Beling & Co Limited

Wensley House 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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 18 and 21 September 2015.

Wensley House is registered to provide accommodation with personal care for 46 older people. People living in the service may have care needs associated with dementia. There were 35 people living at the service on the first day of our inspection.

The overall rating for this service is 'Inadequate'. This means that it has been placed into special measures by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service recently.

The registered provider of the service is a limited company. One of the directors of the company was present in the service during this inspection. We spoke with the director as the representative of the registered provider and refer to the director throughout this report as the provider.

People's medicines were not safely managed. Risk management plans, both for individual people and for the service, were not in place to support people and keep them safe. Staff recruitment procedures were not robust to ensure staff were suitable to work with people living in the service. Staff were not available in sufficient numbers to meet people's needs safely and staff were rushed at times. Improvements were needed to staff deployment to ensure people's safety was consistently monitored.

Up to date guidance about protecting people's rights had not been followed so as to support decisions made on people's behalf and comply with legislation. Staff did not receive suitable training and support to enable them to meet people's needs effectively. Staff performance was not suitably monitored and appraised to ensure good practice was in place.

Records were not always available to guide staff on how to meet people's assessed care needs. People did not always receive the support required to meet their identified individual needs. People did not always have opportunity to participate in social activities and engage in positive interactions.

The service was not well led. There was no identified and competent management in the service. People living and working in the service did not have the opportunity to say how they felt about the home and the service it provided. The provider did not have systems in place to monitor and assess the quality and safety of the service provided so that timely action plans could be put in place where needed.

Staff were knowledgeable about identifying abuse and how to report it to safeguard people.

Arrangements to support people to gain access to health professionals and services they needed were improving.

People were supported by kind and caring staff who treated them with dignity and respect. Visitors were welcomed and relationships were supported.

People felt able to raise any complaints and felt that the provider would listen to them. Information to help them to make a complaint was readily available.

You can see what actions we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People's medicines were not safely managed.

Systems to manage risk for people living in and working in the service were not safe. Recruitment processes were not demonstrated as robust.

There were not always enough staff to meet people's needs safely and improvements were needed to staff deployment.

The provider had systems in place to manage safeguarding concerns.

Inadequate

Is the service effective?
The service was not effective.

Guidance was not being followed to ensure that people were supported appropriately in regards to their ability to make decisions.

Staff were not provided with a level of training and on-going supervision that enabled them to meet people's needs well.

Improvements were needed so that people were supported to eat and drink sufficient amounts to help them to maintain a healthy balanced diet.

Support for people to access appropriate services for their on-going healthcare needs was improving.

Inadequate

Is the service caring?
The service was not consistently caring.

People were not always asked about their preferences and on-going decisions relating to their care.

Staff were kind and caring in their approach to people. People's privacy, dignity and independence were respected.

Visitors were welcomed and people were supported to maintain relationships.

Requires improvement

Is the service responsive?
The service was not responsive.

People's care was not planned so that staff had guidance to follow to provide people with consistent person centred care. People did not always receive care in line with their assessed needs.

Improvements were required to ensure that all people who lived at the service received the opportunity to participate in meaningful activities and social engagement.

Inadequate

Summary of findings

The service had arrangements in place to deal with comments and complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was no manager in post. There were no systems in place to gather information about the safety and quality of the service so as to continually improve these.

Opportunities were not available for people to give feedback, express their views or be listened to.

Wensley House Residential Home

Detailed findings

Background to this inspection

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

The inspection visit was undertaken by two inspectors on 18 and 21 September 2105 and was unannounced.

Before the inspection we reviewed the information we held about the service including notifications received from the provider. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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.

During the inspection process, we spoke with six people and four of their relatives. We also spoke with the provider, the deputy manager and seven staff working in the service. We received information from a healthcare professional who had regular contact with the service.

We looked at 15 people's care and medicines records and records relating to four staff. We also looked at the provider's arrangements for supporting staff, managing complaints and monitoring and assessing the quality of the services provided at the home.

