Care Quality Commission

Farmhouse Care Limited

Farmhouse

Inspection report

Farmhouse Residential Rest Home, Red Street,
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Ratings

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

Overall summary

We carried out this inspection on 9 October 2014. The inspection was unannounced.

Farmhouse Residential Rest Home provides personal care and accommodation for up to 23 older people, some of whom may have a dementia care need. The accommodation is provided in single bedrooms over two floors and has access to an outside garden area.

The service is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager left the service in January 2014 and had not been replaced. At the time of this inspection there was an interim manager in place who was a registered manager at one of the provider's other homes. The interim manager was supported by a deputy manager who had worked at the home for six weeks.

At our previous inspection on 8 May 2014 we found that the provider had not met three of the Regulations of the Health and Social Care Act. We asked the provider to make improvements to ensure that they respected and involved people who used the service. We also asked the provider to monitor the quality of service provision and

Summary of findings

ensure that people who used the service received safe quality care and support. We asked the provider to keep accurate records for each person so that people who used the service would be protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them.

We asked the provider to take action to make improvements in these areas. The provider sent us their action plan but this lacked clarity and detail of how improvements would be made and did not contain dates for completion.

We found that there were not enough suitably qualified staff on duty to supervise people and to keep people safe from harm. Some people had dementia care needs and other people had behaviour that challenged. Staff who worked at the home had not received adequate training in these areas to ensure that they had the skills to meet the needs of people who used the service.

People who were able to communicate with us said that they were generally satisfied with the care they received and that the staff were good with them. Representatives we spoke with had concerns about the care provided and said that their concerns had not been taken seriously by the provider.

People who used the service were at risk of harm. People who were at risk of falling sustained repeated falls and people were not always kept safe from each other. People who used the service did not always have enough to drink and were at risk of developing health problems.

People who used the service did not benefit from safe quality care. This was because the provider did not have an effective system in place to monitor and improve the quality of service provision.

The system in place to manage complaints was ineffective. Representatives of people who used the service felt that they were not listened to and concerns they had raised had not been addressed.

People who used the service did not always receive care and support in the way they preferred it. Individual preferences were not acknowledged. There was a high turnover of staff and people did not receive consistency of care and support.

Records of care were incomplete making it difficult to confirm if people had been given the right kind of care and support. Records of medication were incomplete meaning that we did not know whether some medications had been given as prescribed.

The Mental Capacity Act 2005 sets out those requirements that ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves. The provider did not have systems in place to gain and review consent from people who used the service, and act on them.

The staff who worked at the home did not receive adequate training, support and supervision and new staff did not undergo effective induction training. This meant that staff were not equipped with the right skills and experience to meet the needs of people using the service.

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 this 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.

Staff who worked at the home were not equipped with the knowledge, skills and understanding about how to help keep people safe.

People who used the service were at risk of harm because safe practices were not embedded in their care plans and risks to people were not managed appropriately.

People remained at risk of further harm because the provider had not always responded in a timely manner in relation to making safeguarding referrals.

Is the service effective?

Inadequate 

The service was not effective.

People who used the service did not always experience effective, safe and appropriate care and support.

The provider did not have systems in place to gain and review consent from people who used the service.

People who used the service were not supported by a staff team who had the knowledge and skills to meet their needs.

Is the service caring?

Requires Improvement 

The service was not consistently caring.

Staff took account of and promoted people's privacy and dignity.

People who used the service were not supported to express their views and were not actively involved in making decisions about their care.

People who used the service were unable to build positive relationships with staff as there was inconsistency of staff and manager of the home.

Is the service responsive?

Inadequate 

The service was not responsive.

People who used the service and/or their representatives did not have their concerns and complaints addressed by the provider. This was because there was no effective system in place to listen to people.

People who used the service did not receive individualised care and support that met their personal preferences.

People who used the service were not supported to follow their hobbies and interests.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was no registered manager in place and the provider could not demonstrate good management and leadership.

People who used the service did not benefit from safe quality care because there was no effective system in place to monitor the quality of service provision.

People who used the service were not protected against unsafe or inappropriate care and support arising from a lack of information about them. This was because the provider had not maintained accurate records about each person.

Farmhouse

Detailed findings

Background to this inspection

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

The inspection took place on 9 October 2014 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a person who has specialist knowledge of this type of care service.

