St Anne's Community Services

St Anne's Community Services - Sutherland Court

Inspection report

1-3 Sutherland Court
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Date of inspection visit:
22 June 2021
23 June 2021

Date of publication:
25 August 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Anne's Community Services - Sutherland Court is a residential care home providing care to people with a learning disability and autistic people. The service can accommodate up to seven people. Five people were using the service at the time of the inspection.

We expect Health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people

People's experience of using this service and what we found
The service could not show how they met the principles of Right support, right care, right culture.

The service did not focus on people's quality of life and care delivery was not person centred. Staff knew people well and showed kindness, but they did not recognise how to promote people's rights, choice and independence. People's human rights were not always upheld. Care and activities were not planned in a way that met people's individual needs.

People's communication needs were not met and information was not shared in a way that people could understand.

The service had sufficient staff but they were not appropriately trained. Poor staff performance was not always recognised which placed people at risk of harm. Leaders were out of touch with what was happening in the service.

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

People were not supported by staff who understood best practice in relation to learning disability and autism. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

People enjoyed the meals served which staff said were based on people's preferences. However, staff chose what people ate rather than having planned meals which would ensure people's nutritional needs and preferences were met.

People's care and support was provided in a safe, clean, well-furnished and well-maintained environment

which met people's physical needs.

People were protected from abuse.

People's risks were assessed regularly and usually managed safely.

People had access to independent advocacy. Staff supported people to maintain links with those that are important to them.

The service had no confirmed positive tests from staff and people who used the service throughout the COVID-19 pandemic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 March 2019). The service has been rated inadequate.

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, following a legal framework for making particular decisions, staffing and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

St Anne's Community Services - Sutherland Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors, a medicines inspector and an Expert by Experience carried out the inspection.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Anne's Community Services - Sutherland Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 22 June 2021 and ended on 6 July 2021. We visited the service on 22 and 23 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, the local safeguarding team and commissioners. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We observed how people were being cared for and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a relative, a representative who worked through an advocacy agency and eight staff including the registered manager.

We reviewed a range of records. This included five people's care records and medication records. We looked at a variety of records relating to staff training and recruitment, and the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- People were not always kept safe from avoidable harm. The service had enough staff, who knew the people. However, poor staff performance was not always recognised which placed people at risk of harm. For example, staff did not recognise when they failed to support people to make their own decisions or encourage independence.
- The service had a house vehicle but at the time of the inspection, only one member of staff and the registered manager were eligible to drive. The lack of drivers limited opportunities for people to go out. The registered manager was taking action to address this.

The provider failed to ensure staff were appropriately skilled to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were recruited safely. The provider carried out appropriate checks to make sure staff were suitable before they started working at the service.

Learning lessons when things go wrong; Assessing risk, safety monitoring and management;

- People's risks were assessed regularly and usually managed safely. Assessments covered areas such as epilepsy, moving and handling, dry skin and road safety. One person had an assessment because they were at risk of choking but staff did not consistently follow the guidance to help reduce the risk. The registered manager agreed to address this with all staff.
- The service usually managed accidents and incidents well. Staff usually recognised incidents and reported them appropriately. Managers maintained people's safety and investigated incidents and shared lessons learned with the whole team.
- The service recorded incidents where people's behaviours could challenge themselves or others. Leaders reviewed these incidents and learning from this was taken forward to reduce the likelihood of the incident reoccurring.
- People's care and support was provided in a safe, clean, well-furnished and well-maintained environment. The environment met peoples sensory and physical needs.
- People's care records were accessible to staff, and it was easy for them to maintain care records.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely.

The service had ample PPE which was available throughout the building. Staff were observed wearing PPE, but they did not always wear masks correctly, for example, not covering mouth and nose. The registered manager agreed to reinforce safe working practices to help prevent transmission of COVID-19 with all staff.

● We were assured that the provider was accessing testing for staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The provider had guidance around COVID-19, but their infection prevention and control policy did not reflect full infection control measures to avoid COVID-19 spreading to others. For example, there was no reference to staff wearing masks or eye protection. The provider updated the policy when it was brought to their attention.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People were safe from abuse. Staff understood how to protect people from abuse and the service worked with other agencies to do so.
● A relative and representative told us people were safe. The relative said, "I do feel my relative is safe there and partly that's because we have known some members of the staff for a long time. They used to go there for respite first and feels comfortable with staff as do I."

