Mulberry Manor Ltd

Mulberry Manor

Inspection report

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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**

Summary of findings

Overall summary

The inspection was unannounced, and took place on 11 August 2016. This was the home's first inspection under the legal entity of "Mulberry Manor Ltd." The location was previously operated by another provider within the same corporate structure, and was last inspected in January 2016. At that inspection concerns were identified in relation to staff training, staffing numbers and the way the provider audited the service. We also found on that occasion that the provider had failed to make several legally required notifications to the Care Quality Commission..

Mulberry Manor is a 49 bed nursing home, providing nursing and residential care to older adults with a range of support and care needs. At the time of the inspection there were 40 people living at the home.The home is divided into two discrete units, one being designated for residential care, and one for nursing care.

Mulberry Manor is located in Rotherham, South Yorkshire. It is in its own grounds in a quiet, residential area, but close to public transport links.

At the time of the inspection, the service did not have a registered manager. The previous manager had left their post around six weeks prior to the inspection. 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 and associated Regulations about how the service is run. A new manager had been appointed but they had not yet applied to register with the Commission.

We observed while most staff were kindly in their interactions with people, they often had to work in a task-based way, meaning that they did not always have the time to provide people with the informal support that they needed. On occasion we observed that staff failed to uphold people's dignity or treat them with respect. There were no arrangements in place to enable people to be involved in making decisions about their care.

Staff had received training in relation to safeguarding, although it was not clear whether this training had been effective as the provider had failed to recognise, or act appropriately upon, incidents of abuse or suspected abuse.

Medicines were not safely managed, and there was no evidence that staff who administered medicines had been assessed as competent to do so. Stocks of medicines did not tally with records, and where people required medication on an "as required" basis, there was little guidance for staff to follow.

Where people were at risk of malnutrition or dehydration, the provider had failed to take adequate steps to minimise these risks, putting people at risk of harm.

The arrangements in place for obtaining and acting in accordance with people's consent did not meet legal

requirements. There was little evidence of best interest arrangements being pursued where people lacked the capacity to consent, meaning that decisions were made for people without appropriate legal processes being followed.

Where people's needs changed, their care was not amended to reflect this. The provider had failed to identify people's needs, and care records were poorly kept and at times absent.

The arrangements in place for monitoring the quality of the service were not robust enough to identify or address shortfalls in service quality. Some aspects of the service were not monitored at the provider's own required frequency. The systems in place for improving the service people receive were inadequate.

The provider had failed to make several, legally required, notifcations to the Commission, and the lines of responsibility for doing this had been unclear for a period of time preceding the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

Staff had received training in relation to safeguarding, although it was not clear whether this training had been effective as the provider had failed to recognise, or act appropriately upon, incidents of abuse or suspected abuse.

Medicines were not safely managed, and there was no evidence that staff who administered medicines had been assessed as competent to do so.

Is the service effective?

Inadequate

The service was not effective.

Where people were at risk of malnutrition or dehydration, the provider had failed to take adequate steps to minimise these risks

The arrangements in place for obtaining and acting in accordance with people's consent did not meet legal requirements.

There was little evidence of best interest arrangements being pursued where people lacked the capacity to consent, meaning that decisions were made for people without appropriate legal processes being followed.

Is the service caring?

Requires Improvement

The service was not caring.

We observed while most staff were kindly in their interactions with people, they often had to work in a task- based way, meaning that they did not always have the time to provide people with the informal support that they needed.

On occasion we observed that staff failed to uphold people's dignity or treat them with respect. There were no arrangements in place to enable people to be involved in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

Where people's needs changed, their care was not amended to reflect this. The provider had failed to identify people's needs, and care records were poorly kept and at times absent.

Is the service well-led?

Inadequate

The service was not well led.

The arrangements in place for monitoring the quality of the service were not robust enough to identify or address shortfalls in service quality. Some aspects of the service were not monitored at the provider's own required frequency. The systems in place for improving the service people receive were inadequate.

The provider had failed to make several, legally required, notifications to the Commission.

Mulberry Manor

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 checked 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 was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit was carried out on 11 August 2016. The inspection was carried out by two adult social care inspectors.

During the inspection we spoke with staff, the home's manager, and a senior representative of the company. We spoke with people who were using the service to gain their views and experiences of receiving care at the home. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. We also spoke with the local authority to obtain their views about the home's performance.

