , the sling used for the stand aid was not correctly fitted. We saw this causing discomfort to the person. Another person was using equipment which had not been assessed for their use by a health professional. This meant staff could not be sure the person was being supported with the correct equipment to ensure they were safe when being moved.
- When some people used wheelchairs, the footplates had been removed which meant people's feet were at risk of being dragged along the floor.
- When people had specific long-term health conditions, these had not been risk assessed and the correct support provided to manage their conditions. For example, when people had epilepsy staff did not have the understanding of what action to take when a person had a seizure.
- Some people had diabetes, there was no guidance to show staff how to support people with this condition safely,for example, if their blood sugar levels were below or above a healthy range. .

•When health incidents or accidents had occurred, there was no identified management action, to consider and inform how to reduce any risk of reoccurrence. .
•This meant the provider was not assessing the cause of the risk to learn lessons from when things went wrong to avoid repetition. This put people at continued risk of avoidable harm.
•This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
•People were not always protected from the risk of harm or improper treatment because staff and the registered manager did not always take action to safeguard people.
•There were several incidents of actual or threatened physical harm between two people who lived at the home. These incidents were detailed in people's daily care logs; however, no relevant safeguards had been raised or action taken to address these incidents.
•Staff had completed safeguard training. However staff we spoke with were unable to explain the types of abuse, or how to raise any related safety concerns about people.
•This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
•Some areas of the home were not always maintained to reduce the risk of infection. We saw cleaning schedules in place for the bedrooms, however they had not been completed after the 17 February 2019. There were no cleaning schedules in place for the bathrooms or toilets. This meant we could not be sure these areas would be maintained.
•Some items of equipment in the bathrooms were rusty or had peeling plastic which meant these areas could not be easily cleaned effectively, to help reduce the risk of an acquired health infection.
•The bathroom cabinets contained personal items for people and we saw a disposable razor was left in a bathroom. This placed people at risk of cross infection from communal use.
•The kitchen and food preparation area was well maintained. There was a five-star rating from the food standards agency, which is the highest possible rating. The food standards agency is responsible for protecting public health in relation to the safe handling of food.

Staffing and recruitment
•We could not be sure there was always enough staff to support people's needs. For example, we saw that staff were task focused, providing support for refreshment set times or personal care when transferring people for their meals.
•The communal spaces were left unsupervised for long periods. We had to request the staff support people for their personal needs as no one was able to respond to their request and people had no facility to call for assistance.
•Some people remained in their rooms, these people only received contact from staff when they delivered their meals.
•Staff members told us that they did not use agency staff so when there was staff absence, this was not always covered which had an impact on managing people's care needs. There was no dependency chart in place to consider the appropriate levels of staff to support people's needs.
•We reviewed the records relating to staff recruitment and saw that before staff commenced their role, appropriate checks had been completed to ensure they were safe to provide people's care. .

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met

- At the last two last inspections, one in January 2017 and in June 2018 we found that assessments in relation to supporting people when they lacked capacity had not been completed. There was a breach of the regulations at both these inspections. At this inspection we found that this continued to require improvement.
- Some people living at the service lacked the mental capacity to make some decisions about their care. We found people had not always received an assessment to consider any decisions that needed to be made in their best interests. For example, some people were not able to agree that it was in their best interest to live at the home. They had not received an assessment or a referral made to the local authority to reflect they were being restricted in their best interest.
- We saw that a referral had been made to the local authority for a DoLS, however there was no capacity assessment or best interest process to consider how this decision had been made. No measures had been put in place to reflect the care actions the staff should take to support the person until the DoLS was granted.
- Although staff had received training in the MCA 2005, they continued to lack the understanding to implement how they supported people with their decisions and consent.
- The home had CCTV in place within the communal spaces, there was no consent obtained from people or information provided to show this was in place or what is was being used for.
- This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff had received online training for all their training needs, however their learning was not reflected in their knowledge or the support provided to people. Staff we spoke with were unable to provide the details

required in relation to safeguarding people and the MCA.
•□Standards of hygiene within the home had not been monitored and we saw that guidance in relation to the storage of chemicals used for cleaning was not always in place. For example, the chemical storage cupboard door was left open and the key remained in the door. New chemicals had been delivered, however these had not been stored away and remained accessible to people. This showed staff were not following guidance which had been identified in the training on infection control.
•□Medicines administration training had not been supported by a comprehensive competency assessment, we saw poor practices in medicines administration, which have been detailed in the 'Safe' section of this report.
•□Staff had only received online training in safe moving and handling of people. We saw that people were not moved safely when using the stand aid and wheelchairs. Therefore, we could not be assured the staff had the skills to support people safely.
•□This raised concerns in providing us with assurances that staff had received the sufficient training to protect people from a range of risks within the home and the care people received.
•□This was a breach of regulation 18 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
•□Care and support did not reflect current evidence based guidance. People did not have a pre-assessment or a full care plan to provide the staff with information about the care the person required for their long term illness.

