Laburnum House Limited

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Inspection report

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Bury
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Ratings

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

Overall summary

This unannounced inspection took place over two days on 3 and 4 December 2014. There were 11 people using the service at the time of this inspection.

Laburnum House provides personal care and accommodation for up to 13 people who are recovering from a mental illness. The home is a detached property with a small garden area and is situated in a residential area close to Bury town centre.

The home had a manager registered with the Care Quality Commission (CQC) who was not present on the day of the inspection. A registered manager is a person who has registered with CQC 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.

At our previous inspection on 24 September 2014 the provider was not meeting the requirements of the law. This was in relation to the safety and suitability of the building, supporting workers and assessing and monitoring the quality of the service provided. Following the inspection we required the provider to send us an action plan to tell us what improvements they were going to make. The provider failed to send us an action plan.

Summary of findings

During this inspection we looked to see what improvements had been made and if the Warning Notice, served on the 28 October 2014 following the September 2014 inspection, had been met. We also looked at other areas of the service to check the provider was meeting the regulations.

The Warning Notice was served because the provider had failed to have regard to the professional and expert advice given to them in respect of fire safety within the home. During this inspection we found the Warning Notice had been complied with.

We found that although the staff understood what care and support people required there were not enough staff available at all times to ensure people's needs were met.

People were not protected against the risk of unsafe or inappropriate care because care records were not updated, did not reflect people's needs and failed to show how identified risks were to be managed.

We found that people were not always cared for in a dignified way. Some people looked unkempt and were wearing creased ill-fitting clothing.

There was no encouragement or support for people to undertake activities either inside or outside of the home. No activities were provided to help promote people's well- being.

Inspection of the training plan showed that staff did not receive the necessary training to enable them to have the skills to do their job properly and care for people safely and effectively.

We found the management of medicines was unsafe and did not protect people who used the service. The provider had failed to keep medicines secure. This meant people were able to access the unsecured medicines and this placed their health and safety at risk of harm.

We found that food stocks were minimal and people were not provided with a choice of suitable and nutritious food to ensure their health and well-being were protected. People we spoke with told us they felt they had enough to eat but they would sometimes like something different.

We asked to see the recruitment files of staff who had been employed by the provider since our last inspection of 24 September 2014. We were told that one new staff member had been employed but that the recruitment file could not be found. Records of recruitment must be available to show that people employed by the provider are of good character, fit to do their job and are suitable to work with vulnerable people.

We looked around all areas of the home and found several areas of the home were in a poor state of repair. Carpets were stained, furniture was damaged, wallpaper was ripped, there were problems with some aspects of the plumbing and the home was cold. This affected the well-being of the people who used the service.

The staff we spoke with were not able to demonstrate their understanding of the requirements of the Deprivation of Liberty Safeguards (DoLS). They were also not aware of the procedure to follow in the event of a person being deprived of their liberty. This could result in people being deprived of their liberty in an unlawful way.

There were no systems in place to assess and monitor the quality of the service provided to ensure people received safe and effective care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what enforcement action we have taken at the back of the full version of this report.

During this inspection we found that people were supported by kind and patient staff. The people we spoke with told us they liked the staff. They told us the staff were understanding and they felt safe with them.

The staff we spoke with were able to demonstrate their understanding of the whistle blowing procedures and they knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

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. There were not enough staff available at all times to meet people's needs and to care for them safely.

The management of medicines was unsafe and the health and safety of people who used the service was not protected.

Records of recruitment were not available to show that people employed by the provider were of good character, fit to do their job and were suitable to work with vulnerable people. This helps to protect the health and safety of the people who use the service.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive appropriate training or supervision from senior staff to enable them to care for people effectively and safely.

The home was not adequately heated and maintained and this affected the well-being of people who used the service.

Food stocks were minimal and people were not provided with a choice of nutritious and suitable food to ensure their health care needs were met.

Staff were unaware of how to respond to the requirements of the Mental Capacity Act 2005 and of the arrangements that needed to be in place to ensure that people were deprived of their liberty in a lawful way.

Is the service caring?

Requires Improvement

The service was not always caring. Although people who used the service spoke positively of the staff's kindness we found that people were not always cared for in a dignified way.

Staff showed they had a good understanding of the needs of the people they were supporting.

Is the service responsive?

Inadequate

The service was not responsive. People were not protected against the risk of unsafe or inappropriate care because care records were not updated, did not reflect people's needs and failed to show how identified risks were to be managed.

There was no encouragement or support for people to undertake activities either inside or outside of the home. No activities were provided to help promote people's well-being.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. There was no quality assurance system in place to assess and monitor the quality of the service provided to ensure people received safe and effective care.

