Mr & Mrs M Munif

Lynwood Residential Care Home

Inspection report

57 Mersey Road
Heaton Mersey
Stockport
Greater Manchester
SK4 3DJ
Tel: 0161 432 7590
Website:

Date of inspection visit: 23 & 24 February 2015
Date of publication: 20/04/2015

Ratings

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

Overall summary

This was an unannounced inspection.

A registered manager is in place. 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 home is registered to provide residential care and accommodation for up to 23 older people. There were 21 people living at the home when we visited.

Summary of findings

Accommodation was on three floors which could be accessed via stairs or a passenger lift. Accommodation was provided in single bedrooms although there was one shared room for two people. Four rooms had an en suite toilet facility and of those, one room had an en suite bath. There were three communal areas that supported people spending time together including a communal dining room. There was a large garden to the rear of the property and an off road car park at the front of the property.

People spoke positively about staff and we saw relationships between individual staff and people using the service was warm, compassionate and caring and staff showed empathy in their approach.

There was a daily planned group activity for people and opportunities for people to pursue their own hobbies or go out independently with assistance. People told us they knew how to make a complaint.

Medicines were stored, administered and returned safely and records were kept for medicines received and disposed of, this included controlled drugs (CD's).

People told us they enjoyed the food, and choices were always available. We saw people's nutrition and hydration needs being met. We found that people's healthcare was delivered consistently by staff. The service supported people to access the community to prevent them from being isolated

The provider did not have an effective pre admission procedure. Risks to people were not mitigated because some people had not received an assessment from when they began to use the service. Staff knew how to monitor people's health and make sure they had enough to eat and drink.

Recruitment checks were carried out to protect people from the risk of employing unsuitable staff.

Some staff were concerned that not enough staff were trained in certain areas and had not received an induction at the start of their employment. Records showed three staff had not received up to date mandatory and refresher training including training about whistleblowing.

The manager and staff team did not have a clear understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and were not always following the MCA for people who lacked capacity to make a decision.

The provider had not made an application under the MCA and DoLS for people, even though their liberty was being restricted under the Mental Health Act (MHA) 2007. The correct safeguarding procedures were in place.

There were no systems in place to effectively monitor the quality of the service or drive improvements forward. The manager communicated with staff daily to discuss and share good practice.

Not all risk assessments clearly stated how risks would be managed because they had not been fully completed. Some first floor bedroom windows and inappropriately placed furniture and equipment, did not promote people's safety and wellbeing.

Door locks were not fitted to bathroom and toilet doors and did not uphold the privacy, dignity and independence of people who used the service.

A system of maintaining appropriate standards of cleanliness and hygiene was not being followed regularly.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.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?

Requires Improvement

The service was not safe.

A system of maintaining appropriate standards of cleanliness and hygiene in the home was not being followed regularly.

Staff had limited understanding of the homes whistleblowing policy and procedure and would not know how to report wrongdoing at work.

Risks to people were not mitigated because not all risk assessments had been fully completed, to state how they would be managed safely.

There was no risk assessment to identify that people were at risk from falling from unrestricted windows at a height likely to cause harm.

Is the service effective?

Requires Improvement

The service was not effective.

Not all staff had received up-to-date training, induction and support. Therefore people could not be confident that staff had the skills and knowledge to meet their needs.

The manager and staff team did not have a clear understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This meant that people's human rights were not promoted and upheld.

Is the service caring?

Requires Improvement

The service was not caring.

Door locks were not fitted to any bathroom doors and most of the toilet doors. This meant people's privacy, dignity and independence was not respected and upheld.

People spoke warmly about the staff team. People told us they enjoyed the food, and choices were always available. We saw people's nutrition and hydration needs being met.

Is the service responsive?

Requires Improvement

The service was not responsive.

The provider did not ensure coordinated assessment of people's care from when they began to use the service. This meant that people did not experience appropriate care, treatment and support.

Some care plans did not contain up to date information and did not ensure the person's welfare and safety.

Summary of findings

Is the service well-led?

The service was not well led.