Using medicines safely
● People received the correct medicines at the right time. People's medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Staff followed systems and processes to safely administer, record and store medicines.
● Staff worked alongside prescribers to ensure the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) or STAMP (supporting treatment and appropriate medication in paediatrics) were followed. We saw evidence of use of antipsychotics being reviewed and reduced where appropriate. Antipsychotics are used for some types of mental distress or disorder.
● People using the service or their advocates, staff and specialists were involved in decisions made about the treatment given to a person.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were supported by staff who did not use best practice for people with a learning disability and autistic people. Records showed most staff had worked at the service a long time and had not received relevant training for many years. For example, four staff were asked about autism and learning disability training. Three who had been employed for over five years stated they could not remember receiving the training. The provider arranged for staff to receive relevant training once it was brought to their attention.
- Staff lacked understanding around good care practices and how to meet people's needs. For example, one person who was autistic switched lights off; staff switched them back on and did not recognise this could be due to light sensitivity.

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had regular supervision and appraisal. Managers provided an induction programme for any new or temporary staff.
- Staff received basic training and refresher courses. For example, they completed sessions such as manual handling, health and safety, fire safety awareness and data protection. Staff had recently received diabetes training which was relevant to their role.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

● Staff did not fully understand their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005. This meant that people who lacked capacity or had fluctuating capacity did not always have decisions made in line with current legislation.
● People's human rights were not always upheld. Staff did not support people to have control over their own lives. For example, one person did not like having a shower and often got distressed and cried. There was no evidence to show they had checked a daily shower was the least restrictive option. Staff stopped another person from drinking caffeinated coffee and only allowed them to have decaffeinated coffee. This decision was not assessed or recorded in the person's care records as the least restrictive or in their best interest.
● People who used the service were not undertaking the COVID-19 testing programme even though this was recommended guidance. Mental capacity assessments and best interests decision records were completed but there was no evidence that other professionals were involved in the decision making process.

The provider failed to ensure consent to care and best interest decisions were obtained in line with legislation. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Sometimes, for people that the service assessed as lacking mental capacity for certain decisions, staff had recorded assessments and any best interest decisions. The service had completed capacity assessments for each person around their medicines and identified the level of support they needed. Other capacity assessments and best interests decision records covered areas such as managing finances and use of lap belt.

● Leaders had failed to communicate important information to staff. None of the people using the service had an authorised DoLS because these had expired. The service had applied to the local authority and was waiting assessment. However, staff did not know about the current position. Three staff were asked; one said no one had an authorised DoLS and two said everyone had an authorised DoLS.

The lack of communication meant systems to monitor the quality and safety of services provided were not operated effectively. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care and support plans were not holistic and did not reflect people's needs and aspirations. These did not reflect a good understanding of people's needs with the relevant assessments in place. There were no care assessments which meant people's support needs, skills and abilities, such as, personal care, and daily living had not been assessed. For example, one person's abilities around personal care had not been assessed and staff provided different information about what the person could do for themselves.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff planned, prepared and cooked people's food. They said meals and snacks were based on people's preferences. However, the service did not use a menu for planning meals and staff chose what people ate.

● People enjoyed the meals served and had plenty to eat.
● People had regular drinks and snacks. However, one person asked for bread just before 3pm but was told they had to wait until their evening meal.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had good access to physical healthcare.
● People were referred to other professionals such as positive behaviour support team and learning disability team where appropriate.

Adapting service, design, decoration to meet people's needs
● People were comfortable in their environment and spent time in their own accommodation, communal areas and safely accessed outdoor space.
● Since the last inspection improvements had been made to the premises, which included a new kitchen, flooring, lighting and furniture. The registered manager confirmed several areas were due to be decorated which included lounges and corridors. They said the decorators had already visited the service to measure up.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were not always enabled to make choices for themselves and staff did not ensure people controlled their care and support where possible. People did not have plans about their preferred daily routines and activities which meant staff decided what people did and when. For example, at mealtimes people were only offered drinks after they had eaten their food.
- The service did not understand the importance of staff having the skills to understand and recognise good care, such as promoting independence and exploring the use of different communication tools.
- The service was often task focused. Staff were responsible for and often prioritised housekeeping duties such as cleaning and cooking. For example, staff focused on wiping tables and clearing up after meals were served; people were not encouraged to engage in daily living tasks.
- Staff showed kindness but did not recognise how to provide care in a way that met good practice principles such as promoting choice and independence. For example, everyone wore a clothes protector at mealtimes even though some people did not spill any food or drink. This was a blanket approach and not individually assessed.
- A relative and a representative who worked through an advocacy agency told us people received kind and compassionate care. Comments included, "Some of the staff I'm really impressed with, they have a really caring attitude" and "The staff are kind and caring and this comes out in everyday routines. They understand the residents." We received feedback that one member of staff could sometimes be abrupt.
- People had access to independent advocacy. Staff supported people to maintain links with those that are important to them.
- People's privacy was promoted and respected by staff. Each person had their own bedroom. People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The service did not work in a person-centred way to meet the needs of people with a learning disability and autistic people. They did not follow best practice and the principles of Right support, right care, right culture and were not ensuring that these principles were carried out.
- The service did not plan personalised care or meet the needs of all people using the service. For example, when people expressed emotional distress they did not have effective plans to guide staff. Following an incident an agreed action was to monitor one person's behaviour through charts. However, these were not introduced and the person did not have a positive behaviour support plan. Another person's plan did not identify events and situations that predict when the behaviour would occur or effective strategies to support the person when they expressed emotional distress. A positive behaviour support plan is a care plan to help understand and support people who display behaviour that others find challenging.
- Staff carried out tasks rather than engaged people and encouraged independence, for example, they shopped and cooked for all meals. Staff made drinks for people, took plates to the table for people at mealtimes and collected dishes etc after people had eaten.
- Daily routines were not always person-centred. For example, staff suggested people should get changed and go to bed at certain times. Staff took one person to bed when they did not want to go; the person then came out of their bedroom and stood in the corridor observing what was going on.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or
sensory loss and in some circumstances to their carers.

