ROCCS Residential Community Care Services Limited

Brent Cottage

Inspection report

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Ratings

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

Overall summary

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

Brent Cottage is registered to provide accommodation and personal care for up to five people who live with complex learning disabilities. At the time of our inspection five people lived at the home. A manager was in post however they had not registered with the Care Quality Commission (CQC). 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.

Summary of findings

People felt safe at the home. Staff were knowledgeable about the risks of abuse and procedures for reporting any concerns. However incidents were not routinely reviewed or investigated.

We found there were sufficient staff available to meet people's individual care and support needs. Safe and effective recruitment practices were followed.

There were not suitable arrangements for the safe management of people's medicines.

We found that where people lacked capacity to make their own decisions, consent had not always been obtained in line with the Mental Capacity Act (MCA) 2005. Where MCA's had been completed for people they had not been reviewed regularly.

The CQC is required by law to monitor the operation of the MCA 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS were not always in place where required to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of our inspection not all applications had been made.

Staff received appropriate, training and support to enable them to provide effective care and encouraged further professional development.

People had access to healthcare professionals such as GP's, community nurses and mental health specialists when needed.

People were given appropriate levels of support to maintain a healthy balanced diet.

People told us that staff were kind and gentle. We saw that staff knew people well and met their needs in a patient, individual and caring manner.

People were not always supported to take part in individual meaningful activities or to visit family members.

People had been involved in discussions about how their care was assessed, planned and delivered. People's relatives and health professionals were positive about the management of the home and felt the manager was receptive to suggestions for improvement.

We saw that a system of audits surveys and reviews were not used to good effect in monitoring performance and managing risks.

At this inspection we found the service to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires improvement

The service was not always safe.

People were not always kept safe because incidents or accidents were not always reviewed and reported as required.

There was sufficient staff available to meet people's individual needs safely.

People were supported by suitably experienced and qualified staff. Robust recruitment practices were followed.

Risks to people's safety were not well managed.

People's medicines were not managed safely by qualified staff.

Is the service effective?

Requires improvement

The service was not effective.

Staff received training that enabled them to do their jobs well and meet people's care needs.

People were provided with food and drink that met their needs and maintained their health.

Staff and the manager had a good understanding of the Mental Capacity Act 2005 and obtained consent from people before providing care and support. However Mental Capacity Assessments had not been reviewed regularly and people were at risk of being unlawfully deprived of their liberty.

People received the support and care they needed to maintain their health and wellbeing and had access to health care professionals when required

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring manner and respected people's privacy.

People were well cared for and staff respected people's individual needs.

People were provided with opportunities to give their views and opinions about the care that people received.

Is the service responsive?

Requires improvement

The service was not always responsive.

People received personalised care that met their needs but was not formally and regularly reviewed.

Summary of findings

The home had an appropriate complaints procedure in place. People and their relatives felt able to raise concerns with the staff and manager if they needed to.

People were not always able to choose how they spent their time. Staff did not always support people to access a range of individual activities.

Is the service well-led?

Requires improvement

The service was not well led.

There was not a registered manager in post and incidents that were required to be reported to CQC had not been completed in some instances.

The culture of the home was honest and inclusive.

People were encouraged to contribute their ideas about the service; however the views of relatives had not been obtained.

The quality of the service was monitored regularly through audit checks; however they were not effectively monitored or reviewed when issues were identified.

Relatives and heath care professionals spoke highly of the quality of care people received.

Brent Cottage

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 met 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 29 and 31 July 2015 and was unannounced. When we last inspected the service on 10 May 2013 we found that they were meeting the required standards. At this inspection we found them in breach of Regulation 09, 11, 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider to be in breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We spoke to healthcare professionals who visited the service and sought their views about the service provided.

We spoke with four of the five people who lived at Brent Cottage and spoke with two relatives, the manager, the provider and two members of staff; we also spoke with a visiting health professional.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

We reviewed three people's care records who lived at the home and two staff files that contained information about recruitment, induction, and training. We also reviewed records relating to the management of the home including audits and action plans. We looked at all areas of the home during the inspection and carried out observations in the communal lounge, dining room and gardens.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Brent Cottage. One person gave us a thumbs up and told us, "I like living here, I am happy." A second person told us, "I am very happy here, I like [staff member] they are nice." One person's relative told us, "[Person] is happy to go back there once he has been out; he mixes readily, and has a lot of friends in the other homes."

