Caromar Care Limited

Lane End House

Inspection report

Lane End Drive
Emsworth
Hampshire
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Date of inspection visit: 17 November 2014
Date of publication: 30/04/2015

Ratings

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

Overall summary

This inspection was unannounced and took place on the 17 November 2014. Lane End House can accommodate up to 22 older people with a variety of long term conditions, including those living with dementia and physical disabilities. On the day of our inspection 18 people were living at the home.

The home has a registered manager. 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. In this home the registered manager is also the registered person.

The home was previously inspected on 10 February 2014 where we found non-compliance. At this time three warning notices were served for outcomes which related to care and welfare, infection control and quality assurance. Compliance actions were also made in relation to outcomes relating to safety and suitability of premises and staffing.

Summary of findings

On 8 May 2014 we carried out an inspection to check if the provider was compliant with the warning notice regarding infection control. We found the provider was compliant with the warning notice.

On 17 June 2014 we conducted a further inspection to check if the provider was compliant with the two warning notices and two compliance actions. We found the provider was compliant with the two warning notices and one compliance action. The outcome relating to care and welfare remained non compliant and we deemed this had a moderate impact on people. We received an action plan from the provider stating they would be compliant by 14 July 2014.

When we inspected on 17 November 2014, we found that risk assessments were not in place to prevent and protect people from injury and harm. The storage of medication was safe but risk assessments were not in place to ensure people received their medication when they needed it, including pain relief.

We found care plans did not have sufficient detail to ensure staff had enough information to know and meet people's needs. Activities were provided but these were not based on people's choices. People made little comment about the meals. Records maintained made it difficult to establish how much a person had eaten and drank.

Where people lacked the mental capacity to make decisions the home was not guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. People's independence was not always promoted and people were not involved in decisions regarding their care.

Staff understood the homes policies on safeguarding. The local authority confirmed the manager worked in co-operation with them when investigating safeguarding concerns. We found the provider did not have effective systems in place to ensure the quality of the service provided was good and incidents were learnt from. The premises were clean and tidy but had not been adapted to meet the needs of older people with cognitive impairments.

Appropriate recruitment checks had been undertaken on staff. We have made a recommendation that the registered manager records staff member's qualifications.

The home has a small staff team with some staff consistently working long hours. Staffing levels were not always adequate to meet the needs of people. Staff received a range of training which they found useful.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Due to the level of concerns we served a notice of proposal to vary a condition of the provider's registration and restrict admissions to the service. The provider did not submit representations and we served a notice of decision, which the provider did not appeal against. The notice of decision came into effect on 24 March 2015.

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. Risk assessments were not in place to ensure people were protected from the risks of injury.

Staff were aware of safeguarding procedures, however not all incidents had been reported appropriately.

Appropriate arrangements were not in place for obtaining medication and ensuring people received the appropriate pain relief medication.

There was not enough staff to ensure the needs of people could be met at all times. Staffing recruitment procedures were being followed but information about qualifications was not always recorded.

Is the service effective?

Requires Improvement 

The service was not effective. Management and staff did not show a good understanding of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)

Records of food and fluid intake were not accurate or fully completed.

The environment of the home had not been adapted to meet the needs of people living in the home.

People's health needs were reviewed and people had access to a range of health professionals.

Is the service caring?

Requires Improvement 

Staff were not consistently caring.

We saw staff approaching people in a kind and caring manner on some occasions.

People were treated respectfully and in ways which promoted their dignity, however interactions were usually task orientated.

People's choices were not always well supported.

Is the service responsive?

Requires Improvement 

The service was not responsive. Care plans were not written with the involvement of people and did not contain sufficient information to allow staff to deliver care in a personalised way.

Activities were provided but these were not based on individual choice and had not been planned with people.

Summary of findings

The complaints procedure was displayed around the home and we were told no complaints had been made.

Is the service well-led?

Inadequate

The service was not well led and did not have an open culture.

The home has had a high turnover of staff, and the reasons for this had not been investigated. This has made it difficult for people to receive consistent care.

There was a lack of meaningful auditing to ensure the quality of the service met people's needs. The recording of accidents and incidents was not robust and there was no analysis to ensure lessons were learnt to prevent further incidents or accidents.

