J A Corney and Mrs J P Webb

Thistlegate House

Inspection report

Axminster road, Charmouth, DT6 6BY
Tel: 01297 560569
Website:

Date of inspection visit: 9, 14 January 2015
Date of publication: 09/04/2015

Ratings

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

Overall summary

This unannounced inspection took place on the 9 and 14 January 2015. Thistlegate House provides accommodation and personal care for up to 18 older people. There were 6 people, some of whom had complex care needs associated with dementia and restricted mobility, living in the service when we visited.

There was a registered manager 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 owned the home in partnership with one other person. This person is referred to in the report as co-owner. They were both present in the home providing care alongside the staff.

We had inspected the service in January 2014 and had concerns about the quality of record keeping and how people's care needs were assessed. There were breaches of these regulations. We asked the provider to take action about this and they sent us a plan detailing that they would make necessary improvements by the end of March 2014. At this inspection we found that concerns about how people's care needs were assessed had not been adequately addressed. This meant there was a continued breach of this regulation.

Summary of findings

During our inspection we found a number of concerns. These included people not being protected from avoidable harm because risk assessments were not updated to reflect current risks. We also found the registered manager had not undertaken an investigation requested by the local authority safeguarding team.

People's consent to care was not sought in line with legislation and where they may be required Deprivation of Liberty Safeguards had not been applied for.

Staff were not supported to develop the skills and knowledge they needed to support people living in the home.

People were sometimes treated in ways that were not respectful and their end of life wishes had not been discussed or recorded. This meant that people may not experience end of life care that reflects their wishes.

The registered manager had not identified any areas of development for the service and non of the issues we found during this inspection had been identified through quality assurance systems.

We have made recommendations about improvements in infection control and the provision of meaningful activity for people in the home.

People's representatives were confident in the care provided and felt able to raise concerns with the registered manager and co-owner.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to: quality not being monitored effectively; people's care not being delivered in a way that met their needs; staff recruitment and people being treated with respect. You can see what action 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?

Inadequate

The service was not safe because people were not protected from avoidable harm.

People were at a risk of abuse not being reported immediately because staff did not all know which agencies they could report to.

People had not received their medicines safely.

Is the service effective?

Inadequate

The service was not effective because people's consent to care was not sought in line with the Mental Capacity Act 2005 and they were at risk of them not receiving appropriate support to maintain their health.

Staff were not supported to develop the knowledge and skills necessary to meet the needs of people

Is the service caring?

Requires Improvement

People were sometimes treated in ways that were not respectful.

People told us that care was sometimes rushed.

People's end of life wishes had not been discussed or recorded. This meant that people may not experience end of life care that reflects their wishes.

<Findings here>

Is the service responsive?

Requires Improvement

The service was not responsive because people's needs had not been reviewed regularly and this meant they were at risk of receiving inappropriate care.

Representatives were confident in the responsiveness of the registered manager and nominated individual.

Is the service well-led?

Inadequate

The service was not well led because the action plan from the previous inspection had not been adhered to. The registered manager had told us there were no plans to make improvements in the areas we looked at. Concerns found during this inspection had not been identified or addressed.

The registered manager and co-owner were not working with other agencies to ensure that the service provided high quality care in line with statutory requirements.

Thistlegate House

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 15 January 2015 and was unannounced. The inspection was undertaken by one inspector.

During our inspection we spoke with three people and the representatives of four people. We looked at the care records relating to five people and four people's medicines records.

We spoke with the registered manager and co-owner, three care staff and a cook.

After the visit we spoke with a community nurse, a community psychiatric nurse and three social care professionals.