Inadequate

Is the service safe?

Our findings

We asked two people who were using the service whether they felt safe at the home. One said, "yes of course" when we asked if they were safe. Another said: "It does feel safe here, I wouldn't move unless I had to."

During the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that on occasion people asked for help or assistance but were not attended to by staff. For example, one person was overheard to say to staff that they were "fed up" and "bored." Some staff stopped their tasks to talk to the person, but often there were no staff available to give reassurance. One staff member was observed to simply stand looking at the person without responding to their requests for help.

Another person was assessed as requiring what was referred to by staff as "line of sight" care, meaning that staff should always be able to see them. We observed regular occasions when there were no staff observing this person, meaning they were not receiving care in the way they had been assessed as requiring. One person was asleep in one of the lounges. We observed they were slumped forward in their chair for a period of fifteen minutes, until a staff member went to them and assisted them into an upright position. The staff member doing this said to the person that they were at risk of falling from the chair when they were slumped forward. It was not clear why the staff member had left the person in that position for fifteen minutes if they perceived it to be unsafe.

We checked six people's care plans to check whether there were systems in place to assess and manage risks that people may be vulnerable to or may present. One person's file showed that they perpetrated acts of violence. There was a risk assessment in place, however, it did not give any information about how staff could redirect the person to reduce the risk of harm. Another person's file had notes written in their moving and handling risk assessment which said: "Now has poor mobility and requires two staff." However, it did not set out how staff should support the person to reduce the risk of harm presented by poor mobility.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed a medication round to assess whether medicines were managed safely. The medication round had commenced when we arrived in that part of the home at 9:15am, and did not finish until midday. We saw one person receiving their medication 11.05 when it was prescribed for 8am. The staff member administering medication handled tablets with bare hands, which does not reflect good practice.

We looked at Medication Administration Records (MARs) to check whether people received their medication appropriately. We saw that where people were prescribed medication on an "as required" basis, often referred to as PRN, staff were not recording the time it was administered, meaning there was a risk that people could receive their medication with smaller gaps between dosages than recommended.

Many of the MAR charts we looked at had errors and omissions on them. Many had hand written entries which were not signed or witnessed. We noted errors with the amounts of medication received or administered, so it was not possible to determine whether people were receiving their medication as prescribed. For example, one person's records showed that 100 of their prescribed tablets had been received by the home, but records showed 104 tablets had been administered. The senior care worker who was administering medication could not find any in stock and nor had it been reordered as the system used had failed to identify that the person's medication had run out. It was also not clear where the additional four tablets had come from or whether another person's medication had been used. Another person's MAR chart showed that they had received 21 tablets, however, 28 had been received by the home and eight were in stock, meaning that they could not have been given their medication on one occasion when it had been signed as received.

We asked staff whether they had received assessments of their competency in administering medication. They told us the deputy manager had carried out competency assessments. However, when we spoke to the deputy manager they did not recall carrying out any assessments. We discussed this with the new manager and regional manager who could not find any written documentation of medication competency assessments.

We looked at people's care plans in relation to "as and when" medication. Their care plans included protocols for "as and when" medication, however, they did not contain adequate information. There was no information about the signs and symptoms people would show to indicate that the medication was needed, or what action to take should the medication appear to be ineffective.

Several people whose records we looked at were prescribed medication for constipation on an "as required" basis. In the records we looked at this medication was not given, and was always recorded as "not required" However, we found no records of when people had their bowels opened so was not clear why the medication was not required. Staff we spoke with could not tell us why it was not required, and said they believed people's bowel movements would be recorded in their care plans

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This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff we spoke with told us that they had received training in the safeguarding of vulnerable adults, and the provider's records confirmed this. However, the provider had failed to act correctly upon, or recognise, several incidents of abuse or suspected abuse. We looked at people's care records and found incidents where a person using the service had assaulted another. The provider had not reported this to either the local authority's safeguarding team or made the legally required notification to CQC. Other records showed that an agency worker's practice had put people at risk of harm. The provider was sufficiently concerned about the worker's practice that they stopped using them at the home. However, they had failed to notify CQC of the incidents of suspected abuse.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked whether staff had received training in moving and handling, to ensure whether they knew how to support people to mobilise safely. Records we checked showed that staff had received this training. Staff we spoke with confirmed they had received training in moving and handling. We observed staff undertaking moving and handling tasks, assisting people to move around the building or transfer from chairs to wheelchairs. This was done safely and staff had a good understanding of the techniques required to keep

people safe.