There was no system in place for reviewing and analysing accidents and incidents to enable staff to look at ways of possibly reducing the risk of a reoccurrence.

The provider failed to notify the Care Quality Commission, as required by law, of serious incidents that resulted in police involvement.

Laburnum House Limited

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 3 and 4 December 2014 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before this inspection we reviewed previous inspection reports and notifications that we had received from the service. As this inspection was undertaken at short notice we were not able to request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We spoke with a staff member from the local commissioning team and also spoke with the local authority quality monitoring officer. We used the information we had to help plan our inspection.

During this inspection we spoke with five people who used the service, one relative, three care staff, the cook, the deputy manager and a person acting on behalf of the provider who told us they were the project manager. We did this to gain their views of the service provided. We looked around all areas of the home, looked at how staff cared for and supported people, looked at three people's care records, nine medicine records, staff training records and records about the management of the home.

Inadequate

Is the service safe?

Our findings

The service was not safe. There were not enough staff available at all times to meet people's needs. The duty rosters we looked at for the previous week and the week of the inspection showed that every day between 17:00 to 08:00 hours, there was one staff member on duty to care for and support the eleven people living in the home. Staff told us there had only been one staff member on duty between these hours for several weeks. From our observations and from information received from the staff, the one person on duty was, apart from caring duties, responsible for undertaking domestic and kitchen tasks.

The care records of one person identified they needed two people to assist with most aspects of their care. Staff we spoke with confirmed that two staff were required to care for the person safely. We were told the person became extremely agitated when staff attempted to attend to the person's dressing, bathing and toileting needs and sometimes the person placed themselves on the floor when they were agitated. The care record showed that, to reduce the person's agitation, two staff were needed to attend to their personal care. When there was only one staff member on duty staff told us they were not able to undertake personal care tasks. Staff told us they had to wait for another staff member to come on at the shift change before personal care could be undertaken. This resulted in the person who used the service being left for several hours before they were taken to the toilet or taken to bed. This was despite the recommendations of a continence nurse advisor who informed the staff that the person should be taken to the toilet at least every four hours. Failing to attend to the person's toileting needs placed their health and welfare at risk of harm and did not protect their dignity.

Staff told us there were not enough care staff to meet the needs of some of the other people living at the home. We observed throughout the day that there were tensions between some people at the home and their behaviour at times was challenging. We saw that staff were not always available to supervise and intervene when tensions escalated and this placed people at risk of harm from each other.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient staff were not provided at all times to ensure people's needs were met. This placed the health, welfare and safety of people who used the service at risk of harm.

We looked to see how the medication system was managed. We checked the systems for the receipt, storage, administration and disposal of medicines. As there was no designated medicine room the medicines for the majority of people were kept in individual locked boxes in the staff office. The boxes were securely fixed to the wall.

We checked the medication administration records (MARs) of nine people who used the service. Inspection of two MARs showed the prescriptions were for medicines that were to be given 'as required'. Information was not available to guide staff as to when they may need to administer the medicine. It was also identified from the two MARs that the 'as required' medicines were to be given as a 'variable dose' of one or two tablets. We saw that information was not available to guide staff when they had to administer medicines that had been prescribed in this way. People were placed at risk of not having the correct amount of medicines when they needed them.

We saw twenty containers of medicines awaiting return to pharmacy were left in an unlocked box in the staff office. Although the office was locked when there was nobody using it, throughout the day we saw people who used the service staff members and visitors enter the office. This meant they were accessible to people who entered the office. Failing to keep medicines secure placed the health and welfare of people at risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems for the management of medicines were unsafe and did not protect people who used the service.

We asked to see the recruitment files of staff who had been employed by the provider since our last inspection of 24 September 2014. We were told that one new staff member had been employed but that the recruitment file could not be found. We spoke with the new staff member who told us they had been employed via a recruitment agency and that

Inadequate

Is the service safe?

a criminal records check and references had been undertaken by the home before they started their employment. During both days of the inspection we were told by the project manager that the staff recruitment file was not available. The manager could therefore not demonstrate to us that they had undertaken the right checks before employing this person.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment records must be available to show that people employed by the provider are of good character and fit to do their job. This helps to protect the health and safety of the people who use the service.

The Greater Manchester Fire and Rescue Service had expressed their concerns during a visit to the home on 21 May 2014 about the lack of fire training. A fire risk assessment undertaken on 24 June 2014 by an external contractor who had previous experience within the fire service documented that management needed to ensure that staff who worked alone were fully trained and capable of handling a fire emergency. During our inspection of 24 September 2014 we found the provider had failed to have regard to the professional and expert advice given to them in respect of fire safety within the home. A Warning Notice, dated 28 October 2014 was served on the provider by the Care Quality Commission (CQC) and the provider was required to assess and manage the risk in relation to fire safety and to comply with the Warning Notice by 14 November 2014. During this inspection we found that all staff had been trained in fire prevention and evacuation procedures by the 14 November 2014 and the Warning Notice had been complied with.

