Mrs Jackie Mitchell

The Coppice

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 10 November 2014 and was unannounced.

There were no breaches of legal requirements at the last inspection in March 2014.

The service provides residential care for up to three older people. People are cared for in the provider's home, which is a bungalow and there is an adjoining annexe flat which provides accommodation for one person.

The registered provider manages the service. 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 provider told us she aimed to run the service as a small family home and as such, considered the regulations did not fully apply to the service. As a result, we found there were breaches in many of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Summary of findings

People were not safeguarded from abuse and avoidable harm and there were no comprehensive individual risk assessments in place to ensure people's safety.

We did not see that the provider demonstrated kindness or compassion when providing care to people and there was no evidence of caring relationships that we found from our inspection findings.

People did not receive effective care and their quality of life was compromised because their individual needs were not assessed or planned for. We did not find evidence to support that the provider sought people's consent for the care and support they received and similarly there was no evidence people contributed to decisions about their care.

People did not have the appropriate equipment to support their needs, such as for moving and handling them safely and in accordance with good practice guidelines.

Staffing levels were not sufficient to manage people's needs. For example, two physically dependant people needed two staff to assist them to be moved safely, yet we saw only the provider on duty. Adults providing care were not sufficiently vetted or trained to ensure they were suitable to do so.

There were no systems in place to assess and monitor the quality of the provision. We found the provider was not honest in her responses to our inspection enquiries and this gave us concern about her suitability to provide a service for vulnerable people.

We referred our concerns to the local authority safeguarding team and the local authority commissioners.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not supported to make choices or safeguarded against harm and risks were not appropriately managed. Staffing levels were not sufficient to enable people to receive appropriate support. Medicines prescribed for people were not stored, handled or administered correctly, compromising people's health.

Inadequate

Is the service effective?
The service was not effective.

People were not given choices in the way they lived their lives and their consent was not sought in line with legislation and guidance. The provider lacked understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not assessed and the provider was not proactive in ensuring people had access to healthcare services.

Inadequate

Is the service caring?
The service was not caring.

Interaction between the provider and the people who lived in The Coppice was not caring and people were not treated with dignity, respect or compassion. People were not supported to express their views and we observed the provider made decisions on their behalf.

Inadequate

Is the service responsive?
The service was not responsive.

People did not receive the care they needed and there were no care plans in place that reflected how people would like to be supported. Assessments were not carried out or people's needs regularly reviewed. Care was not centred on each person as an individual and people were not encouraged to express their views.

Inadequate

Is the service well-led?
The service was not well led.

The management of the service was not open, honest and transparent.

The provider did not demonstrate in observations and our conversations that they understood the principles of delivery of high quality; care. As a result, people did not receive care of sufficient quality.

Inadequate

The Coppice

Detailed findings

Background to this inspection

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

This inspection took place on 10 November 2014 and was unannounced.

The inspection was carried out by two inspectors. We reviewed information that we held about the service before the inspection. We had received information of concern from the local authority and a 'share your experience' form submitted to the Care Quality Commission. This is a form in which people who use services or their representatives can provide feedback to us about the quality of their care. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with all three people who used the service and we were able to contact two out of three relatives by telephone following our visit. For the relative we were unable to contact, we left answerphone messages and asked the provider to pass the lead inspector's contact details should they wish to comment on their family member's care. We spoke with the provider, who also managed the service and directly provided care. We observed how people were cared for, inspected the premises and reviewed all available care records for each person. We also reviewed all the available documentation to show how the service was run.

The provider was the only member of staff on duty. We contacted the provider's volunteer member of staff following the inspection as they were unable to be present on the day of our visit.

Is the service safe?

Our findings

People were not protected from abuse and avoidable harm. We saw a lack of dignity and respect for people living in The Coppice and the provider lacked understanding of how to ensure people were safeguarded. There was no safeguarding procedure in place and there were no effective processes to ensure people were suitably protected from abuse. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 11 Safeguarding.