Before our inspection we reviewed information we held about the service including notifications of incidents and the action plan that the provider had sent us after our previous inspection. A notification is the way providers tell us important information that affects the care people receive. We reviewed the Provider Information Return (PIR) during our inspection. The PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

At our last inspection, on 13 January 2014, we had concerns that risk assessments were not being undertaken in a way that protected people from the risks of unsafe or inappropriate care. Where assessments were undertaken we had concerns that the records held were not adequate to protect people from unsafe or inappropriate care. There were breaches of regulations 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. At this inspection we found that risks were not reviewed appropriately. This meant people were at risk of receiving unsafe or inappropriate care.

Risks were not consistently managed in a way that protected people from avoidable harm. Some people had risks identified through assessment and guidance was available for staff about how these risks should managed. People's representatives commented they felt risks were managed practically and this meant people were not restricted. However we also found some people were not protected from avoidable harm because risks were not identified, assessed and managed appropriately. One person had fallen in November 2014. There had been no reassessment following this and two falls risk assessments in their care records stated they had not fallen in the last year. Another person had begun to experience difficulties with incontinence. In July 2014 this had been identified as placing them at higher risk of skin damage. There was no change to their care plan to minimise this risk after it was identified. People were not protected from avoidable harm through appropriate assessment and care planning. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People told us they felt safe. One person said, "I can't see anyone would be cruel." Staff told us they had undertaken safeguarding training but were not all able to describe what they would do if they suspected someone was at risk of harm or was being abused. They told us they would speak with the registered manager and co-owner but did not know which other agencies they could report to. We looked at the safeguarding policy and found that it was out of date and as such held obsolete contact details for the agencies with safeguarding responsibilities. This meant there was a risk that there would be a delay in reporting possible abuse to the appropriate agencies. We were also made aware the registered manager had not undertaken an investigation requested by the local authority in February 2014 following a substantiated abuse. We spoke with the co-owner about this and they told us the member of staff had left and they did not know what the local authority wanted. This meant they had not investigated to determine whether any changes should be made to working practice in the home to prevent abuse, or if any staff should be referred to the Disclosure and Barring service in order to prevent them working with other vulnerable people. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 this corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive their medicines safely. The controlled medicines record was correct. However, we looked at the medicines records of four people and found inaccuracies. One person was prescribed a cream that was important to protect their skin. The medicine record where staff sign to confirm medicines have been given had gaps on five occasions in December 2014 and twice in January 2015. Another person had over the counter pain relief referred to as given in their care delivery records. These were not recorded as prescribed to them on their medicine administration record, however, we saw they had a dispensed packet of this medicine. The tablets had not been taken from this packet. We asked the co-owner and they told us they may have, "given him some of mine". Another person had a painkiller prescribed that they sometimes chose not to take. The medicine administration record detailed that these had been refused 10 times in the three weeks before our inspection. All but one of the medicines that were refused were missing. The co-owner could not account for their whereabouts. There was a risk that people would not receive their medicines as prescribed because the methods of administration were not robust or safe. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, this corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we showed the co-owner that two of the toilets used by people living in the home were not clean. We also showed them how a hole in a bath had been repaired with tape that was now ripped and could not be cleaned effectively. We explained that we would look at how people were protected from the risks of

Inadequate

Is the service safe?

infection when we returned for a second visit. When we returned we found that the toilets had all been cleaned but that it was still not possible to clean the bath effectively. There were also areas of exposed wood on surfaces in bathrooms and around one person's sink. This meant it would not be possible to clean these areas effectively. The rest of the home was clean including communal areas and the kitchen. Cleaning records were only kept for the kitchen and we found gaps in these records. The staff had gloves and aprons available to use when they supported people with personal care.

Staff all told us that there were enough staff to meet people's needs. They told us there were always two members of staff available to deliver personal care because when only one member of staff was rostered the co-owner was always available to assist with personal care. We saw that the registered manager was also available although he told us he did not undertake personal care. We looked at the records relating to the recruitment of three members of staff and saw that there had been no checks on gaps in the employment history of two of these staff, and one of these members of staff had not provided a reference from their last employer. This employer was another care provider. The recruitment policy made no reference to schedule of checks referred to in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010. We noted that this had been raised by the local authority contract monitoring team in May 2014. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, this corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the service consider current and appropriate guidance on infection control and take action to update their practice accordingly.