We looked at what plans were in place in the event of an emergency. Instructions for staff were in place with regards to fire safety, a loss of gas supply, electricity and water. Instructions were also in place in relation to failure of the central heating system.

We saw that policies and procedures were in place to guide staff in the safeguarding of adults. Records showed that staff training had been provided in this area for all the staff. During the second day of our inspection we saw an external trainer was in the home and was providing updated training in the safeguarding of adults. We spoke with two care staff and asked them to tell us what they would do if an allegation of abuse was made to them or if they suspected that abuse had occurred. What we were told confirmed they understood what action would need to be taken.

Is the service effective?

Our findings

The service was not effective. The staff we spoke with told us they did not receive any formal supervision from senior staff to discuss their progress or identify any learning and development needs they might have. They told us they supported each other.

Inspection of the training plan showed that not all staff had received the essential training necessary to enable them to do their job properly and care for people safely. Initial or updated training was needed for some staff members in relation to infection control, moving and handling, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with told us they had not received training in how to deal with behaviour that was challenging. Staff told us this was worrying for them as there had been recent incidents of aggressive behaviour that were directed at the staff and at people who used the service. Training specific to the needs of the people who use the service needs to be undertaken so that staff have the knowledge and skills needed to safely support and protect people.

This was a further breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The health, safety and welfare of people who used the service was not protected because staff did not receive appropriate training to enable them to care for people effectively and safely.

We looked around all areas of the home and found that several areas of the home were in a poor state of repair. The upstairs landing and stair carpet were badly stained, water was leaking from a hand wash sink in a shower room and there was no hot water available from the sink in a downstairs bathroom. In one of the downstairs lounges wall paper was ripped in places, the laminate floor was lifting and a settee and chair were damaged. One of the people who used the service was distressed about the condition of the home. We were told, “The house is a disgrace. They have put no money into this house, they just patch it up. I don’t expect Buckingham Palace but this is not good enough. I am sick of hearing their promises.” We were also told, “I am very upset about the condition of this home; they can’t look after it. I am very house proud and am used to better things.” Other comments made included, “It needs doing but I appreciate I have a roof over my head. This is my home. There are homeless people on the streets” and “They could do it up bit by bit.”

We found the home felt extremely cold and we were told by staff that at certain times throughout the day the heating system was switched off. The outside temperature was two degrees centigrade and the central heating throughout the home was not switched on. People told us they were cold and we saw two people were wearing their coats to keep warm. One person told us, “I am cold. They turn the heating off. It’s on a timer.” We requested that staff turn on the heating system immediately to ensure that people were kept warm and comfortable. Staff told us they did not know how to turn the heating on so we requested that the maintenance person be required to attend. By the end of the inspection day the heating was turned on.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home was not adequately heated and maintained and this affected the well-being of people who used the service.

We looked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. We looked at the dried, frozen and fresh food stocks and saw they were very low. There was no fresh fruit available and the only fresh vegetables in stock were potatoes. There were four frozen fish pieces in the freezer, three bags of frozen vegetables and two pastry desserts. The fridge contained a piece of cheese, five pints of milk, three opened jars of potted paste, a jar of jam and a jar of marmalade. The dried food stocks consisted of bread and one tin of beans. The food in stock could not furnish what was on the lunchtime menu that day so an alternative meal of jacket potato with cheese and beans was provided.

We were told by staff they shopped at the local supermarket every Thursday so by Wednesday, “there was not much left.” Staff told us they were given £100 per week for the food bill for the eleven people who used the service. Staff we spoke with told us they did not think this was a sufficient amount of money to provide adequate food. We were told most of the food was processed, such as pies, pasties and pizzas. We were told that meat was bought separately from the butcher but the staff had to buy cleaning products out of the £100 given to them.

Is the service effective?

We looked at the menus. They were on a four week cycle. They showed there was no choice of meal or dessert. We were told that an alternative meal would be provided if a person did not like the meal that was being served. We questioned how an alternative meal could be provided in view of the limited stocks available. During the inspection we heard one person who used the service ask for a bacon muffin for their lunch. They were told they could not have one as there was no bacon in stock. This person had the only meal that was available; jacket potato with cheese and beans.