Inadequate

Is the service safe?

Our findings

People were not protected against risks in the service including unsafe medicines management, environmental and individual risks and those relating to staff recruitment procedures and deployment. Due to our level of concern at the inspection relating to medicines and moving and handling practices, we reported this to the local safeguarding authority who are responsible for investigating circumstances where people may be at risk.

Arrangements were not in place to ensure that medicines were ordered, administered, recorded and stored safely for the protection of people who used the service. In one person's bedroom we found two plastic medicine dispensing pots. Staff confirmed that these contained a total of five paracetamol tablets. The provider confirmed that staff should have observed the person taking the tablets and not leave them in the person's room for them to take later, while signing to confirm the person had taken their medication. The person's records showed that they had previously tried to harm themselves by taking paracetamol tablets. This put the person at risk of significant harm.

Several packets of prescribed tablets, dated as dispensed in April 2015, were found in another person's ensuite bathroom and so were not securely stored. The person's medicine administration records (MAR) showed that most of these medicines were no longer prescribed for the person. The person was at risk of taking medicines that may no longer be suitable for their needs or that may interact negatively with other medicines they were now taking. Other people living with dementia, who may have gone into that room, were at risk of taking a large number of tablets that were not prescribed for them and could harm them.

One person indicated they were in pain when staff attempted to help them to stand up. Staff confirmed that the person could not have their prescribed pain relief tablets as they had 'run out'. We asked to see the MAR relating to this to check how long the medicine had not been available. Staff told us that they could not find that page of the person's MAR, but believed a staff member had now gone to the pharmacy to get the medication.

One person was receiving their medication covertly. There was no written agreement from relevant professionals, such as the GP or pharmacist, to confirm that the properties of the medicines were not altered when given in this way and no clear medication guidance for staff on how to safely administer their medications covertly.

People's medicines had not been safely management, administered or accurately recorded which placed them at risk of harm.

Risks were not clearly identified or managed to ensure people's safety. The provider was unable to show us, for example, a current fire or Legionella risk assessment and implemented action plans for the service to confirm people were protected from the risk of fire and infection.

Individual risks for people were not always assessed where required so that suitable actions could be put in place to limit their impact on people. One person's records showed they had been admitted to the service in May 2015. Their pre-admission assessment showed they required prompting to eat, had suicidal tendencies, used a walking frame to mobilise and were at risk of falls. There were no risk assessments in place in relation to the person's nutrition, pressure area care or moving and handling.

Where risks had been identified, actions in place to limit the risks were not always followed. Several care record files did not contain an assessment of the risks for the person in relation to their moving and handing requirements. We saw staff support a person to transfer by attempting to lift the person under their arms, which is not a safe way of assisting people and can result in injury to the person and to the staff. The transfer stopped as the person showed they were in pain. The person's relative told us that they had seen staff routinely support the person in this way.

Risk assessments were not updated to ensure staff were aware of an accurate level of risk for the person. One person was identified as being at risk of falls. Accident records showed that the person had recently had an unwitnessed fall. Their risk assessment for falls had not been updated since 3 June 2015.

Some people were assessed as at high risk of developing pressure ulcers. We checked the settings of pressure relieving mattresses that were in place to help to prevent pressure ulcers developing or deteriorating. One person's mattress was set for a person who weighed 100 kilogrammes. The person's weight, which was to be checked monthly due to their risk relating to nutrition and weight loss, was last recorded as checked in June 2015.

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Is the service safe?

This record showed the person to weigh less than 65 kilogrammes. The inaccurate setting of the pump could result in greater pressure being put on the person's body and increase their likelihood of pressure area damage.

Additionally, the electric pump that supported the pressure relieving mattress to inflate showed four lights as lit, including a red light indicating a power failure. This clearly showed that there was a fault. Staff had not noted the incorrect setting on the mattress or the failure light even though the person had been assisted to get up and the person's bed had been made. The failure of the pump could also result in greater pressure being put on the person's body and increase their likelihood of pressure area damage. Staff had not identified and had not acted to limit the risk to the person health and wellbeing.