A medicines audit had been carried out by the supplying pharmacy and the Stockport NHS Clinical Commissioning Group (CCG) in February 2015.

There were no systems in place to effectively monitor the quality of the service or drive improvements forward.

Requires Improvement

Lynwood Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 February 2015 and was unannounced. We made an announced visit to the home on 24 February to continue the inspection. The service met all of the regulations we inspected against at our last inspection on 27 October 2014.

The inspection was carried out by two inspectors. Before we visited the home we reviewed information that we held about the service and the service provider which included incident notifications they had sent us. We also contacted relevant professionals, clinicians and appropriate authorities to obtain their views about the care provided at the home. We did not send the provider a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Some of the people living in the home were unable to give their verbal opinion about the care and support they received. Therefore we used a short observational framework for inspection (SOFI). This is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. During the inspection we saw how the staff interacted with people using the service, and observed staff delivering care and support in communal areas of the home.

We spoke with eight people living at the home, two relatives, one visitor, one chef, one domestic assistant, five health care assistants (HCA) and the providers. We looked at the hairdressing room, the kitchen, the basement laundry and food store, a selection of bedrooms and communal areas.

We reviewed records about people's care which included the care records for four people and the medicine records for all of the people who used the service.

We also looked at seven staff files including supervision records and a sample of records relating to how the home was managed. During the inspection we saw how the staff interacted with people using the service. We also observed care and support in communal areas.

Requires Improvement

Is the service safe?

Our findings

No one we spoke with told us that they felt unsafe. One person said "I do my own thing and the staff let me get on with it; within what is feasible that is". No one we spoke with had any complaints or concerns about the staff team. People said that they were 'lovely' and 'very nice'. Another person said that they thought the home was 'well run'.

We asked three people using the service and two relatives about the staffing levels at the home and received the following comments, they [staff] were, "thin on the ground", "have reduced in numbers, and that's visible", "haven't seen many staff; could do with more faces", "nobody talks to you here; just would like somebody to sit and talk to for 10 minutes" and "they could do with more staff here; nobody really talks to you". We observed two members of staff escorting service users at the person's own pace and speaking kindly with them during the activity.

The home had a medicine's policy and procedure that was followed in practice and monitored and reviewed. Medicines were stored safely and records were kept for medicines received and disposed of; this included controlled drugs (CD's). We looked at the medicine records for 21 people and found records completed were up to date. We asked a person if they received their medicine on time and they confirmed they did. We observed the lunchtime medicines round and saw staff responsible for administering medicines wearing a uniform to discourage interruptions. This helped to prevent errors in medicine administration. We saw people were supported to take their medicines and clinical specialist instructions had been followed during the administration process.

On the first day of our inspection there were three HCA's, the manager, and the chef on duty. Care was being delivered by three HCA's and a domestic who was covering the absence of a HCA. We observed people sitting in the lounge with minimal interaction from staff except when they were guided to their seat or received medication. A domestic assistant told us they were covering for an absent HCA at short notice and in turn their duties were covered by an agency cleaner. However they confirmed that an agency cleaner was not used on the first day of the inspection and care staff shared the cleaning duties on that day. We spoke with two health care assistants (HCA) and a domestic assistant about the staffing levels they said, "We're short staffed, particularly at weekends", "often what it says on the rota isn't what is on duty; some staff just don't turn up and at weekends there have been two of us for a full seven hour shift". They also said, "there are two night staff and if we have a lot of immobile people, it's non-stop", "we have a quick chat to people when we are giving care and that's it". From our observations and looking at the staff duty rota on both days of our inspection we saw there was sufficient staff on duty to meet people's needs on each duty shift. Appropriate pre-employment checks had been carried out to protect people from the risk of employing unsuitable staff.

The manager and staff had received adult safeguarding training and knew how to recognise the signs of abuse and report abuse following local safeguarding protocols. This also included reporting accident and incident concerns to the CQC. All of the staff spoken with confirmed their understanding about how to share any concerns about the care provided. However three staff told us they were not aware of the homes whistleblowing policy and how to report wrongdoing at work. This meant that people might not be protected from the risk of abuse at all times. There is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records showed that the manager recorded incidents that happened at the home including accidents, safeguarding incidents and incidents that prevented the service from running normally.