People we spoke with told us that they felt they had enough to eat but they would sometimes like something different. One person told us, "I don't like the bread it is 'smart price' from Asda. I go to the butty shop. Can you do something about that?"

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with a choice of suitable and nutritious food. This placed their health and well-being at risk of harm.

Inspection of three care records showed that each person had an eating and drinking care plan. Staff we spoke with told us people were routinely weighed every month unless there was cause for concern and then they would be weighed weekly. We saw that people's weight charts were kept in a separate folder from the care plans. Inspection of nine weight charts showed that people were weighed regularly and there was no evidence of any rapid or unexplained weight loss.

The majority of staff had undertaken training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This training should help staff understand that assessments need to be undertaken to determine if people have capacity to make informed decisions about their care, support and treatment. Also it should help staff understand that if a person is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe. Whilst we were informed that no one living in the home was subject to a DoLS, the staff we spoke with were not able to demonstrate that they knew the procedure to follow in the event of a DoLS being required.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were unaware of how to respond to the requirements of the Mental Capacity Act 2005 and of the arrangements that needed to be in place to ensure that people were deprived of their liberty in a lawful way.

Is the service caring?

Our findings

The service was not always caring. Although people who used the service spoke positively of the kindness and attitude of the staff, we found that people were not always cared for in a dignified way. Three people looked unkempt. Their clothes were ill-fitting and creased and one person had food spillage on their sweater. One person had not had a shave. Staff told us that it was difficult to motivate the person to have a shave and that the people dressed themselves and chose to wear the clothes they had on. Despite the home being cold we saw one person was not wearing socks or stockings and their feet were blue and mottled. This person needed staff assistance to get dressed. Staff told us the person did not like to wear stockings; there was no evidence of this in their care plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always cared for in a way which promoted their dignity.

A discussion with three of the care staff showed they had a good understanding of the needs of the people they were supporting. We saw the staff had a friendly relationship with the people who used the service. The people we spoke with told us they felt safe and liked the staff. Comments made included; “They let us have our independence, we can do what we want when we want. They will give you a big hug if you are feeling sad and talk to you” and “They look after my cigarettes to help me manage them if I want them to. They do not penalise you and take your freedom away.” Another person told us, “It’s a good atmosphere. I love it here.”

Two of the people we spoke with told us they regularly had visitors and could see them in private if they wished to. On the second day of our visit we spoke with a visiting relative who told us they felt the staff were, “doing their best” for their relative.

Is the service responsive?

Our findings

The service was not responsive. We looked at the care records for three people who used the service. The care records contained some information to show how people were to be supported and cared for. The care records however had not been reviewed for several months. This was despite there being a change in the care and support that was required for two of the people who used the service.

There had been a change in one person's behaviour and an incident occurred in September 2014 that resulted in the police being called to the home. There was no review and update of the person's care plan to guide staff on how the behaviour was to be managed following the incident. The care plan had not been reviewed since July 2014. The care record of another person identified that their food and fluid intake was to be monitored. When we asked to see the food and fluid monitoring charts staff told us they had not been monitoring the person's food and fluid intake, "for a while", as they now had a good appetite. The care plan had not been reviewed and updated to reflect this change. The last review had been undertaken in July 2014. Care records need to be reviewed regularly so that any change in a person's care needs can be identified and appropriate action taken where necessary.

The care records showed that staff documented in the care plans if people were at risk of harm from any hazards, however they did not always document what action was needed to reduce or eliminate the risk. A 'falls risk assessment' was in place for one person. Although the assessment identified that the person had fallen, there was no information to guide staff on what action was needed to reduce the risk of falls. Failing to manage an identified risk placed the health and welfare of the person at risk of harm.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risk of unsafe or inappropriate care because care records were not updated, did not reflect people's needs and failed to show how identified risks were to be managed.

Inspection of the care records showed people had access to other health and social care services such as GP's, social workers and chiropodists. They also showed that people were supported to attend hospital appointments.

We asked one of the care staff to tell us what arrangements were in place to promote people's well-being and aid their recovery. We were told that no activities were in place, nobody attended any college courses or undertook any outside employment. We were told that it was difficult to motivate people. Whilst people have a right to make choices about their daily routines, staff have a duty to support and motivate those people who are recovering from a mental illness. People we spoke with told us they mainly watched television, went out shopping, visited relatives or walked into the local town centre. One person told us, "I get fed up. I can't go out."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with appropriate opportunities to promote their social needs.

We saw that a complaints procedure was displayed in the hallway. The complaints procedure gave guidance on the procedure to follow and informed people that their complaint would be acknowledged and responded to within specified time frames. It incorrectly stated that if a complaint could not be resolved it would be passed on to CQC for them to investigate. CQC do not have the legal powers to investigate individual complaints. One person told us they had made a complaint and they showed us the response letter from the provider. Although the person was not satisfied with the contents of the response letter they told us they received the letter shortly after they made their complaint.