Supporting people to eat and drink enough to maintain a balanced diet
•□Somepeople were not supported to have enough to eat and drink throughout the day. For example, people only received refreshments at the designated times. We saw for some people they received their meal without a drink. There were no fluid charts inplace for staff to reflect on the amount people ahd received.
•□Staff did not provide people with support and guidance during their meal. For example, we saw one person struggling with their meal, due to its consistency, the alternative given was potato and gravy. This person had already lost substantial weight and required a more nutritional meal to support their needs.
•□There was a choice of meal and people were asked ahead of the meal being served. The cook told us they discussed with people what they would like on the menu and their choices were added.
•□
Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•□When people were unwell the service had not always ensured that people received the necessary care from health or social care professionals.
•□People's weights had been monitiored, however when a person had lost weight no action was taken to seek assessment and advice from any relevant external health professionals. No referrals had been made to the speech and language team to obtain advise.
•□One person was expressing considerable discomfort with their teeth, no attempt had been made to refer the person to a relevant health professional such as a community dentist, for screening, treatment or advice
•□When people's needs changed and they required specialist equipment to support their safe movement referral's were not always made to obtain advice on the correct equipment to be used.
•□After a health incident we saw that one person expressed pain, medical advice had not been obtained to reduce the person's discomfort or to check if any underlying health problems had occurred from the incident. This meant that people were not support with their immediate and ongoing health care needs.

Adapting service, design, decoration to meet people's needs

- People had not been consulted on the changes made to the environment within the home.
- There was no signage to support people to orientate around the home.
- There was no technology considered which could support people with their needs to ensure their safety.
- There was a programme of refurbishment at the home and a bathroom upstairs had been completed to make an accessible shower room, people told us this was a welcome addition to the home.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations were not always met.

Respecting and promoting people's privacy, dignity and independence
•□People's dignity and respect was not always considered. For example, one person remained in their room throughout the day. They did not receive any support from staff with the exception of receiving their meals. A used urine bottle remained in their room at the side of their bed throughout the day. This showed that staff did not consider this person's dignity.
•□When people were upset staff did not respond to them in a caring and kind manner. For example, one person was observed to be upset on several occasions. Staff did not approach the person or provide them with any comfort.
•□Staff showed a lack of respect for people. We saw that on one occasion a staff member push past a person without providing them with an explanation or an apology.
•□This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; equality and diversity
•□There were times when people were not supported or cared for in a dignified way.
•□Some people were sat with bare feet. Staff did not consider people's related comfort or the risk this placed to their safety when they mobilised.
•□Staff did not sit with people and talk with them for any meaningful length of time.
•□We saw that when people received care this was not explained to them clearly or in an accessible way for the person to understand.