We were shown around the home by the provider. We met one person who we were told was living with dementia. We observed that the provider spoke in a disrespectful manner to this person; she addressed the person by touching their face and saying “hello is there any one at home?” The provider did not wait for any verbal response and left the room. We found this person was able to communicate verbally when we spoke with them, although they needed time and patience to consider and respond to what was said. We found the provider’s behaviour was not supportive of the person’s psychological well-being. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 17, Respecting and involving service users.

Risks to individuals had not been fully assessed to ensure people’s safety. For example, the provider told us one person was at risk of falls. Whilst this information was briefly noted on their care record, there was no clear plan in place as to how this risk was managed. In this person’s room there was a rug with a curled edge that may have caused a trip hazard. There was no plan in place to prevent falls or how the person should summon help should a fall occur.

The annexe, which was a self-contained flat attached to the bungalow, had a front and back door, four rooms and a narrow hallway none of which were centrally heated. There was an unguarded gas fire which was providing heat for the lounge on the day of our inspection. We noted boxes of matches on top of the fridge freezer in the kitchen and asked the person if they could light or control the fire. They told us they could not do either and they were dependent upon the provider and/or the provider’s partner to light the fire. Asked what they would do in the event of a problem with a fire they told us they were mobile and could go into the house and ask for help. However, when we asked them how they would call for help if they were incapacitated in anyway, they told us “I don’t know”. There was no evidence the person had been involved in discussions about their safety.

We asked the person to accompany us whilst we inspected (with their permission) the rooms they occupied. There was a television on the bedside cabinet positioned at some distance from the bed on the left-hand side. When we asked how they watched the television whilst in bed. We were told it was broken and never used. On the other side of the bed there was a cabinet with a light and a clock radio again positioned at some distance from the bed. When asked how they reached the light and radio from their bed, we were told they didn't and that they didn't know if the light even worked. We found them both unplugged and dusty but in working order. We saw if any item was plugged in, the drawer at the bottom of the wardrobe could not be opened and this was used to store medical supplies. We found no evidence of risk assessments in place concerning the premises to ensure people’s safety.

We found the person’s bedroom, bathroom and kitchen were very cold. The windows in the bedroom and bathroom were open and the back door had keys on the outside and was often left open during the day of our inspection. We attempted to close windows and found the bedroom window could not be fully locked. The provider told us the person preferred to be cold. Although we saw the person was warmly dressed, they told us sometimes they felt too cold. The provider had not assessed the risk to the person’s health of the premises being cold.

We saw one person was moved in a wheelchair with no footrests. When we asked about the lack of foot rests on the wheelchair the provider told us this was the person’s own wheelchair which was brought by their family. We saw the person was not moved safely in their wheelchair. For example, the provider attempted to push the person in the chair forward without asking the person to lift their feet. We were concerned this may cause injury to the person and when we challenged this we were told that it was not a problem. The person was then wheeled backwards. On another occasion we saw the person wheeled forward but with the chair tipped slightly backwards to elevate their feet. This compromised the person’s safety and is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 16, Safety, availability and suitability of equipment.

Is the service safe?

There were no risk assessments for the premises or comprehensive risk assessments for individual people's care. Accessibility to the annexe was restrictive for people with limited mobility. For example, the driveway had a gravelled surface making it difficult to push a wheel chair to the rear of the bungalow. The steps to right side of the bungalow were in disrepair; the main steps up to the front door were steep and unsuitable for people who used a wheel chair or a walking aid. The door steps were steep and the main kitchen floor uneven. We found bleach and toxic cleaning fluid left in both bathrooms, with no risk assessment to say this was safe practice for the people who lived there. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 15 Safety and suitability of premises.

Staffing levels were not sufficient to meet the needs of the three people who lived in the home. For example, two of the people were in wheelchairs and the provider stated they needed assistance to move as they were unable to walk. We saw the provider worked alone during our inspection and did not attempt to move either of these people; therefore they stayed in their chairs. The provider told us when she needed assistance she called for her volunteer who could come at short notice. However, the volunteer was not available to come during our inspection. This meant people did not have the staffing levels required to meet their needs as the provider would be unable to assist people to move if they needed to, such as for help with their toileting needs or repositioning. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 22 Staffing.