Is the service well-led?

Our findings

The service was not well led. The home had a manager registered with the Care Quality Commission (CQC) who was not present on the day of the inspection.

The registered manager had been on maternity leave from the home since January 2014. Management of the home had been fragmented since January 2014. In the registered manager's absence the home was managed by a deputy manager appointed by the provider. This deputy manager left their position in October 2014 and the home was then managed by a newly appointed deputy manager. On the inspection days the newly appointed deputy manager was present.

Inspection of the duty rosters showed that the registered manager had returned to work at the home from 3 November 2014. On the first day of the inspection we were informed by the deputy manager that the registered manager would be in later that morning. Inspection of the duty roster identified the registered manager was to be on duty in the home that day. The times of duty were not specified. We were informed by the project manager that the registered manager had told them they would not be visiting the home that day.

We looked to see what systems were in place to monitor the quality of the service provided to ensure people received safe and effective care. We were told there was no auditing of practice in place apart from monthly care plan and medication audits.

We looked at the documentation in place for auditing the care plans. The document in use was called a 'monthly care planning cycle checklist' and it was placed in the care record of each person who used the service. Inspection of one of the checklists showed that the care plan had not been audited since June 2014. The other checklist we looked at was in a care record but had no name on it. This checklist was dated from September 2014 to March 2015 but there was no information on the document to show the care plan had been audited. The deputy manager confirmed that auditing of the care plans had not taken place for, "quite a while."

We asked to see the medication audits and were shown a document that monitored the monthly stock balance of medications only. There was no actual auditing of the medication management system.

We asked if meetings were arranged for people who used the service or for the staff. We were told that if meetings were held they were in response to issues of concern identified following inspections by CQC or other agencies. We were told that meetings were always, "reactive."

We asked if the provider sought feedback from people who used the service and their relatives through satisfaction questionnaires. We were told that surveys had not been sent out to people "for a long time."

We asked to see a complaints log but were told the home did not keep a log of complaints; this was despite evidence to show people had complained about issues such as the poor environment and the home being cold. Having a complaints log in place could help staff learn from them and help improve the service.

We asked to look at the accident book and saw there was one entry of an accident. We asked where the accident forms were kept once completed and we were told they should be in a person's care record. We saw no evidence of the forms in the care records. We found amongst an array of documents that had been left on the office desk, three incident forms in relation to incidents that had occurred in September 2014. We asked if an incident log book was kept but were told the incident forms were normally left in people's care records.

There was no system in place for reviewing and analysing either accidents or incidents to enable staff to look at ways of possibly eliminating or reducing the risk of reoccurrence; thereby helping to protect the health and safety of people who used the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had failed to assess and monitor the quality of the service provided. This placed people at risk of receiving inappropriate or unsafe care.

The provider had failed to inform the Care Quality Commission (CQC) of two incidents that occurred in September 2014 that had resulted in police involvement. This placed the health and safety of people at risk of harm. CQC need to be informed of such incidents so they are able to see if appropriate action had been taken by the provider to ensure people were kept safe.

Is the service well-led?

The staff we spoke with were able to demonstrate their understanding of the whistle blowing procedures. They knew they could raise concerns in confidence and contact people outside the service if they felt their concerns would not be listened to.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to assess and monitor the quality of the service provided. This placed people at risk of receiving inappropriate or unsafe care.**

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Systems for the management of medicines were unsafe and did not protect people who used the service.**

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People were not provided with a choice of suitable and nutritious food. This placed their health and well-being at risk of harm.**

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

The home was not adequately heated and maintained and this affected the well-being of people who used the service.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always cared for in a way which promoted their dignity and they were not provided with appropriate opportunities to promote their social needs.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff were unaware of how to respond to the requirements of the Mental Capacity Act 2005 and of the arrangements that needed to be in place to ensure that people were deprived of their liberty in a lawful way.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Recruitment records were not available to show that people employed by the provider were of good character and fit to do their job. This is necessary to help protect the health and safety of the people who use the service.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient staff were not provided at all times to ensure people's needs were met. This placed the health, welfare and safety of people who used the service at risk of harm.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The health, safety and welfare of people who used the service was not protected because staff did not receive appropriate training to enable them to care for people effectively and safely.

The enforcement action we took:
Under Section 28 of the Health and Social Care Act 2008.we have cancelled the registration of Laburnum House Limited in respect of the above regulated activity at Laburnum House Limited 1 Wells Street Bury BL9 0TU.