Before the inspection we had received concerns about the quality of care received by the people who used the service. These concerns consisted of safeguarding referrals raised by professionals who visited the service and whistleblowing concerns raised anonymously by staff members. As a result of the number of concerns raised, the Local Authority Safeguarding Team had commenced a Large Scale Investigation (LSI) of the service. An LSI is organised by a Local Authority when a significant number of safeguarding concerns have been raised about a provider and there are significant concerns about the safety and welfare of people who used the service. We attended an LSI meeting on 15 August 2014 where information relating to the home was shared and discussed with relevant professionals.

We spoke with seven people who used the service and two visiting relatives. Following the inspection we spoke with two more relatives over the telephone. We spoke with six staff members including three care assistants, a kitchen assistant, a domestic assistant and the deputy manager. We looked at records of care and medication. We also looked at records relating to management of the home. These included quality monitoring records, records of complaints and compliments and records of notifications.

Following this inspection we shared information with the local authority safeguarding team about our findings.

Inadequate

Is the service safe?

Our findings

People who used the service were not always kept safe. A person who used the service was concerned about their own safety and welfare. They showed us their bruised finger and told us that another person who used the service had bent their finger over. The person said, "It really hurt when [person's name] did this I thought they had broken my finger." They said, "The girls [staff] weren't around at the time." They also said, "It's ok when one of the girls [staff] is here but they aren't always around and then I am scared." A visitor told us, "I have had to raise the alarm on three separate occasions when there were no staff around and I have seen residents hitting each other and other instances of residents falling." The Local Authority informed us about a number of safeguarding incidents where altercations between people had taken place. The provider had not taken appropriate action to ensure that the risks of altercations and incidents were reduced. This meant that these people who used the service were placed at risk of further harm.

There was no clear strategy in place to ensure that risks of falls were minimised for people who used the service. We saw records contained in people's care plans where they had sustained falls. There had been no review or update of their care plan in order to minimise the risk of people falling again and people had sustained further falls.

Relatives were concerned about the number of falls people were sustaining at the home. One relative said, "My [person's name] has fallen twice and I am not convinced that he is safe now, he is very wobbly." Another relative said, "My [person's name] had a fall whilst getting out of the bath and they had another fall before that. I don't think it is good enough." Safeguarding concerns had been raised because people had sustained repeated falls resulting in injuries and hospital visits and initial investigations had raised concerns that appropriate action had not been taken to reduce the risk of people falling again.

We saw a person who was very confused and agitated trying to stand up in the dining area. This person was taken to their bedroom, where shortly afterwards they sustained a fall. Staff confirmed that the person had fallen whilst trying to stand up. This person had sustained a previous fall and we saw in this person's care plan that they were at risk of falling. Their risk assessment had not been kept up to date. This placed the person at risk of further harm. We looked at care records for three other people who used the service and found that risk assessments in relation to their welfare and safety were out of date. This meant that their care plan was not current and the care and support they received may not be effective.

This was in breach of regulation 09 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.

We observed that another person who used the service had spilled a drink on the floor at lunchtime. A staff member cleaned the floor but left this wet and left the person unsupervised in the dining area. The person was mobile and was, according to their care plan, at risk of sustaining falls. The person started to get out of their dining chair to walk to an easy chair. We tried to find a staff member but had to intervene to prevent the person slipping over on the wet floor.

People who used the service were at risk of harm because not all staff were aware of how to recognise and report abuse. Two staff members we spoke with were unsure of the signs and types of abuse. A staff member said, "I have heard that this can happen but I am not really sure about what it is. I haven't had the training on it." The staff member in charge told us that they had received training in safeguarding but that none of the other staff had had this training yet.

The provider had not notified us about allegations of abuse and poor practice in a timely manner. Safeguarding referrals had been sent to us several weeks after incidents had occurred. The delay had meant that safeguarding procedures had not been followed and that people who used the service may have been placed at further risk of harm.

We were made aware of an incident which the provider should have referred as a safeguarding but had not done so. This was in relation to allegations of neglect of a person, where a staff member had allegedly refused to care for a person using the service. The staff member in charge told us that they were not sure that this constituted a safeguarding referral under the adult protection procedure. This meant that the provider had failed to safeguard this person and they may have been placed at further risk of harm. This was in breach of regulation 11 of the Health and

Inadequate

Is the service safe?

Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we had received concerns that some staff had been administering medication without having received the correct training. We spoke with a staff member who was administering medication. They confirmed that some staff had been administering medication without having received training but that they had now received this. The staff member told us that they now felt confident to safely handle and administer medication.