Lane End House

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.

This inspection took place on 17 November 2014 and was unannounced.

The inspection team was made up of one inspector and a specialist advisor who had specialist knowledge in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection, we examined previous inspection reports, action plans from the provider, safeguarding meeting minutes, and other information we had received, along with notifications. A notification is information about important events which the provider is required to tell us about by law.

Following the inspection we requested information from health and social care professionals and GP's who visit the home. We also spoke with the fire officer about some outstanding fire requirements.

During the inspection we spent time talking to ten people, one visitor, three members of staff, and the registered manager. We looked at the staffing records of two members of staff and records of service quality audits. We looked at the 17 questionnaires people had completed regarding the food, and fifteen from family members. Seven people's care records were also reviewed as were meetings staff had with people discussing the home.

We 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 observed interactions between people and staff.

Inadequate

Is the service safe?

Our findings

One person who required little support with their physical needs told us they felt safe in the home. They felt supported to live their life in a way which pleased them and they felt safe doing this. There were systems in place to ensure when they left the home staff knew of their whereabouts and what time they would be home.

Overall however, people's safety was at risk. Some people had injuries that had not been recorded, reported or investigated appropriately. In one person's records an incident had been recorded differently in two places making it difficult to know which report was accurate. For example, in daily notes an incident was reported in one way. The same incident had been reported very differently in the person's care plan. Records in other people's care plans included reference to cuts, self-inflicted scratches, pressure injury, skin flaps, bruising and carpet burns. This information had not been incorporated into care plans, and risk assessments had not been undertaken to prevent further instances where people may be at risk of injury or self-harm. There were no measurements provided or photographs of these injuries. Injuries had not been investigated appropriately and therefore may have been repeated. These injuries had not been reported to the local safeguarding team. As a consequence people's safety was at risk.

The provider was working co-operatively with the local authority safeguarding team. Staff had received training on safeguarding and knew what action they would take if they had any concerns regarding people's safety. The provider had a policy on safeguarding which included appropriate information and contact details of who to inform of any concerns. However this was not always followed by staff or the manager as details of recent safeguarding concerns and investigations had not been recorded. Staff on duty had no concerns about the way people were treated in the home

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some aspects of medicines management were appropriate and met guidance, but there were others that were unsafe. During lunchtime we observed medicines being administered. The storage of the medicines in the cabinet was secure. The process for managing controlled medicines was found to be correct and the amount in stock corresponded with the controlled records book. The Medicine Administration Charts (MAR's) were organised and up to date. Seven people had been prescribed paracetamol on an 'as required' basis. Two people had been prescribed other pain relief medication. Pain assessments had been carried out. People had been prescribed pain relief products but there were no care plans for staff to identify when a person had pain or if any pain was increasing, and therefore in need of increased pain relief medication. One person had been prescribed pain relief medication but this prescription had not been provided by the day of our visit, which was seven days after the previous medication was stopped. Records showed the district nurse had advised that pain relief should be used before the person's legs were dressed. Appropriate arrangements were therefore not in place for obtaining the appropriate pain relief medicines and people were at risk of not receiving care that met their needs.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels were inadequate. Eight staff, one domestic staff and one cook were employed. There was a high turnover of staff, which has meant a lack of consistency for people receiving care. The registered manager worked in the home covering sleep-in night duties. The home used one agency worker. The registered manager was recruiting more staff and showed us application forms from applicants. The four week duty rota given to us recorded two staff were working continuously long hours. One member of staff worked 60 hours in each of the four weeks. Another member of staff worked 60 hours as well as doing 1 sleep in duty for three continuous weeks. On one week they had worked 60 hours and two sleep in duties. The duty rota recorded the registered manager and one care worker were not on the duty rota for the day of our inspection. However they were both in the home during our inspection, providing care to people.

Despite these increased staffing levels on the day of our inspection, people did not receive care in a timely manner. One person told us about their experience on the morning of our visit: "I have been banging on the door for an hour, I wanted to get out but couldn't, I think they do it on purpose". The person was referring to being in their bedroom. When asked about the incident a staff member

Inadequate

Is the service safe?

was dismissive about the claim. Another person who was waiting for support to get dressed in the morning said, "It is frustrating having to wait, I have been told to read my paper. Some days I have to wait until 11 O'clock". At night from 8:00pm until 8:00am the home had only one waking member of staff on duty and one sleep in member of staff on duty.

