Mrs M K Ahmad

Qumran Rest Home

Inspection report

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Ratings

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

Overall summary

Qumran Rest Home provides accommodation and personal care for up to 11 predominantly older people. At the time of our visit nine people were using the service. Bedrooms were arranged over two floors. There were communal lounges and a dining area on the ground floor with a central kitchen and laundry.

Mrs. Ahmad, the provider of the service, is also the nominated individual for the service and as such holds legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was not present during the inspection and was no longer involved in the day to day management of the service. The provider was represented by her son, Mr. Ahmad, and the manager of another service run by the provider. The service needs to have a consistent management structure in place and we found this was not the case. The provider needs to correct the registration of the service by adding a condition to their registration to have a registered manager responsible for the day to day management of Qumran Rest Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

We carried out this unannounced inspection of Qumran Rest Home on 9 and 12 October 2015. We last inspected the service in July 2013, when we found the service was meeting legal requirements.

Elements of the running of the service were unsafe. We found fire safety regulations had not been fully met regarding requirements for the safety of fire doors at the service. There was no emergency evacuation plan available, giving an overview of procedures to take in an emergency situation.

Risks to people's health and welfare had not been consistently assessed and there was a lack of sufficient guidance to help staff to manage risks safely. The service had not reported allegations of abuse to the local authority in a timely manner.

There were not enough staff available to meet people's needs, particularly during the night. At this inspection we found staff had received some training, however, the organisation and delivery of appropriate training was not taking place. The majority of training was computer based and was not effective or specialist enough to meet the specific needs of people who used the service.

Staff were not supervised or adequately supported to carry out their roles. Staff told us "Supervision is not happening. I have never had an appraisal and I don't feel I get adequate supervision to do my job".

Staff were not always knowledgeable about people's individual care and support needs. This was because staff did not have access to people's care plans. Staff knowledge about the people they cared for came from the relationships they had developed with people and their families. However, staff did not always have knowledge about people's medical history. This did not support people to have continuity of care. People's care and treatment was not planned and delivered in a way that ensured people's safety and welfare. Care records were very brief, did not provide staff with clear direction to be able to meet people's needs, were not up to date, and were not being adequately reviewed.

The service had made regular appointments with health care professionals when needed. However, people's healthcare needs were not consistently met or monitored.

We found the service was not meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards. Where people were deemed as lacking capacity assessments did not evidence how staff came to this conclusion.

Management at the service had not followed the service policy and procedures for reporting allegations of abuse to the local authority.

The service did not have appropriate systems in place to assess, monitor and improve the quality of the service.

Staff interacted with people in a friendly and respectful way. People made choices about their day to day lives which were respected by staff. People told us staff treated them with care and compassion. Comments included; "The staff are nice, if you want anything they [staff] will try to get it", and "The staff are kind and friendly". Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Fire safety regulations had not been fully met regarding requirements for the safety of fire doors at the service.

Risks to people's health and welfare had not been consistently assessed and there was a lack of sufficient guidance to help staff to manage risks safely.

There was no emergency evacuation plan available for people and staff to have an overview of procedures to take in an emergency situation.

There were not enough staff available to meet people's needs, particularly during the night.

The service had not reported allegations of abuse to the local authority in a timely manner.

Is the service effective?

Requires improvement

The service was not effective.

Staff had not received effective training and as a result did not have the skills and knowledge to provide consistent effective care in line with people's specialist needs, such as dementia.

Staff did not understand the legal requirements of the Mental Capacity Act (2005). Staff were not trained to carry out mental capacity assessments to ensure people were supported to make decisions about their care.

Deprivation of Liberty Safeguards had not been followed by the service.

The service had made regular appointments with health care professionals when people needed them.

The service was not providing staff with effective supervision and appraisal in line with its own organisational policy.

Is the service caring?

Requires improvement

The service was not always caring.

People's preferences and choices were not always recorded to ensure they received personalised care.

Not everyone who lived at the service had an up to date care plan in place to meet their needs.

Staff were caring and respectful when people needed support, or help, with their personal care needs.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People were supported to receive prompt and appropriate healthcare when required. However, staff did not always report urgent on-going health concerns to management. This resulted in an inadequate response to health concerns in some situations.

The service did not provide a suitable range of activities for people to participate in.

People and visitors told us they knew how to complain and would be happy to speak with managers if they had any concerns.

Is the service well-led?

Requires improvement 

The service was not well led.

There was no consistent manager in place. The administration of the service had become chaotic and as a result key measures such as care planning, reviews of peoples' care and necessary staff support had not taken place.

There was a lack of appropriate response to the findings of quality assurance and audit processes.