- People's communication needs were not met and information was not shared in a way that people could understand. At the last inspection the registered manager said they were improving documentation and information to make sure people were enabled to communicate their needs. There was no evidence these improvements had been made.

● The service had limited accessible information such as signs and pictures. People had pictorial placemats which were designed to promote choice and displayed food they enjoyed. These were used with three people, but staff could not find placements for the remaining two.
● Support plans were not accessible to people. For example, there was no use of symbols or photographs.
● People had communication support plans, but these did not include important information. For example, one person's record stated that staff should encourage them to make choices but did not explain how staff should do this.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The service did not focus on people's quality of life outcomes. During the inspection people were seen to have sedentary lifestyles and spent long periods with very little stimulation. In one unit, three people were sat on settees in the lounge and the only activity was watching TV. However, only one of the settees faced the TV.
● Activities did not always meet people's individual needs. Leisure activity records were maintained and showed people did not take part in regular social activities or visits to the community. For example, one person had identified goals which included activities in the home, such as baking, but there was no evidence to show this activity was offered.
● Activities were not part of people's planned care and support. The staff rota had a section at the bottom which indicated people had scheduled leisure days. However, these were standard entries and the registered manager confirmed they did not accurately reflect when activities were offered.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had organised several themed events and group activities, such as, St Patricks Day, VE Day 2020, Chinese New Year, Christmas decoration making and science craft sessions. They were planning a 'beach day' and had invited an ice cream van to the service.
● A representative who worked through an advocacy agency told us, "Pre-pandemic activities I know are tailored to what people want to do."

Improving care quality in response to complaints or concerns
● The service had a system for responding to concerns and complaints. No complaints had been received. The registered manager was confident the service would treat all concerns and complaints seriously, investigate them, learn lessons from the results and share the learning with the whole team.
● A relative and representative told us they could raise concerns. Comments included, "If I was unhappy I would speak to [name of registered manager] as I feel I have a good relationship with him and I could just pick the phone up and have a chat" and "It hasn't really occurred, but if I was unhappy I would first of all speak to the member of staff and if it wasn't resolved to [name of registered manager]".

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Our findings from the other key questions showed that governance processes were not effective and did not always keep people safe, protect their human rights and provide good quality care and support.
- Staff did not have the information and training they needed to provide safe and effective care, and follow best practice for supporting autistic people and people with a learning disability.
- Staff did not understand the provider's vision and values or how to apply them in the work of their team.
- Leaders were out of touch with what was happening in the service and they did not understand the services they managed. They did not have effective systems that ensured service delivery was person-centred and met best practice for supporting autistic people and people with a learning disability.
- Management and staff did not understand the principles of good quality assurance. For example, at the last inspection we found the provider was not carefully monitoring if people had nutritionally balanced meals. The service had introduced a system to record meals individually but there was still no evidence these were reviewed to check people's preferences and nutritional needs were met. People's authorised Deprivation of Liberty Safeguards had expired but the service did not have a system in place to ensure the care that was being delivered was the least restrictive whilst waiting for the assessment.
- Information to enable monitoring was unreliable. Record keeping was sometimes poor. For example, staff did not always record people's experiences.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was visible in the service. The representative who worked through an advocacy agency told us, "The manager is very approachable and is very open to talk things through."
- The service had no confirmed positive tests throughout the COVID-19 pandemic. The registered manager told us they were very proud of this achievement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service obtained views of others but there was a limited approach to obtaining the views of people who used the service.

● The service engaged in local improvement forums. Staff and a person who used the service recently attended a dignity day, which was held at a local park and focused on promoting dignity for all.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● Where required, information was reported externally.
● Notifications about significant events were submitted to CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure consent to care and best interest decisions were obtained in line with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were appropriately skilled to meet people's needs.

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 RA Regulations 2014 Person-centred care The provider failed to ensure care and support was appropriate to meet people's needs.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

Warning notice