Recruitment procedures at the home had been designed to ensure that people were kept safe. All staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees. We checked a sample of four staff members' personnel files, and found that all appropriate pre-employment checks had been undertaken.

Inadequate

Is the service effective?

Our findings

We asked two people using the service about the quality of food they received at the home. They told us that the food was good, and that there was always a choice. One person said: "You never have to eat anything you don't want, there's always something good." Another commented that meals were often large and plentiful.

We looked at seven people's care records to check how they were cared for in relation to eating and drinking. One person's file stated that they were at high risk of dehydration and should drink at least 1.5 litres of fluid per day. Their hydration assessment documentation had not been completed since May 2016, so it was not clear how this risk was being managed, or whether it was being managed effectively. Another person's file showed that they were at high risk of malnutrition. There were notes in their file stating that they were on "first line treatment" for malnutrition, and that supplements, fortified food and snacks should be encouraged. Their food and fluid chart had not been completed for over 24 hours, so it was not possible to assess whether staff were managing the person's risk of malnutrition. A third person's records showed that they were underweight, with a body mass index of 18. However, there was no food or fluid monitoring records in their file, meaning that it was not possible for the provider to carry out an assessment of their nutrition.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We carried out an observation of a mealtime in the home. We observed that this was well managed and unhurried, and people appeared to enjoy the experience. Assistance was available for people when required

One person was observed to have some difficulty in eating independently, and we saw that this resulted in them becoming distressed and agitated. However, we saw that they did not welcome assistance from staff which also appeared to cause them agitation. We observed the person eating and identified that they would be able to eat independently, thereby reducing their agitation and distress, if a specific piece of equipment was used. We asked staff about this. They said that no assessment of this had been carried out and it had not occurred to them that this person's mealtimes could be improved with this adaptation.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us that staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and staff we spoke with confirmed this. 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. The

application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

CQC's own records showed that the provider had notified the Commission, as required, when an application to deprive someone of their liberty was made. People's care plans showed that these had been made when required. However, one person who was subject to a deprivation of their liberty had conditions attached to it that the provider was failing to comply with; their DoLS authorisation stated that the person should receive documented one to one support at all times. The home's deputy manager told us that this was not being provided as the body funding the person's care stated that the person did not require this level of support. The provider had failed to recognise that this meant they were depriving the person of their liberty in a way that they had not been authorised to do.

We checked six people's files in relation to decision making for people who are unable to give consent. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. People's care plans did not reflect appropriate decision making in accordance with the MCA. For example, one person's file showed that they lacked the mental capacity to consent to their care. There was a note in their file stating that the person's spouse had consented to staff opening the person's mail. This is not in accordance with the MCA as there was no evidence that a best interest decision had been reached. Another person's file contained mental capacity assessments which included details of decisions being made about their care and the way care should be provided. However, the only person contributing to the decision was the staff member carrying out the assessment. There was no evidence that steps had been taken to involve other people who knew the person well, as required by the MCA. A third person's file showed that they had bed rails on their bed, but there were no records to show this decision had been reached within the framework of a best interest decision. Some of the files we looked at had records of best interest decision making, however, these were pre-printed with a gap for staff to write the person's name in. The decision outcome had already been completed. This did not give assurances that the best interest decision making process had considered the person's individual preferences or wellbeing.

One person's records showed that they did not have the capacity to consent to their care. There was a note in their file stating that the GP had "authorised" the home to give the person some of their medication covertly. This practice can only be undertaken when agreed by a best interest decision. There was no evidence that a best interest decision, as defined by the MCA, had been reached. There was additional information in their file stating that the GP did not "authorise" that the person received their psychiatric medication covertly, and stated that the Community Mental Health Team should be involved in that decision. There were no records within their file indicating that this had been done, however, their medication records showed that they were receiving their psychiatric medication covertly.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with staff about training and communication within the home. They told us they had received appropriate training to do their jobs, although they said this was predominantly in the form of E-learning. Staff said they felt management communicated well with them, and said they felt that they understood what the home's aims and objectives were.