Qumran Rest 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 9 and 12 October 2015 and was unannounced. The inspection was carried out by one inspector.

We requested and were provided with a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with six of the nine people who lived at Qumran Rest Home and who were able to express their views about living at the service. We also spoke with three external professionals who had experience of the home. We looked around the premises and observed care practices on the day of our visit.

At the service we spoke with four care staff, a clinical lead from another service owned by the same provider, the General Manager and the son of the provider. The registered provider was not present during the inspection. We looked at six records relating to the care of individuals, two staff recruitment files, staff duty rosters, staff training records, medicines records and records relating to the running of the home.

Inadequate

Is the service safe?

Our findings

Staffing levels were not adequate considering the level of needs of the people living at Qumran Rest Home. Rotas looked at during the inspection showed there were normally two staff on duty during the day and usually a manager for 20 hrs per week. However, at the time of inspection two staff had recently been suspended. This had placed additional pressure on the number of staff available to cover shifts. We found that only three care staff were available to cover all the shifts through the week. The small staff team was regularly on continuous duty for 24 hours, working a 12 hour day time shift followed by a 12 hour 'sleep-in' shift at night. This practice was questioned during the inspection and the General Manager told us the practice of sleep in shifts following long day time shifts was 'not supposed to happen anymore.' However, it was clear from the rota that it continued to take place. In an audit carried out by the service in September 2015 it was identified that rotas and staffing hours were 'unsafe'.

The service did not employ waking staff to provide care and support throughout the night. There was one staff member who slept at the service and could be woken by people if they used their call bell. However, we found a number of incidents when people had fallen and had been unable to call for help, during the night. A staff member told us, "I believe two staff are enough to meet people's needs. One sleeping night is ok because it's very rare that anything happens, although we did have an issue recently where a person fell and cut their head. We had to phone the emergency ambulance." We reviewed the number of incidents and accidents at the service which showed at least four falls had occurred in the last six months during the hours of 12 midnight to 8am, where people were found by the sleep-in staff member on the floor in the morning. This showed the service was not keeping people safe.

We looked at a person's care plan which stated, 'support and interactions required'. The manager told us staff would sometimes sit with the person as company, particularly in the evening but there was no record that this had happened. The care plan of another person that was confined to bed, stated the person needed, '1 or 2 staff to reposition. Requires 4 hourly repositioning changes and check of pressure areas'. However, this was not happening during the night as there was only one staff member on duty in the home who was on a 'sleep in' shift. In this instance the care plan was not delivered because of the staffing available at night.

There were systems in place to protect people from the risk of abuse. Staff we spoke with had an understanding of how to keep people safe from abuse. However, staff were unclear about when and how to report allegations of abuse to the local authority. We saw the service had not made alerts about potential risks to people to the Multi Agency Referral Unit in a timely manner and in one case an alert had not been raised. Providers must take appropriate action without delay where any form of abuse is suspected or reported.

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

Care planning for people at the service had not been carried out from September 2014 until July 2015. We found the provider had not assessed the risks to people's health and safety or guided staff about how they should support people to minimise risks. Care files did not routinely include risk assessments and control measures to minimise risk. For example, guidance about how staff should support people when using equipment or reducing the risks of falls. The use of bed rails and reducing the risk of pressure ulcers had not been risk assessed. Staff told us they had not had access to people's care plans. This did not help to ensure staff could provide care and assistance for people in a consistently safe way.

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

The service had carried out a recent fire safety audit and had rectified problems with the fire system. However, we found fire safety regulations had not been fully met regarding requirements for the safety of fire doors at the service. There was no prominently displayed emergency evacuation plan available providing an overview of procedures to take in an emergency situation.

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

Medicine Administration Records (MAR) were completed correctly providing a clear record of when each person's medicines had been administered and included the initials

Inadequate

Is the service safe?

of the staff member who had given them. Medicines were securely stored and the service had arrangements in place for the recording of medicines that required stricter controls. These medicines required additional secure storage and recording systems by law. The service stored and recorded such medicines in line with the relevant legislation. The service carried out regular audits of medicines to ensure they were correctly monitored and procedures were safe. A community pharmacist completed a medicines audit during the inspection. Results showed the service was managing medicines safely.

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required, to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks, to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

We saw the service was well maintained; there were no issue with the cleanliness and no malodours anywhere in the service. A cleaner was employed for two hours per day, five days per week. The service kept a maintenance log and ensured that work was prioritised to maintain a good standard of premises. Service certificates were in place to make sure equipment and supply services including electricity and gas were kept safe. Equipment including moving and handling aids, stand aids, lifts and bath lifts were regularly serviced to ensure they were safe to use.