Some people who used the service were prescribed topical creams. These are creams which are applied to a person's skin. There was no system in place to record when these creams were administered. A staff member said that the signing of these was, 'A problem.' Also some of the medication administration record (MAR) charts had not been signed appropriately and there were gaps where signatures were missing. This meant that it could not be identified whether or not prescribed medications had been administered to the people using the service.

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

Inadequate

Is the service effective?

Our findings

Relatives of people who used the service were concerned about the lack of information they received from the provider. One person told us, "Information we get is really poor here." The person went on to tell us about their relative's condition and how staff members did not communicate information about this. They said, "Because not all staff are made aware of [person's name] condition, I don't think [person's name] receives the right kind of care."

Another relative said, "I have to give the staff updates about [person's name]. They didn't even know when they were on antibiotics. A visitor [relative] was distraught that no one had telephoned to inform them that their relative was so poorly. The relative was visibly upset and said, "I told them last night to ring me if [person's name] got worse and no one has called me. I am so angry." The relative said: "I am always worried when I leave here." The senior staff member apologised to them for not having informed them of their relative's condition. The staff member told us that there must have been a lack of communication about this. They said that they thought some staff did not share information very well.

We were able to ask some of the people who used the service if they thought that they were given enough information about their care. They thought that there was room for improvement. A person told us, "They [the staff] just get on with it; they don't really tell you much."

This is a breach of **Regulation 17** 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.

We looked at records of care relating to the above person and saw that these were partially completed. There were no records in place to demonstrate that staff had visited the person regularly to check on their condition. We also looked at records of care for other people who used the service and found that information about people's care and support needs was missing or partially completed. It was not possible to tell how much people had to eat and drink from the records we saw. These were incomplete with gaps where there was no recording to tell if people had been offered food and/or drinks. Assessments of people's nutritional needs had been partially completed but these had not been updated to reflect current information about the person's nutritional status and needs. This meant that we could not identify whether people's care and support needs had been met and that staff did not always respond effectively when people's needs changed. This is a breach of **Regulation 20** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

People who used the service were not supported by a competent staff team because staff had not been not adequately trained, supervised and supported in their role. Staff did not understand people's basic care needs. We observed drinks being served but we did not see staff spending time to assist people to drink when people were unable to do this for themselves. We met with a visiting professional who was concerned that a person who used the service had not had enough to drink to maintain their health needs. The professional was also concerned about the lack of staff knowledge and understanding of the need to ensure people had enough to drink.

Safeguarding referrals had identified that people who used the service had not always been supported to drink adequate amounts of fluids and this had led to people developing urine infections. One safeguarding investigation had recently identified that a person who used the service had been admitted to hospital seriously ill and suffering from dehydration.

A staff member said, "I have had some training but none recently." Another staff member told us, "We get training from time to time but this is mainly to do with things like manual handling and fire safety. I haven't had any training on nutrition." This meant that staff did not have essential knowledge of people's basic support needs and would not always know how to respond effectively when people's needs changed.

Staff had not received training to meet the needs of people with dementia. A number of people who used the service needed support to meet their dementia care needs. We saw people sitting in communal areas for long periods with little or no staff interaction and/or stimulation. There was a lack of awareness about how to provide stimulation for people with dementia needs. No adaptations had been made to the environment to meet the needs of people with dementia and when we spoke with staff about this they were not aware of what this meant. There had also been a number of repeated altercations between people with

Inadequate

Is the service effective?

dementia care needs where staff had not intervened to keep people safe. A staff member said, "I don't know why [person's name] does that. I don't know what to do to calm [person's name] down sometimes." Staff told us that they had not received dementia care training but would like to do this. A staff member said, "I haven't had dementia training and we do have quite a few people with dementia here so it would be really helpful to do this. I think this may be planned." Staff also confirmed that they had not received training on how to support people with complex needs and/or behaviour that challenges. This meant that staff were not supported to deliver care to people safely and to an appropriate standard. This was a breach of **Regulation 23** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

We asked about induction training for new staff. The person in charge was not aware of induction training taking place and we could not find any records that new staff received this. When we spoke with a new staff member they told us that they had not yet had any training for their job role but thought that this was planned. The provider did not have a learning and development plan in place for staff to ensure that they would be trained and supported to meet the needs of people who used the service.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA sets out the requirements that ensure decisions are made in people's best interest when they are unable to do this for themselves. DoLS are part of the Act, they aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

The provider did not have systems in place to gain and review consent from people who used the service. People who used the service told us that they were not routinely asked for their consent to care and treatment. A person who used the service said, "They don't really ask me about anything they just get on with it." A relative said, "[Person's name] is never asked to consent to anything as far as I am aware."