Inadequate

Is the service effective?

Our findings

The service was not effective because consent to care was not always sought in line with legislation, there was a risk that people's health needs were not addressed and staff training was not always reflected in the way they worked.

An external trainer had delivered Mental Capacity Act 2005 training to staff in the home in November 2014 and the PIR stated that there were policies and procedures in place to ensure the MCA 2005 was followed. However, we found people had not had their mental capacity assessed when appropriate. For example people, for whom an assumption of capacity was not clear, had not had their mental capacity assessed to consent to care or to make important decisions such as where they lived, having help with medicines, or using equipment that restrains them to keep them safe. One person's care plan described that they had a wedge put against them when they were in bed to stop them falling out of the bed, and another detailed the person had to be checked because they tried to not take their medicines. Information in care plans and discussions with people, staff and representatives suggested that people may not have the mental capacity to make these decisions. Where people cannot give their consent the MCA 2005 details the way that decisions must be made in their best interests. We found that best interest decisions had not been made in this way for anyone living in the home. This included people who had dementia who sometimes resisted personal care or refused medicines. Some staff described seeking consent in a practical manner, for example using distraction techniques with someone who was refusing care and then asking them again, and we saw that one person who had the mental capacity to make their care decisions had a care plan that supported this.

The service had a policy on restraint that had been written in 2010. This did not make reference to the MCA 2005 although it provides a legal framework. There was also a policy about involving relatives that stated that relatives could have full access to their relative's records. This policy did not refer to gaining the person's consent for this or considering if it would be in their best interests if they did not have the mental capacity to decide this.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people in the home required restrictions to be in place to keep them safe and for them to remain living in the home. This included someone who sometimes referred to not being allowed to leave the home and used the phrase "you can't leave" on one occasion to the inspector. The registered manager had not applied to the local authority to deprive anyone of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that there are checks that there is no other way of supporting a person safely. We discussed this with the co-owner during our inspection visits and identified the relevant contact in the local authority. We reminded them of the importance of applying for DoLS on the 22 January 2015 following our inspection. The local authority confirmed that they had contacted them and started the process after this.

Staff did not have training and support that ensured they were following good practice. People told us most staff were good at their jobs. One person said, "Some of them are kind, and take their time." Staff told us that they had received an induction to working in the home and been able to shadow staff and learn how people had their care and how to use specific mobility equipment. This induction did not cover other important training such as safeguarding, first aid, moving and handling or infection control. We spoke with the co-owner and they told us that staff slot into the rolling programme of training and this means they will undertake training within their first year. Three staff told us that not all their training was up to date and we saw from the records kept by the co-owner and registered manager that moving and handling training had not been offered since July 2013. One member of staff with responsibility for cooking for people had not undertaken food safety training since 2009; the certificate indicated that this needed to be repeated in 2012. The co-owner told us that manual handling training was up to date. We asked them to check this and send us dates of any training not recorded in the training records or referred to by staff. We did not receive this information.

We spoke with staff about how they were supported in their role and how their professional development was encouraged. They were not able to describe how this happened. One member of staff was not sure who they would have discussions of this nature with and told us, "I don't know I suppose that would be (co-owner)" Another

Is the service effective?

member of staff commented that they felt supported but they did not know how they talked about training they might need. The staff had not been offered appraisals. People, a representative and staff commented on the practice of one member of staff. We spoke with the co-owner who acknowledged that they had been made aware of this and had spoken with the staff member concerned. We asked if this had led to changes in their practice and they told us that all they could say was the staff member worked well with them. There had been no formal intervention and no checks had been made to determine if practice had improved. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not receiving appropriate support for their health. There was evidence of good liaison with some health professionals but the care and support people needed to maintain their health had not been adequately assessed. People told us they were happy with the support they received to maintain their health. There was evidence of liaison with health professionals within people's care records and staff told us health professionals always recorded their visits. One representative told us that their relative had needed to see a dentist and that this had been arranged. We spoke with a health professional who visited the home regularly. They told us that they believed staff contacted them when people's needs changed, however they were not aware that someone in the home had lost a substantial amount of weight prior to Christmas 2014. They also told us, "There is always evidence that they take on board what we have asked them to do."