People who lived at the service told us they were happy with the care and support they received and believed it was a safe environment. One commented, "I'm happy here. I'm well cared for and the girls (staff) are very nice".

Requires improvement

Is the service effective?

Our findings

The service did not have a system for supporting staff by providing regular supervision and appraisal. Staff were not supervised, supported and trained to carry out their roles effectively. Records showed no documented history of staff supervision and this was confirmed by staff. Appraisals had not happened since 2010. Staff told us, "I can't remember the last time I had supervision and I've been here a long time. I have been told supervisions and appraisals will be starting next week."

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

We spoke with staff about the training they had received. One staff member told us, "I didn't have much training initially. I'm now working on training, I've just done my food hygiene recently." We checked staff training records for one staff member which recorded no training for a number of key areas including safeguarding vulnerable adults, dementia training, mental capacity act, and First Aid. Staff confirmed the lack of training they had received over the last year. The service training schedule was mainly computer based. Staff we spoke with told us they had received no hands on training in areas such as how to safely move a person or how to use specialist equipment..

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

People did not always have the necessary medical care in place to keep them well and comfortable. We reviewed medical notes for one person that demonstrated that staff had followed the direction of a GP concerning a person's deteriorating health. However, staff did not alert management when the person's condition changed. There were no records of a deterioration in another aspect of the same person's health and so appropriate treatment was not requested. Staff were unclear about the underlying medical condition that had led to the person's current medical needs. There was an unspoken acceptance that medical advice had been followed without question. We discussed the situation with the manager who acknowledged, "They (staff) are not grasping what they have to tell me". This was followed up with staff members who said they were unsure what the underlying condition was and we found there was no documentation on the medical notes which painted a clearer picture. The person had been prescribed paracetamol for pain relief and there was a note on the care plan stating the doctor would prescribe stronger painkillers if requested.

The general manager told us staff had undertaken training in the requirements of the Mental Capacity Act 2005 (MCA). The MCA is designed to empower those in health and social care to assess capacity themselves, rather than relying on expert testing from clinical professionals.

This applies to everyone involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those people who lack capacity. The service did not have an up to date policy about the MCA and the procedures to be followed when assessing a person's capacity to make a decision. Staff at the service told us they did not know there was an MCA policy at the service.

Staff had completed mental capacity assessments for people. We found these were frequently inaccurate and showed staff did not have a working understanding of the principles of the MCA and how these applied to people who lived at the service. For example, people living with dementia had been assessed as 'not having any impairment in functioning or disturbance of the

mind'. This meant staff were making decisions about people's ability to make decisions based on inaccurate decision making. We spoke with the general manager about this and the manager acknowledged, "We've pushed a bit too hard to get the paperwork completed and didn't check enough that staff actually understood what the assessments meant".

We found the service had not recorded people's consent to their care and support. As previously stated, care records had not been kept up to date and did not reflect the current needs of the people they were about. We found four 'Allow Natural Death Orders' (ANDO) on file, completed on the same day, for which consent had not been recorded. There were no mental capacity assessments or best interest decisions recorded about whether it was appropriate to have an ANDO in place for people. . Completion of ANDO forms requires that where a person does not have the capacity to understand or consent to the decision a multi-disciplinary team should contribute to the decision, such as relatives, social workers, GP's etc. In most

Is the service effective?

cases people's relatives had not been consulted about their views on these decisions. We found decisions were consistently taken only by the acting deputy manager from the service alongside a GP.

The service had not appropriately considered the impact of restrictions put in place for people that might need to be authorised under the Deprivation of Liberty Safeguards (DoLS). The legislation regarding DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. A provider must seek this authorisation to restrict a person for the purposes of care and treatment. In March 2014 the criteria for when someone maybe considered to be deprived of their liberty had been clarified. The service had provided CQC with information before the inspection that stated, 'staff are educated in the changes to the law regarding mental capacity not being a blanket statement and the context of deprivation of liberty safeguarding'. It was evident this was not the case. The provider had not taken the criteria into account when assessing if people might be being deprived of their liberty. The service had not requested appropriate authorisation from the local authority for people who were being restricted. The general manager acknowledged that this was something they were aware needed to be assessed for people who lacked capacity. The PIR the provider completed stated 'consultation with other stakeholders is included in the process'. There was no evidence to support this statement.

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

We saw that people were being restricted through the use of door alarms for which no consent had been given and no attempt had been made to assess whether the use of the alarms were in the persons best interests. There were no assessments or best interest decisions recorded regarding the use of these alarms, which restricted people's ability to move around the service at particular times of the day. These restrictions of personal freedom had not been considered appropriately under the Mental Capacity Act to ensure that they were necessary and appropriate restrictions to impose on people. The rights of people that lacked capacity were not being protected adequately.