We looked at the care records for four people who were using the service. There were risk assessments in place, however in one person's care file we found that a falls risk assessment and moving and handling assessment had not been completed. The lack of detailed information in care plans might be putting people at risk from unsafe care practices. There is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had an emergency evacuation plan that explained what to do in the event of an emergency. We walked around the home and saw there was specialist equipment such as wheelchairs, walking aids, hoists, bedrails and crash mats to keep people safe. However, we saw a mattress, crash mat, and other pieces of disused equipment being stored in an alcove on the first floor corridor. These items restricted the access to two fire evacuation chairs. We asked the provider to clear the space to make sure the area was safe.

Requires Improvement

Is the service safe?

We were able to fully open some of the first floor bedroom windows and there was no risk assessment to identify that people were at risk of from falling from unrestricted windows at a height likely to cause harm. There is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at a sample of bedrooms. Whilst most of the bedrooms we saw were clean and tidy we saw a bedroom being used that was particularly grubby, smelled offensive and needed immediate cleaning. Another bedroom smelled strongly of urine and the carpet needed deep cleaning. We saw dried faeces on one toilet seat which had not been cleaned at regular intervals. We asked the provider to make sure each area was cleaned to make sure people were safe and their wellbeing was promoted. There is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The CQC had received a number of statutory notifications from the provider that were associated with the delivery of the service. However we had not been advised about an incident that occurred last year which required police investigation. There is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

Our findings

People spoken with told us they felt the staff were skilled enough and knew what to do to meet people's needs. Two people said, "staff are marvellous", "hard workers here; they never stop".

All of the people spoken with were complimentary about the food served. People said, "the food is excellent here", "I enjoy the meals here" and "it's very nice food". The food looked appetising, was flavoursome, balanced and nutritious. People were able to have a second helping if they desired. We saw staff assisting people to eat to maintain their nutrition. Where people had received a speech and language assessment (SALT) we saw these instructions were being followed by staff.

The speech and language therapy service provides assessment and treatment for people who have swallowing and/or communication difficulties.

There was no structured staff supervision plan in place. Staff supervision and staff annual appraisal sessions were not taking place regularly. Whilst the seven staff files we looked indicated that two staff had received supervision in 2014 and five staff had received supervision in 2013, it was apparent that this system was ad hoc and future supervision dates had not been planned.

Three staff told us they had not received an induction when they started work at the home although they had received information about their roles and responsibilities including the values and philosophy of the home through their individual staff handbook. Two staff spoken with indicated they felt insufficiently trained in particular areas such as dementia awareness. One staff said, "We could do with some training in dementia; the seniors tend to get more training than the care assistants".

Three staff told us they had not undertaken fire awareness training however, they had completed mandatory training in moving and handling and adult safeguarding. They told us they were concerned that not enough staff were trained in certain areas and had not received an induction at the start of their employment. The staff training and development (T&D) plan confirmed that in 2013 five out of 17 care staff had received training in safeguarding, nine had undertaken moving and handling 'update' training and 10 had received induction dementia training. The T&D plan did not show further staff training had been planned. This meant that people could not be confident that all of the staff had the skills and knowledge to meet their needs. The manager told us that she thought staff training and induction was up to date because the previous deputy manager was responsible for staff training and recruitment. There is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Staff told us they knew to report their concerns to the manager if they suspected people using the service were subject to abuse. However the manager and staff team did not have a clear understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) legislation and were not always following the MCA for people who lacked capacity to make a decision.

From the care plans that we looked at we saw that one person was subject to the MCA and DoLS. We found there were a number of people who were living with dementia who lacked capacity and DoLS applications for three people whose liberty was being restricted under the Mental Health Act (MHA) 2007 had not been made. In such cases under the MCA the manager is required to complete a DoLS assessment for people and send the assessments to the relevant Local Authority. There is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

A tour of the home showed it had been adapted to help people access the facilities in the home. Accommodation was on three floors which could be accessed via stairs or a passenger lift. We checked some of the furnishings and fire equipment in the home and found they had been properly maintained and had undergone recent safety checks.