People's care plans did not detail the help they needed to maintain their health. For example, we saw that no assessments or care plans were in place describing the support people needed to maintain their oral health. We spoke with the co-owner who told us that people were assisted in the day and in the evening with oral care. We spoke with staff who told us that they did not clean anyone's teeth or provide any other oral care.

One person had lost a significant amount of weight during a period of ill health prior to Christmas 2014. This weight loss had been recorded but had not led to a review of their assessed care needs. The last assessment of their nutritional needs had been undertaken in July 2014 when their weight was stable. We asked the cook if they had received any direction about this person's nutritional needs since their illness. They told us that they hadn't but that they had noted the person had been ill and so had provided smaller more nutritious meals. The person had not been weighed since December 2014 so it was not possible to assess whether this informal response was effective. There was a risk that people were not receiving the support they needed to maintain their health because their needs had not been assessed. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's likes and dislikes were known by the cook and they spoke confidently about these. We saw that one person required their food and drinks to be thickened. We asked the cook about this and they described accurately the amount of thickener this person needed. People told us the food at Thistlegate House was good. One person said, "Oh it is very good." Another person said "The food is excellent." We observed that some people ate in their rooms and others ate in the dining room. We spoke with staff and people who told us that this was a reflection of individual choice.

Requires Improvement

Is the service caring?

Our findings

The service was not caring because people's dignity was not always respected and people told us they were not always treated with respect and kindness.

People said the staff were busy and only usually had time to speak whilst they were undertaking care tasks. Two people told us that sometimes their care felt rushed and gave examples of how this felt. One person told us they did not like it when staff were, "abrupt for no reason" and told us "One of the staff can be irritable." Another person told us sometimes staff rushed in the mornings and this meant the water they had to wash in had not run warm. They told us when this happened they used a mug of boiled water to heat their wash water. The language used about people was not always respectful; this was reflected in care plans where we read phrases like: "if they can possibly get away with it" and "fits of temper". This demonstrated a lack of understanding of people's needs and a lack of compassion and kindness. Another care plan also showed a lack of respect and compassion towards a person whose needs had increased. The care plan that had been updated in April 2014 referred to someone no longer eating in a communal area because they had become a "messy eater". This meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to live aspects of their lives in ways that they chose. For example, people who were able to make choices chose whether or not to join others in communal areas, how they spent their time in their rooms and they ate food that they liked. Two people described how much they liked living in a house like Thistlegate House. They appreciated it aesthetically and this mattered to them. However staff were not aware of people's end of life wishes. One person we spoke with told us about their end of life wishes. Care plans did not contain this information and representatives reinforced that they were not aware that discussions to gather people's wishes had happened. Staff were aware of the people for whom a doctor had signed a DNACPR, but were not sure of people's spiritual needs in respect of their end of life wishes or day to day care. A DNACPR is a document that states that the person should not receive cardio-pulmonary resuscitation if their heart stops. There was a risk that people would not experience care at the end of their lives that reflects their wishes.