The provider's husband was present during some of the inspection. The provider told us he sometimes took one person on outings. However, we knew from information given to us by the local authority he had no current Disclosure and Barring Service (DBS) check or any relevant training to be able to support people safely. The provider said her husband would not be having any such checks or training and the person he supported was also a family friend. The provider also told us she had a member of cleaning staff who had not been suitably vetted. Training records for the provider and the volunteer staff showed mandatory training in areas, such as moving and handling, safeguarding and the Mental Capacity Act (MCA) had not been completed. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 21 Requirements relating to workers.

We found systems in place for managing people's medication were inadequate. Medicines were not handled, stored or administered correctly or safely and this potentially compromised people's safety and health. We asked the provider if any of the three people required medication. The provider told us nobody received medication. We asked the provider what she would do if a person had any pain. She told us she would be able to 'get them some Paracetamol if they needed it' but reiterated nobody needed any medication. However, upon our inspection of the annexe we found large quantities of medication for one person stored inappropriately in the drum of the washing machine, amongst some items to be washed. In this person's bedroom within a plastic carrier bag, amongst some items of shopping, we found more supplies of their medication. The person confirmed to us the shopping was not theirs, but the provider's. The person was unable to say what medication they took, or where this was stored, but said the provider gave them 'two tablets' every day.

Some of the medication we found was dated March 2014 and the packets contained tablets that had not been given to the person. This gave us cause for concern that the person may not have received their medication when they needed it. We discussed this with the provider and asked why she had said no one was on any medication. The provider told us it had 'slipped their mind'. When asked why the medication was in the washing machine and a carrier bag, the provider told us she did not know why she had put it there, but had been in the process of preparing the person's medicines when we arrived.

We asked the provider to show us how she prepared the person's medicines. She showed us three small dishes and placed these in an unlocked kitchen drawer. She told us she had seven ramekins and she put tablets in these for each day of the week. There was no indication which medicines were used or which days of the week they were given, or if they were given at all. The provider told us she did not keep a record of medicines given to this person and she was unable to evidence they had been given their medication appropriately. We saw a prescription for the person that showed they should receive daily medication. We referred our concerns to the local authority safeguarding adults team immediately following the inspection. The provider also confirmed that neither she nor the volunteer member of staff had done any training in the safe handling of medicines. We were informed during a

Is the service safe?

telephone conversation following the inspection by the relative of another person in the home, their family member was supposed to be on medication. However, the provider did not inform us of this and there was no evidence to show the person was in receipt of any medication. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 13, Management of medicines.

We found people were not sufficiently protected by the prevention and control of infection. We saw the main part of the premises was visibly clean and free from odours. In the annexe, the provider told us, and we saw daily records to the effect that the person cleaned their own room and tidied up. However on another occasion, the provider said they cleaned everyone's rooms. We were told by the person that they did not clean anything themselves and that either the provider or a person 'wearing a white smock' cleaned their rooms. There was a heavily stained and discoloured dishcloth hanging over the tap in the kitchen of the annexe.

We saw evidence of poor hand hygiene facilities. There was a bottle of sanitising gel in the bathroom but not in the annexe. There was hand wash and paper towels on a roll in the annexe kitchen but not in the main house kitchen or bathroom where we saw cotton hand towels were in use. There were no suitable bins lined for the disposal of clinical waste and people in the main house did not have did not have individual hygiene products. The shower head was dirty and the connecter to the stand was broken.

The outer bedding on all the beds looked well-presented. For example, clean and dressed with small cushions. However, underneath there were no sheets. We found both beds of the two people in the main house were covered with a thin, almost threadbare, mattress cover, which were both soiled. They were then covered with a small plastic backed protector sheet spread lengthwise. The outer bedding of the person who lived in the annexe was also superficially well presented. However their mattress was covered with plastic and the plastic sheet spread again lengthwise. The person told us they "did not know why it was like that" as they had no need of a plastic sheet.. We discussed this with the provider who agreed to make sure people had appropriately clean bedding

Inadequate

Is the service effective?