Staff we spoke with were knowledgeable about identifying abuse, and told us they would report any concerns immediately to the manager. One staff member told us, "It's not just about the physical harm, it's knowing the person and knowing when they are not right in themselves. I would take any concern no matter how small to the manager." We found there were suitable arrangements to safeguard people against the risks of abuse which included reporting procedures and whistleblowing concerns. Information about how to report concerns was displayed and included contact details for the relevant local authority. People's relatives had access to a copy of the local authorities safeguarding protocol, and also a copy of the Brent Cottage safeguarding policy.

Accidents and incidents were recorded; however they were not always investigated. For example, staff recorded when an incident or injury had occurred, and handed a copy of this to the manager. When we looked at the incident record, we were not able to see where an investigation had taken place or where a review of a person's care had occurred as a result. The manager told us they reviewed the information; however they had not looked for patterns, triggers, themes or trends.

We found that risks were not always positively managed and reviewed when there was a change in people's needs. For example, one person had become agitated and aggressive three times in one particular day and on each occasion had been sent to their room. The care plan for this person's behavioural needs had not been reviewed since June 2013 and did not provide specific information about this person's triggers and how to manage them positively. When we spoke with staff about the behaviour, they were not able to tell us what may trigger this behaviour. We saw a second incident occurred where one person had thrown a dinner plate across the room, staff had recorded this as, "No apparent reason." They had instructed the person to clean up the mess, and calm down in their room. [Person] has lost their takeaway tomorrow." The behaviour plans that were in place, merely focused upon isolating the person in their room, with little reflection or positive distractions. Where some staff were able to comprehensively describe why people may present behaviours that challenge, they were not able to tell us why each individual person may, and personalised ways to manage this. We asked the manager why people's behavioural needs had not been positively addressed and assessed, they told us, "I think we have become a bit risk adverse." This meant that as people's behavioural needs had not been positively supported or assessed, people were at risk of being harmed by the actions taken that did not address their underlying needs.

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

People were supported to take their medicines by staff trained to administer medicines safely. People's preferences were clearly documented so staff were aware of how people took their medicines. We saw there were suitable arrangements in place for the safe storage, and disposal of people's medicines. Staff told us they had received medication training to safely administer people's medicines. Medicine records we looked at were completed with no gaps or omissions in the administration record. Where people had medicines as they required them, (PRN) the manager had developed a protocol to inform staff when to administer the medicines and what symptoms a person may display to suggest they required them.

However, when we checked the numbers of medicines remaining for people we found there were surpluses of medicines. This suggested that people had not always received their medicines. We looked at the monthly stock audits that the manager carried out. We saw from this they had incorrectly calculated the number of remaining tablets. For example, one month they had recorded 140 tablets into stock when they had received 112. This left a surplus of 22 tablets which meant the manager could not be sure people had been given the tablets as they were prescribed.

We asked the manager if they had physically counted the tablets when they audited the stocks. They told us they had not, and that they carried out an audit of medicines as a paper exercise only. This meant the manager could not be

Requires improvement

Is the service safe?

certain that people had received their medicines as required. This demonstrated to us that the manager did not have an effective system in place to correctly monitor medicine stock levels.

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

People had personal evacuation plans in place to assist staff in swiftly evacuating people in an emergency and the local emergency services had also carried out their own risk assessment. In addition the manager had developed a business continuity plan that detailed emergency contact numbers, local hotel contact details and the overall evacuation plan in case they were unavailable. In the event of an emergency the provider operated an out of hour's emergency number for staff to use. This meant people were kept safe in the event of an emergency, as the provider had a business continuity plan in place to provide emergency accommodation and care for people.

There were sufficient numbers of staff to meet people's needs and keep them safe. People's support needs were kept under review to ensure that staff with the necessary skills, abilities and experience were available to provide appropriate care and support. Staff employed at Brent Cottage had consistently worked there for a number of years. The manager was able to demonstrate to us that sickness, or annual leave was covered by requesting support from other homes operated by the provider, or by using known agency staff.

Safe and effective recruitment practices were followed to ensure staff were of good character. We saw that each member of staff recruited had provided satisfactory references of previous employment and had undergone a criminal records check. There were no gaps or omissions in people's employment history, and where appropriate the required documentation was available to ensure people were legally entitled to work in the United Kingdom.

Requires improvement

Is the service effective?

Our findings

People's relatives and health professionals told us that staff had the necessary skills, knowledge and experience to provide effective care and support. One person told us, "[Staff] are all really good and help me with things when I need them to."