Staffing levels were not sufficient to meet people's needs and this constituted a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our inspection, records showed staff had appropriate recruitment checks before working in the home. We did note the application form did not include a space to record the person's qualifications and this had not been recorded anywhere else. This demonstrated the provider was not ensuring staff had the appropriate qualifications to carry on their role.

We recommend the provider follows the guidance detailed in Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities Regulations 2010)

Requires Improvement

Is the service effective?

Our findings

People made few comments about the food and their preferred choices. One person had been given a different breakfast which they had enjoyed as they were sick of flakes.

Staff had received training on the Mental Capacity 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Staff lacked knowledge in how to apply their MCA and DoLS training when working with people. Decisions which potentially restricted people's movement were made without the appropriate authorisation, or without taking into account people's wishes or abilities. People's care plans contained little information regarding assessing and detailing people's capacity to make decisions. In four people's care records we saw standard statements in relation to consent but these did not take into account the person's ability to make these decisions. Care plans made reference to people's mental state and included comments such as "mild vascular dementia". However these statements had not been considered when planning the person's care. No consideration or assessment had been given as to whether people had capacity to make decisions regarding consenting to their care. Appropriate notifications had been received by us with regards to one person going missing from the home on two occasions. The person was still at risk of leaving the home as their care plan made reference to carrying out 15 minutes checks. However, there was no evidence of a capacity assessment or best interests meeting having taken place. We found there had been no consideration as to whether a DoLS application should have been made.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had received training in a variety of areas which included first aid, safeguarding, moving and handling, fire awareness and infection control. The training had included a trainer going into the home and providing face to face training. Staff had found this very beneficial. Two new staff were working through the Common Induction Standard workbooks. These are the standards employees working in adult social care need to meet before they can safely work unsupervised. New staff found the manager supportive and approachable and were receiving formal support in supervision sessions.

People were at risk of not receiving appropriate hydration and nutrition according to their individual needs. The fluid charts showed each person had a fluid intake target of 2000ml. This was printed next to the title of the form. There was no adjustment for an individual's weight or their health or an assessment of why this was the total. Records showed only one person missed the 2000ml target every day. However, some of the recorded amounts were not robust as they were large and were the same rounded off figure. Records of nutrition were poor. In one care plan the following was recorded, "SALT re swallow. Pureed diet." (SALT refers to a speech and language therapist). There was no further information. The nutritional intake was recorded three times a day as "100%". There was no indication on any person's record about what was offered and how much had been offered. It was not possible to monitor an individual's nutritional intake. A member of the SALT team told us staff and the registered manager had little understanding of the eating and drinking needs of people. They felt people were put on puree diets if they did not finish their meals as it was seen as an easier way to get them to finish their food, and there was great emphasis on residents finishing their meals. One member of staff and the registered manager talked about ensuring people ate adequate food. They explained "Some people say they do not want any more, we have to encourage them as they have dementia and they do not know if they are hungry". However, no capacity assessment or consideration of a

Requires Improvement

Is the service effective?

best interest decision had been completed or considered. There was no assessment or care plan to consider that the person at times may not want to eat their meal.

The premises had not been adapted to meet the needs of people with cognitive impairment such as those living with dementia. The home did not provide an enriching or stimulating environment for people. The home had a lounge area and one dining area, together with a conservatory, which was too cold to sit in at the time of our visit. People sat around the outside of the room, some alongside the television and some facing it. The layout of the room meant staff had to walk through the lounge in front of people to get to other rooms. This obscured the view of people watching the television. The layout of the lounge meant people sat near the three exit doors. People had walking aids, which meant the gaps to get out of the doors was limited. On one occasion one person leaving the lounge got their walking aid entwined with another person's walking aid who was sat by the door. Insufficient consideration had been given to how the environment could be adapted to best meet the needs of people. For example, in the identification of rooms such as toilets, there were no pictures/symbols on the door or contrasting colours to help people locate them.