Our findings

We found the provider lacked the skills and knowledge to ensure people received effective care and had a good quality of life. For example, the provider demonstrated a lack of insight into the needs of those living with dementia and there were no plans in place for any further training to support people's needs.

There were no systems in place to support the one volunteer in their work, such as through supervision meetings. The provider told us supervision would be done if there were more staff working more hours, but as the home was small this was not necessary. Training for the provider and the volunteer was inadequate to meet people's needs and there was no clear development plan to update their knowledge and skills.

We saw the delivery of people's care was prescriptive and decided upon by the provider, with limited opportunity given to people to make choices and be consulted. When asked about this, the provider told us 'they have dementia, they can't make choices, they would forget within seconds of being asked." This showed a lack of understanding of people's needs and rights.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider had no understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards (DoLS) and no training had been done in relation to this legislation. There was no evidence people's mental capacity had been assessed. Consent was not sought at any time during our visit but was assumed. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 18, Consent to care and treatment

The provider told us she provided home cooked foods for people and she said she knew what their preferences were. We did not see people involved in decisions about what they ate and drank. We were told by the provider that they used their lounge-dining room for parties and that everyone ate in the kitchen. However the person who lived in the annexe said they never ate in the kitchen.

On the day we visited we saw one person at the kitchen table being helped to eat their lunch. Lunch was served to the person in the annexe at 11.30 am. It was a large bowl of coloured cooked pasta and a glass of non-alcoholic lager. The person did not know what was for pudding. We asked the person if they could choose what to eat and we had seen in their care plan said they could ask for food when they needed it. They told us they never knew what was for lunch and ate anything they were given by the provider or their partner who normally brought their food and drinks. We saw another person was served lunch in their room. None of the people ate together and the meal time we observed was not a social occasion.

The provider told us that the person in the annexe used the kitchen to make themselves cups of tea. We saw jars marked tea and sugar were empty and there were no available teaspoons. The jar marked coffee had a small amount of solidified coffee granules in the bottom. The person told us that the provider's partner used the kitchen to prepare food. We saw the provider had prepared the dogs food in a bowl on the draining board.

There was no record of a nutritional assessment available for any of the people living at the home. No weights were recorded although some people were very thin and there was a scale in the bathroom in the main house. We saw an entry in the district nursing record for one person that said when asked about the person's weight they were told by the provider that 'since the person's clothes still fitted they knew the person had not lost weight'.

We also saw a record of emergency nurse call outs on 4 and 26 October and 6 November 2014 for medical attention for one person. The nurse advised that the provider ensured the person was given additional fluids. There was no evidence of any nutritional records. We saw no evidence that this person was receiving extra fluids. For example there was no water jug on their table or drink within their reach.

One person we saw wore glasses. We asked when they had last seen an optician but they could not recall when. We saw that this was not recorded in the care plan. Records showed this person was seen regularly by a District Nurse from the rapid response team who was called to provide medical treatment and monitored the person's pressure areas. The person told us they had not recently been taken to a GP or for a hospital appointment and the provider confirmed they had not had any recent medical review. The

Inadequate

Is the service effective?

provider explained this was because the GP expected her to take people to the surgery to be seen, when she felt the GP should make a house call. This meant people may not have their day to day health needs or access to healthcare services when needed.

Inadequate

Is the service caring?

Our findings

People were not respected or treated with dignity, kindness or compassion. The provider often spoke disrespectfully in front of people often referring to them as 'they'. Care that we saw given was focused on the task rather than the person. The provider and their partner did not knock before entering any rooms, which did not show respect for people's privacy and dignity. Doors remained open during personal care and we observed that people were without personal hygiene and grooming effects.

We saw no evidence of any caring relationship between the provider and the people in the home. For example, when we were shown in to the annexe and introduced to the person there was no sign of warmth or affection between them. Interactions we observed between people and the provider were brusque and minimal.