Most staff spoke about people with kindness and we saw some interactions were gentle, respectful and caring. For example a member of staff sat down and spoke with a person when they brought them their drink. This made the task of giving out drinks more personal. We also saw the registered manager speaking with a person about their life experiences at a time when they had been anxious. This showed respect for the person and distracted them and this meant they were able to calm. A representative told us that one member of staff had actively sought out activities that a person might enjoy and had involved their representative in this. Representatives were happy with the care people received, making comments like, and "I am very confident leaving them in their care." The homely environment complemented some people's feelings about how they were respected. Two people and their representatives recognised that a larger more modern building would not suit them or the person they cared about. One of the people told us, "It doesn't feel like a home (care home). That is good." Representatives told us they felt welcome to visit.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 13 January 2014 we had concerns about how people's care was reviewed and the records kept by the service. There were breaches of regulations 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action to ensure that the way they reviewed people's care needs and the records they kept protected people from unsafe or inappropriate care. At this inspection we found that improvements required to ensure people received appropriate and safe care had not been sustained.

People were at risk of receiving inappropriate care The service was not responsive because people's needs were not reviewed regularly and this meant that their care delivery plans did not contain enough accurate detail to ensure they received their care in an appropriate and safe way. After our inspection in January 2014 the provider wrote to us and told us they would review people's care needs at a minimum on a monthly basis. We looked at care plans related to five people and saw that whilst care had been reviewed and changes made this was not done on a regular basis. For example one person's care plan had not been reviewed since July 2014. There had been a dementia screening by a Community Psychiatric Nurse in October 2014 and the outcome of this had not been added to their assessment or care plan. Two people had begun to use pads as a result of incontinence and this was not reflected in their care plans as there had not been a review of their care needs.

Representatives were confident that the service was responsive to people's changing needs. One representative said, ""they are very practical." Staff also told us that they knew people very well and shared information verbally about changes in their needs. We saw that this was sometimes the case, but we also found there were discrepancies in their understanding. For example, one person was asleep a lot during our inspection. A member of staff told us that this person had dementia and this may impact on their sleep. Another member of staff told us that this person did not have dementia. This person's care plan did not reference dementia care needs. There was a risk that people were receiving inappropriate care because their needs had not been assessed. This was breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not have access to adequate meaningful activity. There was no program of regular activity. People, staff and representatives commented on the level of available activity in the service. One representative said, "There isn't much stimulation." Another commented that the person they represented was usually alone. During our inspection we noted that most people spent time on their own except when staff were involved with personal care or offering drinks. People received regular checks from staff but this was largely visual or a brief verbal interaction. Two people commented that there wasn't anything they wanted to join in with. Staff spoke about games that two people liked to play and in the summer they said they encouraged people to sit in the garden. We spoke with the nominated individual about activities and they told us that the level of organised activities is responsive to the wishes of people living in the service.

There were no complaints recorded since our last inspection. People's representatives told us they felt able to speak with the registered manager and nominated individual and other staff about concerns. One representative said, "I can say anything the staff are very approachable, responsive and helpful." One person was not happy about some aspects of their support. We spoke with the registered manager and nominated individual about this and they were aware of the concerns. These had not been recorded and as a result it was not clear how the concerns had been addressed.

We recommend that the service seek advice and guidance from a reputable source, about using meaningful activity to support people's health and mental well- being.

Inadequate

Is the service well-led?

Our findings

The service was not well led because the leadership did not work effectively with other agencies or objectively review the quality of care people received.

The action plan submitted to us, after our last inspection, stated that the registered manager and co-owner would assess people's changing needs and update care plans accordingly; stating that this would happen at a minimum on a monthly basis. The action plan also stated that concerns identified at the last inspection were due to an over reliance on trust in staff practice. The plan stated that "clear supervision and appraisals" would be undertaken as a result. The co-owner and registered manager stated that the regulations would be met by 3 April 2014. During this inspection we found that these plans had not been completed. Care plans had not been reviewed on this basis and staff had not received formal supervision or appraisal. Night staff told us they did not have spot checks.

People did not receive high quality care that complied with legislation because the registered manager and co-owner did not work positively with external agencies. Requests made by external agencies were not prioritised by the management team. For example the internal investigation into a safeguarding requested by the local authority in February 2014 had not been completed or submitted. Follow up information requested by the inspector was not provided in a timely manner. The information contained in the PIR did not accurately reflect the circumstances we found in the home. We also found concerns we identified around the implementation of the Mental Capacity Act 2005 and safe recruitment had been highlighted to the registered manager and nominated individual by the local authority in February 2014 and May 2014 and no practice changes had been made.