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

People who lived at the service said the food was nice. There was a two week rolling menu with two hot lunch options and a good range of foods available. One relative said, "From what I have seen the food is always very good. It looks like fresh home cooked food. (Person) certainly loves the food". A person who used the service said, "The food is fine. Recently we have had more of a choice. Staff usually talk to us before a meal to remind us what the options are.".

We found there were no food or fluid charts available for two people who we were told were monitored for their eating and drinking . The general manager told us charts were completed sporadically to get a snap shot of food and fluid intake but there was no documentary evidence to support that any had been completed. The general manager told us they were, 'not sure' where the paperwork for this was. Information recorded in care plans about food and fluid intake was out of date and contradictory; for example one person was recorded as having 'a good appetite at the minute' and also as having lost weight 'due to decreased appetite and dementia'. The service was not adequately ensuring that people who required it were properly protected from the risk of inadequate nutrition and dehydration.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people used specialist mattresses for which pressure records are required to make sure they are appropriate for the individual using them. We were unable to review these records as there was confusion between management and staff about where they were recorded. It was stated on care plans that these were recorded on skin bundle records but when checked this was not the case. It was apparent that the organisation of records concerning the monitoring of people's care and support was not in place and this was acknowledged by management.

Requires improvement

Is the service caring?

Our findings

There was a relaxed and friendly atmosphere at the service. We saw people felt at ease to move about freely and engaged in a relaxed way with each other and staff. People told us they were happy and we saw people spent time in the communal lounge watching television or privately in their bedrooms. People had the ability to use private space at the service to meet with others if they wanted to.

Staff were caring and respectful when people needed support or help with personal care needs. A relative said, "They are nice here, very caring.". One person who used the service said, "Staff are very respectful and helpful. Nothing's been too much trouble for them to give me a better quality of life. I've had a couple of hospital appointments and staff have been excellent at supporting me to attend these appointments.". Another person said, "I like it here. The people are very nice and it's a very nice situation by the sea. I am very happy here.".

There was a question over the level and quality of care provided to people who had less mobility. For example, two people were unable to leave their rooms due to health conditions. We observed there was little stimulation for them with only their televisions which stayed on all day.

While visiting one person who was in bed, we were accompanied by a staff member. The person who had very limited speech was watching a screen with an information message in the centre of the screen, but staff who attended her did not notice.

People were actively involved in making simple day to day decisions about whether they wanted a drink and which choice of meal they had. People told us they could express their views if they wanted and had had an opportunity to share with each other and staff at a recent residents meeting. The manager told us people had asked that a fire be installed in the lounge during the meeting and this was planned to happen. However, it was not usual practice for people to be involved in making more formal decisions about what their care, treatment and support would be. People were not involved or consulted in putting their care plan together or in reviewing their care.

There were no restrictions on visitors coming into the home at any time during the inspection. Those we spoke with told us the service kept them informed and involved in their relatives care and support informally when they visited the service rather than any formal involvement in care planning reviews.

Requires improvement

Is the service responsive?

Our findings

People told us they received care and support when they needed it. Call bells were answered promptly during the day and we saw people were assisted appropriately and with patience by staff during the two day period of the inspection.

People told us they could express their views about what was important to them and about their health and wellbeing. People said they normally did this by talking to staff rather than by any formalised, written process. One person told us, "I would tell them if I wasn't happy with the way I was cared for.".

Relatives told us they were kept informed verbally about changes to people's needs. Family members were not routinely invited to meetings concerning people who used the service.

We saw that routine care planning reviews had not taken place. People told us they did not know what was contained in their care plans. People had not been asked to sign their care plans to agree they knew what was written in them. The service did not have a process for assisting people who lived with dementia to be involved in their care management.

As detailed in the effective section of this report, care records did not always contain appropriate and up to date information about people's health and social care needs. Plans were not individualised and relevant to the person. Records gave very little guidance to staff on how best to support people and staff had been prevented from seeing people's care plans for a prolonged period of time, because the previous deputy manager had not made them available to staff.

We found no structured activities were offered to people. Staff told us, "we play dominoes sometimes but mostly people want to watch TV and do their own thing". We saw people mainly sat in the conservatory chatting or watched television in the lounge. On the second day of inspection the manager had put up posters advertising a Halloween party, which we were told would be an opportunity for the provider's family to come and meet with the people who used the service.