People were at risk from poor food hygiene practices. People were not supported to clean their hands before receiving their meals. We saw that some people ate with their fingers. Catering staff handled people's food directly when putting it onto their plates while serving lunch. Care staff directly handled people's food when serving sandwiches onto individual plates in the kitchen before presenting them to people at teatime. Care staff directly handled biscuits when they provided them to people with their mid-morning drinks. Staff did not wear suitable gloves or use tongs to protect people from the risk of cross infection.

People were at risk of being unable to gain help and support when they needed it. One person who stayed in their upstairs bedroom called out to us for help as we walked past their room. The person was visibly distressed and told us that night staff had removed their call bell to stop them calling for assistance. We called for staff assistance for the person using a call bell in a nearby bedroom. The senior staff member who responded searched the person's bedroom, ensuite bathroom and the garden outside their window in case the call bell handset had fallen out. The staff member confirmed that the person did not have a call bell available to them to enable them to gain support and ensure their safety and well-being.

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

Staff deployment was not effective. There was no clear system in place for staff to monitor people who stayed in their bedroom and who may not always have the capacity to use their call bell to seek assistance. While a staff presence was often available in the main lounge area, there were periods of time when people sitting in the rear lounge were not monitored by staff. Two of these people's records identified that they were at high risk of falls and required constant supervision. Another person was found on the floor in that room later in the afternoon. On one occasion when there were no staff in the dining room one person, who was sitting alone at a table waiting for their food to be served, stood up, took a sandwich from another person's plate and attempted to eat it. Staff had told us the person could not eat solid food due to the risk this posed for them. We intervened and called a staff member to support the person and provide their pureed meal.

A relative told us they felt staffing levels were suitable as call bells stopped ringing so were answered promptly. Another relative told us that staffing levels could be better. Staff told us that staffing levels were suitable when there were six staff on duty, but that this did not always happen. The provider told us that they tried to have six staff on duty so that the deputy manager could be supernumerary but they did not always succeed with this as some staff had left and they were endeavouring to recruit more staff. The provider confirmed that they did not know what information had been used to decide the current staffing levels. This meant that the provider could not be sure that staffing levels were suitable to meet people's changing needs.

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

People were not protected by a robust staff recruitment process. One member of staff was recorded on the staff rota only by their first name. We asked the provider and deputy manager for the full name of this staff member, who the rota showed was regularly working in the service as a care worker. The management team told us they were unaware of the person's full name. We asked to see the person's recruitment records to show that the required references and checks, including criminal record history checks, had been completed before the person started working in the service. The provider confirmed that this record was not available. We asked to see records relating to agency staff working in the service during our inspection. These were

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Is the service safe?

not available although the provider told us they had requested them from the agency. This meant the provider could not be assured that staff were suitable to work with people living in the service.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had attended training in safeguarding people and had a good understanding and knowledge of how to keep people safe from the risk of abuse. One staff member said, "It could just be using cold water to wash people, would you like that done to you? Or hitting people back, that is like asking if I would hit my own mother. Never." Staff knew how to report any suspected abuse and confirmed they would report this to their senior or manager without hesitation to protect people.

The provider and deputy manager told us that had recently been made aware of their responsibility in reporting concerns and on the process on how to raise safeguarding concerns with the local authority. Copies of the provider's or the local authority's polices and protocols in relation to safeguarding and whistleblowing were not available when requested. The provider advised that they were in the process of arranging for new policies and procedures to be provided by an external organisation and these will be made available to all staff.

Inadequate

Is the service effective?

Our findings

The provider and staff team had not completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and they had limited knowledge and understanding of their responsibilities. The previous registered manager had made applications to the local authority for DoLS assessments.