People had contact with GPs, podiatrists, health and social care professionals, opticians, hearing aid specialists, speech and language specialists and district nurses. Two health and social care managers told us they have had regular contact with the home. They informed us that the registered manager would consider any improvements they suggested, but that he was not proactive at making changes until they were pointed out.

Requires Improvement

Is the service caring?

Our findings

One person found the staff helpful and kind. One frequent visitor was pleased with the care their friend had received. They felt their friend had improved since coming in to the home and the staff offered good support to them.

People were not always supported in a caring manner. Staff did approach people in a well-meaning and friendly way which was kind and caring. This was demonstrated through staff sitting alongside people and speaking with them. However, contact was brief and nearly always task orientated. For example, staff sitting and feeding people at the dining table. The staff smiled at people and spoke with them in respectful ways but terms such as "love", "darling", "sweetie" was commonly used in place of people's names. People's care plans had no information to show that these terms of endearment were their preferred form of address. At tea time, one person sat at the dining table, rose and wandered on several occasions. A staff member on two occasions told the person, "Go and sit down". They did not check where the person wanted to go. One person was asleep in the lounge at tea time. Staff made no attempt to wake the person and said the person would not eat their tea if they were woken up. This information was not recorded in their care plan. When this person woke up there was no staff present. The person said to us, "Don't let them hurt me". The person was unable to tell us what this information related to. One person called for their son and was asking to go home. A staff member said, "I'll phone your son and let him know". There was no record made about this by the end of our visit, four hours later. This demonstrated that staff were not always caring or knowledgeable about how to care for people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was little evidence people were involved in decisions about how the home was run. People did not appear to understand what we meant when we asked them if they had a care plan or had been involved in the planning of their care. Care plans gave no indication people or their relatives had been involved in their development. Care and support was not individualised and people's independence was not prioritised. It was not possible to establish if people's recorded choices were supported.

Minutes of a residents meeting held in September 2014 did not give any detail of the previous meeting or any actions which may have been needed to be followed up. Fourteen people had attended and the minutes recorded the topics covered at the meeting. The minutes did not include any comments from people; they just listed the various topics that had been talked about.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to individual requirements. Assessments and care plans were not tailored to individuals and did not include details on how each person's specific needs should be met. Care plans did not have sufficient detail to ensure people received the care and support they required. People had not been involved with the planning of their care. Local authority staff told us they had found people's care plans to be very similar and not focussed on the person as an individual. This meant people were at risk of receiving care and treatment that was not personalised to their individual needs.

Three care plans recorded that people were being treated for a urinary tract infection (UTI) but there was no plan of care to ensure the person's comfort or to prevent a recurrence of a further UTI. For one person the care plan made reference to the person being partially sighted in both eyes and the person having a diagnosis of dementia. There was no care plan for sight impairment or dementia. The notes for this person recorded they had three separate incidents of bruising. The care plan recorded "Staff to monitor bruising daily". These incidents were not transferred to the person's care plan and there was no explanation of how the bruising had happened or how staff should try and prevent further bruising from happening. We saw where people had behaviour that may be considered challenging the "Cognitive Improvement Care Plan" stated, "Staff are required to monitor X in the light of challenging behaviour. X will scratch and push staff away" The plans did not provide staff with the information they needed to meet the person's needs. There was no exploration of why and when a person expressed behaviour which challenged. There was no guidance for staff on how they should care for people when they expressed behaviour which challenged.

One person was sat in the lounge for long periods, where they repeatedly called out for reassurance. There was no care plan about how staff should provide care and support which would comfort the person in these situations. There was no specific behaviour support plan and the only record made relating to the person's behaviour related to the person causing other people discomfort by frequently calling out. Staff had not received appropriate guidance on how best to support the person when they became distressed.