Supporting people to express their views and be involved in making decisions about their care
•□There was no evidence that people had been consulted about their care. Care plans had not always been completed and staff had not established knowledge about people's care and daily living preferences .
•□Staff did not always recognise when people needed or wanted help. We had to ask staff to support some people for their personal care.
•□Relatives told us they could visit when whenever they wished. During our inspection when visitors arrived, we saw they were not always made welcome with seating and refreshments.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. We found a breach of regulation.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- Care plan records were not accurately maintained to provide staff with the information they needed, to ensure people received consistent, safe and effective care. Several people had no pre-admission assessments completed to help inform their care, before they commenced their stay in the home.
- These people and others did not have a care plan to reflect their care needs. Where a care plan had been completed, it lacked the detail for staff to know what care was required and the persons related preferences. For example, for one person there was no detail in relation to the support they needed with their nutritional needs. This meant the person did not receive food of the correct consistency that they were able to manage.
- Another person did not have the guidance provided for staff to know how to support them with equipment and the support they required for their personal needs. We saw staff did not use the equipment correctly which caused the person visible discomfort.
- Because of their health condition, some people expressed themselves with behaviours which placed themselves and others at risk of harm or abuse. We saw within the daily care logs, several incidents when these people had expressed their anxiety through aggression or behaviours which could be challenging for others . There were no plans in place to show staff how to support people effectively and safely, if they became anxious or distressed. Staff members confirmed they did not have clear guidance and felt uncomfortable supporting the people. The impact of this meant that staff did not interact or provide support to these people when needed.
- The provider did not ensure people's care and treatment met their needs. Some people remained in their rooms throughout the day of the inspection. No staff member spent time with these people, other than to deliver their food to their room.
- When people were at the end of their life, measures were not in place to support their dignity, comfort and choice. There was no care plan in place to consider this, such as for any equipment or anticipatory pain relief. Staff did not have the training to understand how to support people at the end stage of their life.
- There were no alternative communication methods provided. There were no picture boards or objects of reference, or information in an easy read format to support people's communication needs.This meant the Accessible Information Standard were not being met.
- Within the care plans there was no consideration for people's equality needs.
- This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- On the day of the inspection we saw no interaction or stimulation offered to people. However, there was usually an activity person, who was on annual leave. People told us they usually enjoyed a range of activities and some people had been given the opportunity to go out of the home.

Improving care quality in response to complaints or concerns

- The provider had received no complaints about the service since our last inspection. However, there was no information visibly displayed within the home for people to know how to raise a concern, or make a complaint.
- There was also no consideration of how people could access this information if they were no longer able to read.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- At our previous inspections in January 2017 and in June 2018 we found measures were not in place to audit the quality of the service being provided and to drive improvements. This was a breach in the legal regulations. At this inspection we found that this continued to require improvement.
- There was a lack of leadership, care coordination and provider oversight which failed to drive the necessary improvement. After the last inspection we asked the provider to complete an action plan, to tell us how they were going to improve .However we found the improvement actions agreed to be completed had not been done.
- Systems were not in place to monitor and improve the quality of the service. The provider had conducted some audits; however, these had not identified the scale and extent of care concerns we identified during the inspection.
- When an area had been identified for improvement, there was no remedial action recorded, or date to show this had been addressed. For example, the medicine audit did not reflect any stock checks or a review of the storage arrangements. The missing lock from the fridge was identified on a health and safety audit completed in January 2019, however, no remedial action was recorded with a date of completion.
- The infection control audit, stated wheelchairs were clean and in good repair. We observed equipment, including wheelchairs which were not clean or hygienic and the footplates were not in place for people's safety on some wheelchairs. Slings used with equipment had been identified as needing to be laundered weekly. There was no identified schedule and we found the slings to be soiled.
- There were no audits completed of accident or incident occurrence. We saw in the daily care logs additional accidents and incidents had occurred, which had not been reported. This included accident from falls and one person's skin tear from a wheelchair. When the accident forms had been completed there was no detail to define what remedial action had been taken to reduce the risk of the situation reoccurring or the support provided to the person
- This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no effective systems and processes to ensure monitoring against the regulations. The rating of the last inspection had not been displayed.
- When there had been serious incidents or events which stopped the service, the provider had not

informed us of these events. There had been no notifications in relation to any safeguards.
•□This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
•□Staff told us they felt supported by the registered manager. However, we could not see any formal supervision which had supported the staff to develop their roles.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□People had not been consulted on the care they received or given the opportunity to express their views when considering improvements to the home. On the day of the inspection there was some refurbishment in progress to the dining area. There was no risk assessment in place to consider the risks to people during the time the work was carried out. We observed people left sitting in the dining area whilst tables and chairs were being moved around them.
•□There had been no survey or questionnaire for people or their relatives to reflect on the care and support provided at the home. There had been no meetings held for people and this meant they were unable to contribute to any developments within the home.

Continuous learning and improving care; Working in partnership with others
•□There was a lack of understanding regarding the principles of good quality care and measures had not been put in place to continuously make improvements or learn from incidents.
•□There was limited collaboration with external partners to enhance or support people's lives. Referrals had not been made to relevant external professionals when people's needs had changed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent us notification about incidents and events at the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not respected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not obtained in relation to the requirement under the MCA

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 had not been protected from the risk of harm or abuse.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not provide o ensure people's care was safe.

The enforcement action we took:

We imposed a condition to restrict admissions and we requested on going information in relation to improvement and actions taken in relation to our concerns in relation to people's safety.