Assessments of people's capacity had not been completed in line with Mental Capacity Act where decisions had been made about their care and treatment. The arrangements for the administration of covert medication, that is medication given in a disguised way, for example, had not been assessed for individual people. One person person's records showed that the person had received their medicines covertly since November 2014. There was no formal assessment completed to explain why this was in the person's best interests and how exactly the medicines were to be given covertly. This meant that important decisions about people's health and welfare were being taken by staff who were not appropriately authorised to do so.

Closed circuit television cameras (CCTV) were fitted in all bedrooms. They were directed in such a way as to view and record the whole room including when people undressed or were supported with personal care while in their bedroom. There were no assessments of people's capacity regarding this and no record of people's consent to the CCTV. One person, assessed as having capacity, had signed their agreement to their draft care plan. The person told us they were not aware that there was CCTV in their bedroom. They also told us they did not like this and had not given their permission for it. The provider told us they had contacted everybody's relatives for their agreement to the CCTV being operational in people's bedrooms. The provider did not have confirmation that relatives making that decision had the legal authority to do so on each person's behalf so as to comply with the legal requirements of the MCA 2005. The provider told us they had not considered this as they were not aware that this was required.

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

The deputy manager told us that they had worked in the service in various roles for about six years. There had been no recognised induction programme in place for staff during that time. The provider told us that records of staff training had been kept by the registered manager who no longer worked in the service. The provider also told us that they now knew that staff training was not up to date and they were not confident that staff had received all the training suitable and necessary to their role. The deputy manager told us that staff supervision was no longer taking place and that assessments of staff practice and competence were not completed. Staff did not use the learning from their completed training effectively in their day to day practice as observed in relation to, for example, medicines and moving and handling of people. The poor practice and skills levels we observed showed that staff had not received suitable training, on-going observation and assessment of their practice to make sure they were competent for their role and that their competence was maintained so as to meet people's needs.

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

People experienced differing levels of care in relation to their nutrition and hydration needs and improvements were needed. People who were able to told us they enjoyed sufficient amounts of food and drink and that there was a choice. One person told us, "We have roasts on Wednesdays and Sundays. There are alternatives and the portions are fine. We have enough drinks throughout the day." Another person told us, "The food is nice."

During the morning, staff told people the available lunch choices and asked people for their preference. Staff however did not remind people at the mealtime what they were eating to support people living with dementia. Condiments were not provided to people until well after the meal had commenced. Where people needed their food pureed, all the components of the meal were mixed into one which presented a brown coloured meal. Foods were not pureed individually and served separately on the plate to tempt the appetite with colour, smell and flavour. People's weights were not routinely recorded and monitored to support their nutritional well-being.

People's healthcare needs were being effectively managed. We had received information of concern prior to our inspection relating to poor support for people's foot and nail care. The provider showed us recent communication with the chiropodist. This confirmed that arrangements would be in place to support the healthcare professional to provide people's treatment and showed planned

Inadequate

Is the service effective?

appointments for people to receive this service. The chiropodist had recently attended people in the service. The provider had notified some relatives of an additional date to enable them to attend so as to support people in the service to accept the treatment offered by the chiropodist. This was confirmed by a relative who told us they were happier with the way this was now being managed. Another health professional told us that staff had monitored people's health, noted changes and called them in appropriately.

Requires improvement

Is the service caring?

Our findings

Overall people and their relatives told us that staff cared for people in a caring and compassionate way. Our findings however, in terms of how staff were trained and supported to ensure people's well-being and all support functions including care records and management support, did not concur with people's comments about a caring service.

Records showed that some people had signed their draft plan of care as evidence of their involvement. However, we were not reassured about the accuracy of this involvement process. One person, for example, had signed their record despite their assessment stating they were unable to read and write. There was little evidence to show that people were actively involved in the proper planning of their own care and support, or that they had agreed the contents of the care plan, as in several cases there were no care plans available for people. Care records were not regularly reviewed so there was little evidence to show that people were involved in making decisions about their on-going care needs.