Staff and the manager had received MCA 2005 and Deprivation of Liberty Safeguards (DoLS) training. They demonstrated a good understanding and were able to explain how the requirements worked in practice.

We found that people's capacity to make decisions had not always been properly assessed. We looked at mental capacity assessments that had been completed for people and saw these had not been reviewed since they were developed in July 2013. These assessments had not sought the views of other people who may know the person well such as relatives or an advocate. Where people had been assessed to lack capacity, the manager had solely made decisions on people's behalf such as decisions about managing people's medicines, personal care and finances. These decisions did not consider the views of the person or family member to make key decisions in their lives such as medical treatment or financial matters.

We also found that Deprivation of Liberty Safeguard applications (DoLS) had not been made when required. One person had left the home without the staff knowledge. They were found in the local shops and returned to the home by local police officers. The manager told us the person was unable to leave the home unsupervised as it was in their best interests and to keep them safe. A best interest meeting had not been held to consider depriving the person of their liberty as required, and the person was not free to leave the home whenever they chose to. An application to deprive the person of their liberty had not been made, which meant the person may have been unlawfully deprived of their liberty.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We observed throughout our inspection that staff sought people's consent prior to supporting them. On numerous occasions we saw staff ask people if they could assist them, or if there was something particular a person may wish to do. When the person did not understand what the staff member was saying, they used hand gestures, objects of reference or spoke slowly to explain themselves. Staff then only assisted people once the person clearly understood what they were being asked.

Staff received appropriate professional development, training and support to enable them to provide effective care. Staff undertook an initial induction program and completed a range of mandatory training in areas such as safeguarding, moving and handling and epilepsy awareness. Each staff member had achieved a nationally recognised qualification in care, and the training manager was actively seeking further development opportunities with staff and the manager. Staff told us that the manager was supportive and approachable. One staff member told us, "[Manager] is really lovely and supportive and supports me with anything I need."

People were supported to make choices about the food they had and were encouraged to eat a healthy balanced diet. We saw staff supported people to make their own meals and helped them make choices about what they were going to eat. On the day of our inspection people helped staff go to the local supermarket. We observed that all people were asked what they would like and the list was developed solely based on people's wishes. For example, in addition to the range of weekly food shopping items, people requested items such as peppermint tea, peach juice, chocolate, fruit and apple juice. Records of food provided confirmed that people ate a range of fresh meals, which also catered for people's individual likes and dislikes. People were encouraged to plan the weekly menus and actively assisted with preparing meals daily.

We observed people eating their meal and found the atmosphere in the dining area was relaxed and created a sociable environment for people who clearly enjoyed their meal. People were not rushed to finish their lunch, and were provided constantly with a choice of drinks.

People's health needs were regularly monitored and where people required support from health professionals, staff ensured this happened swiftly. For example, where one person had put on weight, we saw that staff supported the person to make informed choices about healthy eating. Where this person wanted to eat chocolate, staff offered a range of alternatives, and helped the person to understand why. Where people required the support of other health

Requires improvement

Is the service effective?

professionals, such as GP's, psychiatrists, learning disability teams and opticians we saw staff promptly referred people for treatment and support. One person's relative told us, "His health is good and they keep on top of that."

Good

Is the service caring?

Our findings

People we observed were happy and content in the company of staff. Staff and people had developed a positive and close relationship. People told us that the staff were caring and kind. One person smiled, raised their thumbs above their head and told us, "I love [staff member] they are really nice, we have good staff here."

The staff team at Brent Cottage was very well established and long serving. Staff we spoke with had been continuously employed for over ten years in the same home. This had enabled staff to adopt a very clear and personal understanding of people's needs based on a long history of working with them.

We observed throughout our inspection that staff were kind, patient and respectful at all times. They clearly knew people they supported well and demonstrated this when providing support to people. For example, we observed staff assist one person who had become sad and tearful. They swiftly responded to the person in a warm, calm and patient manner and quickly ascertained why they were upset. They spent time together talking and holding hands until the person was quickly settled and once again content. They then spent time with them writing a letter to a friend in another home inviting them to visit.

Staff knew the likes and dislikes of each individual person and their preferences in relation to their care and support. It was clearly evident that people were looked after as individuals and their specific and diverse needs were respected. People were very positive about the care provided by staff. One person told us, "It's the best here, I like the staff, and they are kind." One health professional told us, "I think the care provided by the team is very good, they seem to really know people here."