Requires Improvement

Is the service caring?

Our findings

We asked five people using the service about their experience of the care and support they received. Their responses were mostly positive. One person said: "I can't fault it." Another said: "There's plenty to pass my time, I like playing bingo." They told us everyone got on well together and said this was important to them. However, two people told us that they wanted to go out more. One said they had not left the home since moving in some months earlier. Another told us: "We don't go out. I'd like to. They said we might go out when the weather improves."

We carried out observations of staff interactions with people using the service throughout the inspection. We noted that the quality of interactions was varied. Most staff took time to speak with people and give assurances and support when required, however, this was not consistent. We observed a 45 minute period in one of the lounges. During most of this time there was one staff member present. Two people in the lounge presented as quite agitated and distressed, however, the staff member did not provide any intervention or support to them. One person asked the staff member several times what time lunch was, but the staff member did not respond. When other staff came into the lounge it was often to carry out care tasks, for example, accompanying someone into the lounge or supporting someone to leave. At times this meant that these staff also didn't respond to people's questions. There was a film playing on the TV in the lounge, although staff had not consulted people on what film to put on, and when it finished there was no further entertainment provided.

We observed that staff did not always uphold people's dignity or privacy. For example, we observed that one person spat onto a cushion. Staff attended and removed the cushion, but then loudly told another staff member, in front of other people using the service, what the person had done. One person was showing signs of distress and agitation, and in response one staff member said to another: "She's getting worse, she is worse than yesterday." This did not convey respect to the person, and was said in front of other people. We observed that one person was wearing a jumper that appeared to be stained with food or drink. We asked a staff member if the person's clothing was going to be changed, but they shrugged and said that they didn't know. The person's top was not changed during the course of the inspection.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at six people's care plans to check whether people had been involved in their care planning, and whether care was delivered in a person centred way. We did not see any evidence that people had been involved in formulating their care plans, and no evidence of use of an external advocate where people may have difficulty in contributing their views.

Inadequate

Is the service responsive?

Our findings

The home had a dedicated activities coordinator who appeared to know people's preferences well. They told us that they organised three trips out per year, and organised a singer to come to the home every week. There had been a recent fayre which was attended by local politicians and local authority staff as well as people's relatives and friends. The fayre was used to raise funds in order to improve activities at the home.

We checked care records belonging to seven people who were using the service at the time of the inspection. We found that care records lacked detail, and often key records were incomplete or blank. When people's care was reviewed, appropriate changes were not always made to their care plans. For example, one person's care records showed that they were experiencing significant weight loss, however, their review documentation stated that the person had a normal appetite and no action was required. This care plan had not been reviewed for five months, suggesting that the person's weight loss had not been recognised, and the care that was being provided to them did not suit a person whose weight had reduced. Another person showed signs of anxiety and was regularly seeking assurance. However, their care plan had no information about this, or guidance for staff about how to provide support to this person. One person's care plan stated that they were at the home on a respite basis, however, staff told us the person was now a permanent resident. Their care plan had not been updated to reflect this.

One care plan we looked at stated that the person needed to be supported by a one to one staff member. We observed that this was not the case and the person was not receiving care in this manner. We asked the deputy manager about this. They told us that the person no longer required care in a one to one capacity. We asked why their care plan had not been updated to accurately record what kind of care the person needed, but they told us they didn't know. The same person had an assessment in their file in relation to sleeping and night time support. This document stated that if the person didn't want to go to bed, then they had been assessed as being able to sleep on a recliner chair in the lounge. The assessment stated that this was to be considered "as a last resort." However, in the person's daily notes we saw that they had slept in their chair "for observations" which indicated it was for staff convenience and not as a last resort. Another person's file contained information in relation to how they should be supported at night time. There was no reference in this document to staff carrying out positional changes during the night. However, in their bedroom there was a record of staff undertaking two-hourly positional changes. It was unclear who had made the assessment that the person needed to receive positional changes, or why staff were carrying this out when it wasn't in the person's care plan.

One person we met presented as frustrated due to the difficulties they had in communicating. There was no information in their care plan about the use of communication aids or how staff should communicate with the person to reduce their frustration. We asked staff if the person had been referred to an external healthcare professional to assist with their communication difficulties, but this need had not been recognised by the provider and therefore such action had not been taken.