Requires Improvement

Is the service caring?

Our findings

People and their families spoken with told us they were happy with the care and support provided at the home. Three people spoken with made positive comments such as, “Yes, they [staff] are nice girls; they are caring”, “The girls are very nice” and “they look after us well, very kind”.

We saw staff and people who lived in the home interacting well with each other and people in their bedroom were given regular attention from staff. When asked, they indicated that staff respected their privacy and their need for time alone.

We considered people’s overall experience of the service by using a SOFI and perceived people were mostly satisfied with the care and support provided. We saw staff and people who lived in the home interacting well with each other. We saw staff showing empathy and kindness, delivering care in a person centred manner to people. There was a relaxed atmosphere in the home and staff spoken with told us they enjoyed caring for the people using the service. People had free movement around the home and could choose where to sit and spend their recreational time.

We saw staff asking people where they preferred to sit in the shared lounge and assisting them to their chosen seat.

We also saw staff speaking to people in a kind, comforting and sensitive manner throughout the inspection. Staff were polite and respectful when they talked to people. Staff knocked on bedroom doors before entering people’s individual rooms. The service kept any private and confidential information relating to the care and treatment of people securely in a locked office.

We walked around the home and saw that one communal toilet in the home had a lock fitted to the door whilst all other shared bathrooms and toilets did not have locks fitted. Staff did not confirm how people were treated with consideration or how their dignity and privacy was managed when people used the shared bathroom and toilets. We saw that an inside and outside lock had been fitted to the staff/visitor toilet door. There is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There was a policy and procedure to provide people with end of life care. The manager told us that end of life care would be delivered individually according to the person’s wishes and their family to make sure that the person’s needs would be regularly assessed and reviewed by a multidisciplinary team of professionals including a GP. This would help make sure people could live and die in the place and the manner of their choosing.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt their complaints would be taken seriously and felt staff took people's concerns into consideration. They knew who to speak with if they wanted to make a complaint or had a concern and told us that they felt comfortable approaching the manager and staff about their concern. Two people said, "I'd tell the girls [staff] if I had a complaint" and "No complaints here". A relative spoken with said, "everything is fine; no problems. Mum's been here for nine years. I can text message the deputy if I have any concerns and she can text me back". Staff knew how to respond to complaints and understood the complaints procedure.

We saw information about how to complain or comment was displayed on the home notice board to guide people about they should make a complaint. People we spoke with knew how to make a complaint.

Some people who used the service had maintained good links with the community which helped them to engage in local community life. The home had arranged for the local Vicar to visit other people at regular intervals in the home to follow their religion in this way if they wished.

There was a daily planned group activity for people and opportunities for people to pursue their own hobbies or go out independently with assistance. Planned reminiscence care home entertainment in the form of sing along songs, was available for people to watch and participate in. We saw people singing along, dancing and tapping their feet to songs with staff encouragement.

Most people had an up to date individual care plan which was being followed by staff. Three staff spoken with were able to clearly tell us their understanding of the care plan details and knew to refer to them daily and said, "because there might be changes to the person's care". From the four care records we looked at we saw that one person had received a comprehensive local authority pre-admission assessment on 22 May 2014. However not all of the information for example, next of kin contact details and a "My Life" document [social history] had not been completed. The manager said, "the staff had endeavoured to complete the person's social history section of the care plan but it seems to be impossible to have a normal conversation with him".

Other forms not completed were, a consent to have medicine's administered form, a falls risk assessment, pressure area care assessment and moving and handling form. A care plan assessment sheet had been completed and last reviewed on 15 September 2014. A note relating to this was made on 15 October but there was no additional follow up information. A note written in August 2014 regarding major concerns about the person's weight loss and the need for staff to report accurately about the person's dietary intake, particularly as there were issues about the person's weight and food intake, was also discussed with manager. A Waterlow score had not been completed. This helps to protect the person from the development of pressure sores. The manager contacted the CPN immediately to gain further advice about reassessing the person's healthcare needs.