People's rooms, cupboards and drawers contained items of the clothing and personal items that belonged to the home owners. In the annexe we saw plastic bags in the corner containing children's toys. The person told us the bags of toys did not belong to them but to the provider and the provider confirmed these were personal shopping items stored in here for safekeeping.

We saw people had limited personal possessions. For example, one person owned one drawing, one photograph, one picture, some clothes and one pair of shoes in the wardrobe. There were no individual personal grooming or washing items for the people who were said to be in the home for respite and day care.

We saw people spoken with abruptly and handled roughly, without kindness or compassion. For example, we saw a person being taken to the bathroom by the provider for a wash of their hands and face. The process was rushed and consent for this intervention was assumed rather than sought. We saw they washed the persons face in a rough way and then grabbed their right hand roughly and proceeded to wipe it. The provider then put the cloth in to a bucket of fluid that smelt like bleach and which was kept on the floor of the bathroom.

We saw that the person was in distress from this intervention but we observed that the provider did not make any attempt to reassure the person or change their approach. They then left suddenly without drying the person. We followed and asked for the person's towel to dry them and were told to take any 'one from those in the bathroom'. We saw that the person had no personal effects for washing or grooming.

Whilst we dried the person's face and hand and spoke to them about how they felt the response was "what have I done wrong?" The provider then suddenly appeared again and hurriedly removed the person from the bathroom saying she was taking them to the lounge as they liked to watch television, asking "don't you?" to the person who did not reply. The person was quickly taken to the lounge which had a comfortable settee and chairs. However, they were left to sit in their wheelchair facing the television. It was switched on to a channel chosen by the provider who asked "you like to watch television don't you?", but there was no response from the person.

When we asked, one person told us they were looked after 'very well' by the provider. They told us they thought the provider's partner was 'all right'. They told us the provider and partner 'were business people who had not caused them any trouble and they 'don't want to give them trouble'.

The provider told us one person's relatives visited approximately four times a month. The person told us their relatives did not visit unannounced as we had done but contacted the provider to make arrangements before they came. The person told us they had no means of contacting their relatives should they wish to speak with them.

Is the service responsive?

Our findings

We did not see evidence of personalised care that was responsive to people's needs. People's care needs had not been adequately assessed or care planned and delivered in accordance with their individual needs. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 9, Care and welfare.

For the three people we saw during our visit, only one person had a completed care record and this lacked detail and was not informative enough for someone to understand what care had been delivered. One person had scant records that again, lacked detail. One person had no documentation to show how or whether their needs had been assessed. The provider told us one person came for day care only. However, we saw evidence the person's bed had been slept in. We spoke with the person's relative following the inspection and they confirmed the person was resident at The Coppice and had not had day care there for several years.

Hobbies were recorded for one person but there were no plans of how they were supported to undertake them and they told us that they did not. There were statements in one person's personal history that said they read books, but when asked there were no books in the room and the person said they had never been taken to the library. There was also a statement that said they read the newspaper but none were seen in their room and they told us they did not get a newspaper delivered. They said they spent most of the day watching television. The person told us they liked to sketch but there were not any drawing items in the room. They said they used to enjoy going to art classes but did not attend them now.

We saw daily records for this person were inconsistently completed with large gaps in the information. For example, in April 2014 there were no entries between 21 and 29 August 2014, there were only entries from 14 to 29 September 2014 then nothing recorded until 12 October 2014. These daily records were scant, such as 'out for the day' and 'hairdresser' and often conflicted with the person's understanding. For example, it was recorded on the 21 of October that they had a small party with food, whereas the person could not recall ever having a party or celebration at the home. The daily entry on the 3 November said 'tidy up room' and on the 8 November the entry was '[person] cleaned [their] room, yet the person had told us the provider or others did this. The provider told us this person would not be able to give reliable information due to them having short term memory loss; however, there was nothing in the person's records about their memory or mental capacity.

People's care and support did not promote their social and emotional needs. We saw although there were three people being cared for, they did not come into contact with one another and there was little in the way of social interaction. For example, one person who lived in the annexe told us they never came into the main house, although the provider told us this was because they preferred their own company. One person we saw was seated in their wheelchair throughout the inspection and another person was seated in their chair in front of the television.