People spoke very positively about the staff and their caring attitude. One person said, “Most of the staff are fine, I have one or two favourites. Staff are kind and considerate.” A relative said, “I am very happy with the care provided. I feel the majority of staff are outstanding – very kind, considerate, caring and patient. I know [person] is well cared for and content.” Another relative told us they were reassured because the person who used the service had good relationships with the staff who supported them. They said, “The day staff are really good, they always speak nicely, politely and kindly.”

People who needed support with personal care were assisted discreetly and with dignity. Staff spoke quietly with people about matters relating to personal care. A health professional told us that staff respected people’s dignity by assisting people to go to a private room for their treatment. People told us that staff respected their privacy by knocking on doors before entering.

People were supported to maintain relationships with family and friends. Relatives told us they felt welcome in the service and visited at all different times.

Inadequate

Is the service responsive?

Our findings

We had received information prior to our inspection that care plans were not developed for several people who used the service. The provider confirmed this during our inspection. The deputy manager gave us a list of 11 people to whom this related. This included people had who had lived in the service since April 2015. Care plans were not in place for an additional two people admitted to service during our inspection. People's preferences were therefore not identified so that care and support could be provided in the way they wished or that maintained their skills and independence. The lack of care plans meant that people's specific needs were not identified so that actions could be planned to enable these to be met, particularly where people were unable to communicate their needs verbally. It also meant that people's care could not be monitored easily to identify if changes were required to ensure that the care provided was responsive to meet people's changing needs.

Staff did not have clear guidance on how to provide person centred care to people who used the service. On the second day of our inspection we found that some staff were not aware of two newly admitted people who were living in the service. Staff had therefore not been given any written or verbal information on the people's needs or how to meet them. A visitor told us they were concerned that staff supporting their relative did not know that the person had recently had a fall, so they could monitor the person and respond appropriately in case of any impact.

Care provided was not always responsive to people's needs and preferences. One person asked for a cup of tea and was told they would have to wait for five minutes until lunch. The person was taken to the dining room 30 minutes later and was given a cold drink after a further five minutes. Staff did not respond in a timely way to the person's need for a drink and to their expressed preference. We were not reassured that people who remained in their bedroom received appropriate encouragement and support to meet their nutritional care needs. Records were not available, for example, to show whether staff had responded to one person's deteriorating mental health needs and if they had any foods or fluids during the day, it was also not clear if the person had received any contact from staff providing contact and engagement at any point during the day. Daily care records showed occasions where another person, for example was described as 'shouting and crying', 'up most of the night wandering and shouting', 'complaining of pain in foot' and 'found on the floor'. The care records did not show what interventions staff had provided in response to these situation to demonstrate how the care was managed to promote people's well-being.

People's experience of social interaction and opportunities varied. Some people we spoke with chose to stay in their rooms. One person told us they chose not to do activities, that there was no one for them to converse with. They said they preferred their own company and read their magazines and newspapers in their bedroom where they also watched television. A relative told us that there were more social activities available in this service than in the previous care home the person had lived in.

On the first day of our inspection there were limited opportunities for people to be involved in entertainment and social activities. On the second day, a staff member employed to support social stimulation for people was on duty. They provided group games during the morning and a quiz during the afternoon, which many people watched or joined in with. There were limited or no such opportunities for those people for whom there was no space to sit in the main lounge and who remained in the small lounge, and for those people who remained in their bedroom. Activity records were maintained and showed such limited and repeated entries as "in bedroom" and "walking around" as the activity for one person. The activity records contained no entries for another person, who was unable to mobilise independently, between the week of the 31 August 2015 and the second day of our inspection on 21 September 2015. Daily care records did not show how people spent their day.

People's social and personal care needs had not been assessed and managed appropriately. People were not receiving care that met their needs and promoted their wellbeing.