There was no protocol in place for gaining consent. We found no recording of consent to care and treatment contained in care plans and other documentation. There were no signatures to evidence that people had agreed to their care plans or that people had been consulted about their care. Reviews of care had not included the person and/or their representative and people told us that they were not asked if they would like to take part in reviews of their care plans. This was a 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.

We were made aware that the provider had made applications of DoLS in respect of two people using the service. The provider had recognised that these two people may be at risk of being restricted and had made the appropriate referrals under DoLS. We did not see any evidence of these people or other people being restricted or deprived their liberty.

People who used the service told us that they thought the quality of the meals served in the home was good. A person who used the service said, "The food here is very good and there is always a choice." We observed that lunch was taken in two dining areas and people were able to take their meals in their bedrooms if they wanted to. Another person told us, "I can choose what I want to eat and if I don't want what there is on the menu they will cook me something else."

Requires Improvement

Is the service caring?

Our findings

When we inspected the service in May 2014 we found that there was no evidence of how people who used the service and/or their representatives were involved in their care. We told the provider that they must improve to ensure that people who use the service are respected and involved in their care.

We found that the provider had not made the necessary improvements. People who used the service and/or their representatives did not feel involved in their care. A relative told us: "They have never once asked me how [person's name] prefers things done and what they like. I may as well be invisible." A person who used the service said, "I don't know about my care plan, they just get on with it. They don't really ask me." A relative said, "I am not at all involved in [person's name] care but I would like to be. The home is not very good with giving me information I have to keep asking all the time." There was no evidence contained in care plans that people were enabled to make, or participate in making decisions about their care and support. People who used the service told us that they were not asked for their views and opinions about their care or the service. This was a breach of **Regulation 17** 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.

People who were able to talk with us told us that they were treated with dignity and respect. One person said, "Oh all the girls are helpful and they are all very kind." Another person said, "The staff are always busy and don't have much time but they are kind. The new carer seems good." We observed that staff were kind and spoke to people with dignity and respect but staff were busy and rushed. This meant that staff did not spend much time listening to people.

A staff member told us, "There are some staff here who are very good and some who don't care and they need to change or leave. There had been a high staff turnover at the home over several months and an influx of new staff or agency staff. People who used the service had noticed the changes in staff and some people had found this unsettling. A person told us, "There are so many new faces here. I know some staff but not many and you never know who is on duty." This meant that it had been difficult for staff to get to know people who used the service and develop positive caring relationships with them. We observed that staff were mindful of people's privacy and dignity. Personal care was delivered in people's bedrooms and/or bathrooms. Doors were closed and staff were seen knocking and waiting for a reply before entering people's bedrooms. People who used the service were addressed by their preferred name and staff were friendly and caring in their manner.

Visitors told us that there were no restrictions on visiting times and that they could visit anytime. One person told us, "This is not a problem. It's good because I come at different times as I work shifts."

Inadequate

Is the service responsive?

Our findings

The provider did not routinely listen and learn from people's experiences to improve the quality of care. There had been no effective monitoring of concerns and complaints and representatives of people who used the service were not confident that their concerns would be addressed. A lot of people were unable to provide answers due to their dementia care needs so we spoke with family members. The relatives we spoke with told us it was difficult to raise concerns as they felt these were not taken seriously. A relative said, "I have spoken with staff about a particular problem time and time again and nothing gets done about it." Another relative felt that trying to obtain information from the staff about their relative was, "Like pulling teeth."

We met with a visitor who was visibly upset and distressed as she told us that the concerns she had raised had not been taken seriously. She said: "I have concerns about personal care not being done properly. There is a lack of communication between staff, and I am really concerned about their safety and welfare." The visitor said, "Nobody seems to take you seriously and act upon concerns. The care [person's name] receives depends on what staff there are on duty at the time." We spoke with two other relatives who told us that they felt that nobody listened to them and that nobody addressed concerns they had raised.

People who used the service did not always have the confidence to raise concerns about their care. People we spoke with felt able to speak with some of the staff but said that it depended on which staff were on duty. A person said, "There are a lot of new faces and I don't know some of them." A relative said, "Some staff will listen but others don't, it depends who is on duty."