We looked at the care file of a person who moved into the home on 20 February 2015. We saw there was no care needs assessment record or up to date care information written by the home. Whilst there was a care plan developed by a domiciliary care agency being kept in the file, we noted that this had been written in March 2013. This meant the risk of people receiving unsafe or inappropriate care, treatment and support was not minimised due to ineffective assessment and there was potential for the home to admit a person whose needs could not be met. The manager said, "I just haven't had the time to start a care plan for them".

We looked at another care file that belonged to a person who had moved into the home for a short stay at the beginning of February. A care plan that came with the person was used to provide care in their own home, had not been updated by Lynwood staff for use at Lynwood. The manager acknowledged the plan should have been amended to help make sure it was person centred and considered their immediate needs whilst living at the home. When asked the deputy manager was able to describe the care being provided in the home in line with the care plan instructions.

There is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People received regular dental care and were supported by staff to maintain good dental and oral hygiene on a daily

Requires Improvement

Is the service responsive?

basis. Where people required urgent dental treatment they were referred to the local NHS out of hour's dental service. Staff told us they knew to contact the GP or dentist if there were further issues or concerns.

Requires Improvement

Is the service well-led?

Our findings

A registered manager is in place. The manager was registered with CQC in 2011.

We asked four people using the service, two relatives and one visitor for their opinions about the quality of the service. People told us they had not been asked by the manager or staff about the service quality. Feedback had not been encouraged from people using the service and their families recently because an up to date service user satisfaction survey was not in place and the manager was unable to locate records in relation to this. She told us this was something she used to do on an individual basis, but had 'let it slip'. She recognised that a system should be in place to help improve outcomes for people using the service.

The manager was unable to provide us with records to show that they monitored the quality of the care provided by completing regular audits for areas such as care records, admissions, and discharges and deaths. This meant that people did not benefit from a service that continually identified monitored and managed risks. There is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A medicines audit had been carried out by the supplying pharmacy and the Stockport NHS Stockport Clinical Commissioning Group (CCG) in February 2015.

All the staff spoken with told us they felt supported and enjoyed their work. They told us that the providers were 'lovely people' and one staff member said, "It's a good home to work in; they treat us like family, that's why I've been here for so long". They told us that the manager always acted immediately on any concerns they reported. Staff told us, "The manager was approachable and always thanks us at the end of the day for doing a 'good job'. The values and philosophy of the home were discussed in the staff handbook which staff confirmed they had read.

Staff told us they were always informed about any changes that had been implemented and staff feedback was sought through staff meetings and shift handovers. The manager gave us a copy of the notes from the most recent staff meeting held in November 2014. She told us that feedback was used to make changes to the service. Staff spoken with felt that communication with the manager was good but could be improved through more frequent staff meetings and staff individual supervision.

Staff told us that the manager and deputy were approachable and there was always a manager present in the home during the week and at weekends.

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 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: We found that the registered person had not protected people against the risk of inappropriate or unsafe care because people using the service did not receive an assessment from when they began to use the service. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: We found that the registered person had not protected people against the risk associated with inadequate cleanliness and hygiene because a system of maintaining good standards of hygiene was not being followed regularly. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

We found that the registered person had not protected people against the risk of unsafe premises because risk assessment were not in place to prevent people from falling from unrestricted windows at a height likely to cause harm.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: We found that the registered person had not protected people against the lack of privacy and dignity because door locks were not fitted to bathroom and toilet doors. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: We found that the registered person had not protected people by considering restrictions where they lacked capacity. This amounted to Deprivation of Liberty Safeguard (DoLS) which had not been authorised. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

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 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: We found that the registered person had not protected people against the risk of inappropriate or unsafe care because not all staff had received up to date relevant training, induction and support and the manager and staff team did not have a clear understanding of whistleblowing, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

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 How the regulation was not being met: We found that the registered person had not protected people against the risk of inappropriate or unsafe care because some care risk assessments did not state how risks would be managed and had not been fully completed. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.

How the regulation was not being met:

We found that the registered person had not complied with the regulation to notify the CQC about an event involving the service in a way that could affect all of the people who use it.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Notification of other incidents.

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.