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

People told us they would feel able to raise any concerns and to discuss these with the registered provider. The provider had a complaints policy and procedure in place. This gave people timescales within which response and actions would be implemented so people knew what to expect. Information was also included to guide people on

Inadequate

Is the service responsive?

how to take their complaint further if they were dissatisfied with the provider's response. The complaint procedure was displayed throughout the service, with a copy in each person's bedroom. The provider told us they had become aware that complaints had been raised but that records were not available to demonstrate any actions or learning identified.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The registered manager had left the service early in August 2015. At the time of our inspection, the deputy manager was leading the service with support from the provider. The provider told us, and the deputy manager confirmed, that the deputy manager did not have the management skills and competence at this stage to manage the service safely and effectively. The provider told us they were in the process of recruiting and appointing an experienced manager to lead the service, who they hoped would commence on 1 October 2015.

The provider had not notified the Commission, as required by regulation, of the registered manager's leaving their post or the arrangements the provider had put in place to ensure the service was properly managed. The provider told us they were unaware of their legal responsibility in relation to this, or that they were required to have notified us of a serious injury to a person living in the service or that a safeguarding concern had been raised.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

The provider told us there were no systems in place to assess and monitor the quality of service provided to people. No audits were available such as in relation to medicines, care records, health and safety or infection control. Checks were not in place to monitor pressure mattresses and not all falls were recorded. No analysis was completed for example, of falls or pressure ulcers, to identify trends so that action could be implemented to limit their occurrence and improve people's care. Required records were not properly maintained, for example, in regard to people's care, staff recruitment and training or complaints. The provider told us that they were unable to locate a number of records they had expected to find maintained in the service.

Systems to support staff were not effective. The night staff team did not include a senior staff member or a person identified to lead the staff team. There was no method in place to assess people's dependency needs and no system to calculate and review the number of staff required to meet people's changing needs. The provider had not visited the service regularly to check on the quality of care people received. They had not required that information about all aspects of the service was sent to them on a regular basis, so they could reassure themselves that suitable monitoring of the service was in place to keep people safe and to continuously improve the quality of the service people received.

There were no systems in place to seek people's views on the service. The last recorded meeting for people using the service and their relatives was dated September 2014. The provider told us that people had not been given the opportunity for some years to complete a satisfaction survey to share their experience of the service and identify improvements that could be made.

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

The provider told us that the service had been, at one time, part of the My Home Life initiative and some staff had been trained as dignity champions. These staff had now left and the My Home Life approach, advertised in the main entrance of the service, had now lapsed. The service was not part of any other local initiatives.

Staff told us that the provider was in the service much more often now and was approachable as was the deputy manager, who the staff advised as supportive and helpful. Staff also told us they were looking forward to having a new manager in the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered provider had not ensured that people's care was planned for so that staff had information to guide them on how each person's needs and preferences were to be met and ensured that the care provided was person centred and met the person's identified needs. This was in breach of Regulation 9(1) and (3)(a)(b)(d) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence How the regulation was not being met: The registered provider had not notified the Commission, as required by regulation, of the registered manager's leaving their post or the arrangements the provider had put in place to ensure the service was properly managed. This was in breach of Regulation 14 of the Health and Social Care Act 2008 Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not ensured that staff had received suitable training, on-going supervision and appraisal to make sure they were competent for their role and that their competence was maintained. This was in breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The registered provider had not ensured robust recruitment procedures to make sure they only employed fit and proper staff to provide care to people in the service. This was in breach of Regulation 19(1)(a)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered provider had not protected people against the risks of inappropriate or unsafe care as effective arrangements were not in place to assess and monitor the quality of the service provided. This was in breach of Regulation 11(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We have served a warning notice to be met by 27 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks of inappropriate care and treatment. This was in breach of Regulation 12(1) and (2)(a)(b) (c) (d) (e) (g) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We have served a warning notice to be met by 27 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not protected people against the risks of inappropriate or unsafe care as effective arrangements were not in place to assess and monitor the quality of the service provided. This was in breach of Regulation 17(1)(2)(a),(b) (c) (d) (e) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have served a warning notice to be met by 27 November 2015.