There were few records of how meaningful activities were provided to people. During the morning and in the afternoon a staff member spoke to some people in the lounge area. They said "We are going to play some ball now". People said they did not want to so the staff member said "We are going to play some quiz now". The quiz was a children's game and involved guessing what the offspring of certain animals are called. The questions included a Tiger's child is called 'a cub'. For the most part the staff member had their back to the other people sitting in the lounge, who were therefore excluded. Some people's leisure time activities were identified but it was not possible to establish these had taken place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The provider had a complaints policy. Details of the complaint procedures were displayed in the home, and gave details of the relevant contact details if anyone wished to complain. The registered manager told us he had not received any complaints or concerns from people or their relatives. No complaints were recorded in the complaints log. The home had a comments box in the entrance hallway where people could leave comments anonymously.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post who was also the registered provider. The duty rota showed they spent considerable time in the home and worked regular sleep-in duties. In the two weeks prior to the inspection and the week of the inspection they had worked six sleep-in duties each week.

The service had recently been the subject of safeguarding concerns of a similar nature to previously reported concerns which related to institutional abuse. This demonstrated the provider was not learning from events that were happening.

Care and support practices at the home were not reviewed. Whistleblowing information and concerns raised with the local authority demonstrated the provider did not have an open culture where concerns could be discussed. Whilst concerns have been raised with us from a number of sources the provider told us they have not received any complaints or concerns.

Records had not been audited. The registered manager confirmed they had not been aware of all the incidents and injuries to people. The home did not have an incident book so injuries had not been recorded. The home had an accident book but these did not record all the incidents of bruising, skin flaps and falls recorded in people's records. The lack of consistent recording in the accident book meant it did not give an accurate picture. The recordings in the accident book had not been audited to see if there could be any learning from them. The lack of systematic auditing in these areas meant people remained at risk of having further accidents, which may have been prevented. The registered manager had not shown good leadership skills by not picking up this information and ensuring the home was well led.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People were not supported to exercise their choices during the night. No audits had been carried out to assess the needs of people at night. The registered manager said this had not been raised as a problem by night workers. When looking at one person's notes at night we noted they required support to change their continence pad twice during the night consistently over a two week period. We did not know how many other people required this support at night as this was not recorded in people's care plans and there was no clear recording or analysis to look at this area of care. The provider had no systems in place to determine the needs of people at night to ensure their needs could be met.

15 questionnaires had been completed by family members or representatives of people living in the home. These were mainly 'yes' or 'no' answer question which asked about staff, comfort, food, choices and bedrooms. We saw that all questionnaires were positive from family members. 17 people who lived in the home had returned surveys. These only referred to food. There was no reference to any other aspect of their care. The registered manager seemed unsure about this and told us he was planning on including more aspects of care in future questionnaires. When we asked people about the quality of the home, for example about food, they were reluctant to speak to us. A group of people agreed it was best not to say too much, but they did agree it depended who the cook was.

Minutes of staff meetings were not available, but the home had a small staff team, which changed on a regular basis. Two members of staff on duty were both new to working in a care home. Both felt supported in their role and had received regular supervision sessions, which they found supportive and helpful. Staff were unsure of the values of the home, but held their own values on how they would treat people with kindness and respect. The home has had a high turnover of staff. The provider was not sure what the reasons were and had not carried out exit interviews with staff to establish what the reasons might be.

A range of weekly and monthly checks and audits took place, which included medication, food hygiene, health and safety and infection control. These demonstrated the manager undertook some aspects of the responsibilities of the running of the home.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 (1) (a) (b) (3) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse. People did not have relevant risk assessments to ensure they were protected from harm.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and Welfare People did not have assessment to identify when they were in pain and how staff would be able to establish if people's pain was increasing. Regulation 9 (1) (a) (b) (i) (ii) People did not have care plans to address areas of identified need. Staff did therefore not have guidance on how to meet the needs of people. Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines.

This section is primarily information for the provider

Enforcement actions

The provider must obtain medication and ensure people receive this on time. Regulation 13

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have adequate quality assurances in place to assess and monitor the quality of the service provided. The provider did not have systems in place to ensure there could be learning from incidents in the home. This was a breach of Regulation 10 (1) (a) (b) (2) (c) (i)

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not made suitable arrangements to ensure the independence and choices of people was promoted and that people were involved in decisions regarding their care.

This was a breach of Regulation 17 (1) (a) (b) (2) (ii)

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.

Regulated activity	Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not made suitable arrangements to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff.

The enforcement action we took:
We have issued a Notice of Decision to restrict admissions to the home.