The relative of a person said, "I don't think there are any organised activities going on. But occasionally they'll have a MacMillan tea party to raise funds." People could not access activities in the local community unless supported to do so by their own friends or family. Staff told us, "People don't go out unless they go out with their families. They are very dependent on their families to go out". The service was not providing a choice of activities and options for people to meet their needs and support their independence.

We found people were not assured of consistent, co-ordinated and person-centred care at the service or when they moved between services because of the limited information recorded in care plans and the lack of care reviews. This meant care was not properly planned in a way that met the person's individual preferences and needs.

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

The service had a policy and procedure in place for dealing with complaints. However, some people told us they were not aware of how to make a complaint and would feel uncomfortable doing so. Other people said they would tell staff or management if they were unhappy. We were told there had been no complaints received by the service, however, we found a relative had raised a complaint about the care of a relative in feedback supplied to the service. This was not recorded as an incident or complaint, as the management of the service were unaware of its

Requires improvement

Is the service well-led?

Our findings

We found the provider did not have an effective system to regularly assess and monitor the quality of service that people received. The culture of the home was essentially caring but highly disorganised and as a result was missing essential good practice such as person centred care planning and meeting the wider needs of people, for example activities in peoples day to day lives were not met.

Leadership at the home had broken down in the run up to this inspection and the current manager was actively managing both this and another service on a part-time basis. Staffing levels were at a minimum, placing additional pressure of existing staff members who worked long shifts to ensure cover was maintained.

The provider stated they had been unaware of the scale of the problems that were happening at the service as they had not worked consistently at the service for much of the previous year. The deputy manager who had taken charge of management at the service had not received any supervision for the first three months in post and sporadically after this. The situation had escalated to such a level that disciplinary procedures were put into place resulting in staff leaving the service and the full extent of poor practices coming to light.

The son of the provider and the registered manager of another service run by the provider had sought to implement a structured management plan to re-order the running of Qumran Rest Home. At the time of this inspection this plan was being implemented. Management were clear about the failings in the running of the service and did not underestimate the seriousness of the issues identified. At the time of inspection a clinical lead, employed by the sister home of Qumran Rest Home had begun working at Qumran one day per week. In addition, a business manager had also come from another service to Qumran for two days per week to take responsibility for the finances of the service and add additional resource to organising the administration of the service.

The service had sought the views of people whose relatives lived at Qumran Rest Home in the form of a quality assurance satisfaction questionnaire. Ten of these were completed and returned in April 2015. Views were mixed about the quality of the service. The provider was unaware of the feedback that been received.

Other professionals who were familiar with the running of the home were not routinely asked for their views about the care and support provided at the service. However, we spoke with four professionals after the inspection and found professionals views were mainly positive about the quality of care people received.

Documentation which related to the management of the service required vast improvement including care planning, care reviews, risk assessments, daily records and recording of food and fluid charts. This would ensure that staff would have guidance, information and direction in how to provide specific care to people in a consistent manner.

There was a lack of consistent quality assurance and audit processes that reflected the reality of practice at the service. Since becoming aware of the issues as highlighted in this report, the provider's son had begun a comprehensive audit of practice and procedure at the service. The catering manager from the sister home run by the family, had undertaken an audit of infection control and catering procedures. A local community pharmacist undertook an audit of medicines management practices and generally, senior staff were working to rebuild all areas of the service that required it.

Records for the service were not well maintained and it was difficult for the manager and staff to find requested records. Some care documentation had been worked on following the discovery that care plans had been neglected and reviews not completed. For those people who care records had not been updated, care documentation was not well organised or presented. This made it difficult to find specific information in files. The manager acknowledged there was much work to be done in this area.

Incidents and accidents had recently been monitored to cover the period between January to the end of September 2015. There were nine accidents in total, five of which happened between 8pm in the evening and 8am, during the staff sleep in shift. The level of accidents during the night did not ensure the care provided was safe and responsive to people's needs.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person was not ensuring care and treatment was designed with a view to ensuring people's needs were met. Regulation 9 (1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Need for consent. The registered person was not acting in accordance with the Mental Capacity Act (2005) and associated Deprivation of Liberty safeguards. Regulation 11(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Fire safety regulations had not been fully met regarding requirements for the safety of fire doors at the service. There was no prominently displayed emergency evacuation plan available providing an overview of procedures to take in an emergency situation. Regulation 12 (2)(b).

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

The service had not reported allegations of abuse to the local authority in a timely manner. Regulation 18 (1) and (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service were not receiving appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to consistently operate systems and processes to ensure compliance with assessment, monitoring and improvement of the quality and safety of the service and to mitigate risks relating to the healthy safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 17 (1) and (2) (a) & (b).