There were no formal systems to gather people, staff, representatives and other agencies views about the service. People told us that they were not asked regularly if there was anything they would like to see change in the service. Some representatives felt their views were heard, for example one representative told us they had asked that the closest parking space be kept free for easier access and this had been agreed and acted upon immediately. Staff told us they did not have meetings but that they saw the registered manager and co-owner daily. Professionals we spoke with felt their views and expertise were not sought to improve care quality. For example, the Community Psychiatric Nurse had not been asked for advice on quality dementia care. This was important because we found discrepancies in staff understanding about people's dementia care needs..

The registered manager and co-owner did not behave in a way that evidenced they understood current expectations of personalised care. We spoke with the co-owner about the use of disrespectful language by some members of staff in care delivery records and used in care plans. They commented that they had told staff they couldn't "write it as it really is". We asked if the co-owner or registered manager belonged to any forums or groups to enable them to stay up to date with good practice. The co-owner told us they received the magazines to do with care but they did not belong to any groups.

The leadership structure of the home included the registered manager and co-owner providing day to day staffing cover as well as management oversight of the home. Both live on site and staff, representatives and people commented positively on their availability. We observed that they ate their lunch with the member of staff on duty and chatted informally about the care of people at this time. Whilst this presence had clear positives for people and staff, we also noted that some people and staff were concerned that their confidential conversations with the inspector may be listened to.

People were not protected by robust quality assurance processes. The registered manager and co-owner told us they provided quality care for people and this was based on creating a family feel and an ethos of caring. They told us that they worked alongside staff to ensure that this happened. They had also identified in the PIR that one of the means they use to achieve this was: "By ensuring our robust policies and procedures are followed and carried out by the care team." We found that policies were out of date and did not reflect current legislation. For example the safeguarding policy had not been updated to reflect changes to external agencies that staff should contact to report concerns.

Quality assurance was a part of the general day to day management of the home, and the co-owner told us that they did not audit to identify problems as a result. This was

Inadequate

Is the service well-led?

not effective as we found errors and omissions in care plans, omissions in staff files and problems with infection control that had not been identified by the informal oversight.

There was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to regulation 17 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

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1) HSCA (RA) Regulations 2014** **The registered person did not make suitable arrangements to ensure that people were treated with respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) (2) (3) (5) HSCA (RA) Regulations 2014** **The registered person did not have suitable arrangements in place to obtain and act in accordance with the consent of people or to act within best interest decisions of people in line with the Mental Capacity Act 2005.**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (g) HSCA (RA) Regulations 2014** **The registered person did not make arrangements to ensure that people's medicines were administered safely.**

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

This section is primarily information for the provider

Action we have told the provider to take

	Regulation 13 (1) (2) (3) (5) (6) (7) HSCA (RA) Regulations 2014 The registered person did not make suitable arrangements to safeguard people against the risk of abuse by taking steps to identify the possibility and responding appropriately. Where restraint is used the registered person did not have suitable arrangements in place to ensure that restraints were lawful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (e) (f) HSCA (RA) Regulations 2014 People were not protected from the risks of unsafe care a treatment by the means of an effective quality assurance system. The registered person did not have regard to appropriate professional advice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) HSCA (RA) Regulations 2014 The registered person did not have suitable arrangements in place to ensure that staff were suitably supported to enable them to deliver care safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2) (a) (3) (a) The registered person was not operating an effective recruitment procedure.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) (iii) The registered person had not taken steps to ensure people were protected from the risks of unsafe or inappropriate care through assessment of needs and subsequent planning and delivering care.

The enforcement action we took:
We have served a warning notice and told the provider to take action by 30 March 2015.