We looked at daily notes and recording charts and found that records were not always kept of the care people received. Two people's notes we looked at were blank in relation to the personal care that the

people concerned had received the preceding day. Another person's had not been completed for the preceding three days.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was information about how to make complaints available in the communal area of the home, and people we spoke with told us they would feel confident in making a complaint should they feel the need to. One complaint had been received by the provider since registering at this location. We saw that it had been responded to in a timely manner, although we did not see that the proposed action arising from the complaint had been implemented

Inadequate

Is the service well-led?

Our findings

The home's registered manager had left their post some weeks prior to the inspection, and a new manager had been appointed. The new manager had been in post for two weeks at the time of the inspection, and described that they were in the process of identifying which aspects of the home's operations required improvements.

A programme of team meetings, supervision and appraisal had commenced. Staff told us that they felt supported by the new manager, and said that communication within the home was good. We looked at a sample of team meeting minutes, however, it was not clear that the meetings were effective. For example, in one recent team meeting, staff were reminded to ensure that care records were accurately completed, but we found that this was still not being done to an adequate standard. In another meeting, staff had raised concerns about the lack of disposable gloves at the home, however, senior management responded that the home used more gloves than other homes of the same size and therefore the supplies were appropriate. This meant there was a risk that people would not receive care in a safe manner.

We looked at the provider's arrangements for auditing and monitoring the quality of service provided, however, we found it was not fit for purpose. A senior manager attended during part of the inspection, and told us they undertook a formal, monthly assessment of the home. We looked at records for recent assessments and found that they had identified some of the concerns in the home, but this had not resulted in change or improvements. The assessment which was undertaken a month before the inspection rated the home as "Inadequate" and identified that care planning was poor and the arrangements for obtaining and acting in accordance with people's consent were ineffective. However, at the time of the inspection this remained the case, so the assessment had not functioned as a trigger for improvements. There was an action plan attached to the assessment, which recorded that the required work in relation to consent was completed. This was clearly not the case as the inspection identified consent arrangements did not meet the standards required by law.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We reviewed information provided by the local authority, which set out how many incidents of abuse or suspected abuse the provider had reported to the local authority safeguarding team. This showed that there had been several incidents which the provider had failed to notify CQC about, which it is legally required to do. We spoke with the deputy manager about this, who had been responsible for making such notifications once the previous manager had left. They told us that they didn't know about this, and thought that the regional manager would do it. The regional manager told us that such notifications had been the responsibility of the deputy manager, but that they would be making them from now on. We advised them that retrospective notifications needed to be made, however, the provider has failed to do this.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009

Some of the safeguarding alerts submitted to the local authority concerned a person using the service who left the building unaccompanied at night, putting themselves at risk of harm. We asked the home's manager and regional manager if there were any issues that increased the ability for the person to leave the building at night. They described how they suspected person left the building, and identified a possible weak point in the building's security which had enabled it to happen. However, despite this risk being suspected by the management team, no action had been taken to address it. This meant that the provider had failed to act on information it held to mitigate the risks to people using the service.

We looked at the quality audits carried out by members of the management team, which monitored various aspects of the home's performance. However, we found that they were not always completed at the provider's required frequency. The kitchen audit was completed regularly, but the tissue viability audit should be carried out monthly, but had not been completed for two months, and monthly audit of care plans had not been undertaken for three months.

An audit of medication was completed frequently, however, it had failed to identify or address areas of concern. For example, the audits of May, June and August 2016 all identified a specific shortfall, but no action had been taken to address this. The audits of August and May 2016 identified missing medication, but did not record what, if any, action was taken to address this. Nor was there any evidence of action being taken to reduce the risk of recurrence. This meant that the provider did not have effective systems in place to learn from untoward incidents to improve the service in future.

This is a breach of 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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide care and treatment in a manner that met people's needs or had regard to their wellbeing. Regulation 9(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. Regulation 10(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place to ensure it acted in accordance with people's consent. Nor did it act appropriately when people lacked the capacity to give consent to their care or treatment. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not take sufficient steps to ensure the care it provided was delivered in a safe way. Medicines were not managed safely. Regulation 12(1)(2)9a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not take appropriate steps to ensure people using the service were protected from abuse or the risk of abuse. Regulation 13(1)(2)(3)