We could not find any records to evidence that these complaints had been addressed by the provider and the staff member in charge could not locate these records. They said, "I have only been here for a few weeks and am not aware of these complaints." A relative said, "There was supposed to be a relative's meeting but this was cancelled and we were not told about it. I wouldn't have known if I hadn't asked. It's not good enough" This was a breach of **Regulation 19** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

People who used the service did not receive personalised care that was responsive to their needs. Care plans contained some information about personal preferences and choices but there was no clear evidence of how this care was embedded, implemented and delivered to the people who used the service on a daily basis. Only three life history's had been completed, which are integral for new and agency staff to understand the background to people. This also helps staff to communicate with people with a level of empathy, especially people with dementia care needs.

People who used the service were not supported to follow their personal interests or hobbies. A person who used the service said, "There's not much going on here. It gets a bit tedious." There were no records contained in care plans to show that people who used the service had been asked about their interests and hobbies or what they would like to do. A person said, "I would like to go out sometimes that would be nice. If I could get out into the garden I would but I can't get down the steep incline outside the patio doors." When we looked at this we saw that there was an area outside the French doors which was quite uneven for people to access the garden. Another person said, "I would like to go out more especially shopping." Staff did not encourage people to participate in activities and people were asleep in chairs or in their rooms and often in the communal areas with no supervision for long periods of time. There were no organised activities taking place on the day of the inspection and staff we spoke with were unsure what activities were carried out at the home. This was a 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.

Since our last inspection the provider had employed an activities person to work on a part time basis. This person was not working on the day of the inspection. The person in charge said, "There needs to be more things going on for the residents." They said there had not been any outings for people who used the service since they had started to work for the provider six weeks previously.

Inadequate

Is the service well-led?

Our findings

At the inspection on 8 May 2014 we told the provider that they must make improvements to ensure that people using the service benefitted from high quality care.

At this inspection we found that the provider had not made the required improvements we had highlighted in our previous inspection. There was no evidence that people who used the service and/ or their families were involved in their care or were actively involved in developing the service. Relatives we spoke with told us that they did not feel involved, included or informed in the care of people who used the service. One person said, "You are passed from pillar to post if you need to find anything out or talk about something." There was no evidence to demonstrate that people who used the service and/or their relatives were involved in their care planning or reviews of their care. The provider had not sought the views and opinions of people who used the service in order to bring about improvements to the care people received.

The provider was unable to demonstrate continual good management and leadership. Quality monitoring was in its infancy at the service and there was as yet no clear pathway as to how the provider intended to improve the standards of care. In their action plan they sent us following the previous inspection the provider had told us that they would "monitor the quality of service provision via quality audits, postal questionnaires, accident analysis, comments box and questionnaires for people who used the service." When we looked at the current system we found that a generic quality assurance system had been started with basic audits in place but this did not influence actual practice and had not brought about improvements within the service. This is a breach of **Regulation 10** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

There had been no registered manager in post at the home since January 2014. We had received concerns about the lack of management and leadership at the home and were aware that two managers had been recruited and appointed over the previous weeks but had not taken up the position. Staff told us they had not received guidance and support and had not received adequate training and supervision. This had led to inconsistency, unrest and low staff morale.

The provider did not have a system in place for monitoring records. The person in charge said that when they first came to work at the home they felt there was no organisation and no guidance. One of their current concerns was that staff did not, as a matter of course, document information about people who used the service and said staff needed to be constantly reminded to do this. The person in charge particularly acknowledged the poor quality of the daily records of care. Prior to the inspection we had been made aware of concerns about poor record keeping for people who used the service. We identified that accurate records had not been maintained for people who used the service in respect of care plans, daily care records, staff training, staff supervision and medication. The provider did not have clear procedures in place that were followed in practice, monitored and reviewed to ensure that records were accurate and up to date. This is a breach of **Regulation 20** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service could not be assured that they would be kept safe from harm and protected from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who used the service could not be assured that they would be safe and that their health and welfare needs would be met because staff had not received suitable training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks of receiving inappropriate or unsafe care. Risks were not assessed or managed to meet people's individual needs and ensure people's safety and welfare. Professional guidance was not consistently followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Suitable arrangements were not in place to ensure consent to care was gained in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation

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 9 HSCA (RA) Regulations 2014 Person-centred care People who used the service were not consistently enabled to make, or participate in making decisions relating to their care.
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered provider must operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use service and others were not protected against the risks associated with unsafe or unsuitable care and treatment by means of an effective system in place to regularly assess and monitor the quality of the services provided. People who use the service were not protected from the risks of receiving unsafe or inappropriate care because accurate and up to date records were not maintained.

The enforcement action we took:
We told the provider to make improvements to the above Regulation (previously Regulation 20 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) by 16 March 2015