Where care plans were in place, these were inadequate as they contained little or no personal information or any information about how individual care needs should be met. There was no evidence that people or their families had been consulted or involved in the planning of people's care.

The provider stated there had been no complaints about the care she delivered and all families were happy with the care of their relatives. The provider said feedback from families was obtained informally and verbally, and not specifically requested to improve the quality of the provision.

Inadequate

Is the service well-led?

Our findings

There were no systems in place to assure the delivery of high quality person centred care. We had been given false and conflicting information throughout our visit. in relation to our key lines of enquiry about people's care, medication and staffing. The provider expressed an unwillingness to meet the legal obligations and requirements of registration, in spite of being aware there were multiple breaches of the regulations.

The provider lacked insight into her roles and responsibilities in providing an adult social care service. Although she acknowledged the framework for inspection had changed, the provider told us she has provided this care for over 20 years with no concerns raised; therefore there was no need to drive improvement. She stated her facilities were small and family based, therefore did not feel the regulations should apply. For example, there were no systems or processes for auditing and monitoring the quality of the service provision. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 10, Assessing and monitoring the quality of service provision.

There was limited documentation to evidence the quality of the care provided and any documentation seen was tokenistic and sparse. Monthly reviews noted in the one completed care plan did not consistently record any useful information. We saw one entry had no date or signature whilst another had the date overwritten. Policies and procedures were not comprehensive, contained the briefest of information and were not reviewed or dated. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 20, Records.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Insufficient numbers of staff to safeguard the health safety and welfare of service users in the home A lack of suitably skilled and qualified staff to carry out the care in the home

The enforcement action we took:
Notice of proposal to cancel registration

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 Lack of effective processes to ensure that people are protected from risk of abuse by means of taking reasonable steps to identify the possibility of abuse before it arises and responding effectively to any allegations of abuse

The enforcement action we took:
Notice of proposal to cancel registration

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 providers Evidence of a lack of effective systems in place to identify, assess and manage risk relating to the health and welfare of service users

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 Inadequate assessment, planning and delivery of care which does not meet the individual service user's needs and ensure the safety and welfare of the service users

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Poor practices in relation to ensuring the dignity, privacy and independence of service users Poor practices in treating residents with dignity and respect Poor practice in relation to the involvement and empowerment of residents within their care

The enforcement action we took:
Notice of proposal to cancel registration

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 Lack of any system or process in place to address issues in relation to obtaining consent from residents for the care and treatment received and acting in accordance with the resident's wishes. In particular the service has no awareness of its legal duty to comply with the Mental Capacity Act 2005

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Lack of effective recruitment procedures in place to ensure the safe recruitment of staff

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Lack of suitable arrangements in place to ensure that staff employed at the home are adequately supported in relation to their responsibilities to enable them to deliver effective care to service users safely and to an appropriate standard

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Lack of systems and processes in place to ensure that residents are protected from the risks associated with the unsafe use and management of medicines including poor recording practices, handling, using, safe keeping, dispensing, safe administration and disposal of medicines

The enforcement action we took:
Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Residents were not protected against the risks of unsafe or inappropriate care and treatment because there was a

This section is primarily information for the provider

Enforcement actions

lack of proper information recorded about them by means of maintenance of an accurate record documented for each resident in relation to their care and treatment provided

The enforcement action we took:
Notification of Proposal to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA 2008 (Regulated Activities) Regulation 2010 Requirements where the service provider is an individual or partnership A lack of assurance that the registered service provider is fit to carry on the service in respect of concerns in relation to possessing the necessary qualifications, skills and experience to discharge responsibilities in this role

The enforcement action we took:
Notification of Proposal to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises There was no assurance that appropriate measures were taken to maintain the premises to ensure people's safety in relation to access to the premises and surrounding grounds

The enforcement action we took:
Notification of Proposal to cancel the registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Equipment used was not adequately maintained or used safely. People did not have access to equipment they needed to support their care.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Notification of Proposal to cancel the registration