We observed that when staff spoke with people they did so in a manner the person was able to understand, and used objects of reference to assist with their explanations. When people approached staff to ask for support, the staff member spent as much time as was needed to listen to the person's views and respond appropriately.

We saw that staff treated people in a dignified manner when supporting them. For example when assisting people with personal care, staff ensured doors were closed and their voices were softened so people outside the room could not hear what was being discussed. When staff approached people to ask them if they required assistance with their personal care, they did this in a quiet and respectful manner.

Requires improvement

Is the service responsive?

Our findings

People had an assessment of their needs prior to them moving to Brent Cottage. Staff used this information and developed a support plan for people to ensure the care received from day one suited their needs.

Care plans we looked at were accompanied by pictures and symbols that enabled people who had difficulty reading to understand and take part in their reviews. We saw care plans had been developed with input from the person, but not always with their relative. For example, on the day of our inspection we saw one person's care being reviewed by the manager and keyworker with a visiting professional and the person themselves. Their relative had been invited, however was unable to attend due to illness, but had provided their thoughts and views to be included. The review clearly centred on the person's needs and they were constantly asked for their thoughts, views and opinions. However this was not consistently applied to all the people living there. One person whose family lived a long way from the home had not been involved with reviewing the person's care. Where they did not regularly visit the person no attempt had been made to seek their opinions via telephone, email or letter. We spoke with one person's relative who had not been able to contribute to their loved one's care plan. They told us, "[Person] used to have an annual review but they don't seem to have happened, we haven't been invited for many years now, If everything was going to okay, I wouldn't mind a written update."

Peoples care plans had not always been reviewed when there was a change identified with their support needs. Incident records noted when people had become agitated, frustrated or had lashed out. We looked at their risk assessments and saw that the manager had not reviewed them to consider what had caused the person to become agitated. The only responses to the person's behaviour was planned activities were removed. The manager told us that this was to enable people to develop a sense of responsibility regarding their actions. For example, one person whilst waiting to go to a dance class had pulled another residents hair. The record of the incident noted that one of the preceding factors was, "Looking forward to dance lesson." The action recorded in March 2015 was, "[Person] has lost their dance lesson." They subsequently since that date had not been supported to attend a dance lesson. They also had not been to the cinema for a similar period of time. Where some people had their activities removed in response to their actions, and the manager had not sought support from professionals or reviewed the care plan, this response was used as a punishment. We overheard one member of staff say to one person that they needed to work harder if they wanted to attend their activity. We spoke with the provider about this who told us they would look at a range of alternatives, such as a local autism friendly cinema. The provider said they would support the manager to look at how they could better develop the persons care plans and support the person in a positive manner, using a variety of techniques that would seek to reward and reaffirm positive behaviour.

We found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were encouraged to remain independent where possible with household tasks such as laundry, cleaning and cooking. Where people were able to staff supported them in the kitchen to bake cakes and assist with meal preparation. Staff told us it was important to ensure that people helped with household tasks as this enabled them to maintain their independence.

People were sometimes supported to maintain relationships with family and friends, and we observed staff arranging telephone calls to people's family, and also writing letters. One person's relative told us, "I can phone when I want to and he can phone me when he wants to." However, where people had expressed their wishes to visit their family, this had not always happened. We saw from one person's care plan that they were to be supported to visit their relative. They lived a number of miles from the home.. However, we saw this person had become anxious and agitated when travelling in the car used by the service and staff had ruled out using this as a means of transport for longer journeys. Staff had considered alternative transport options but these had not been carried out and no further alternatives had been considered. For example, the same person's activity plan noted on a Thursday the person was to be supported to be out in the community and to use the bus. None of these activities were provided. This meant that this person had not been supported to maintain links with family as they had indicated in their care plan.

We saw that each person had their own activity schedule for the week which documented activities personal to them

Requires improvement

Is the service responsive?

and enabled them to spend time following their own interests. For example, people had been supported to attend church, visit local café's, shopping, local walks and art therapy sessions. The manager had formed close links with other local homes operated by the provider and was planning a barbecue with another home the evening of our inspection.

This meant that people were not always encouraged and supported to develop and maintain relationships with people that matter to them, or supported to always follow their individual interests.

We found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were opportunities for people who lived at Brent Cottage to have a say about the day to day running of the home. 'Service User' meetings were held regularly; menus, activities, birthdays and household chores were examples of items discussed. People were aware of how to raise their concerns and staff noted people's grumbles and the manager responded to these. For example, one person had said they were not happy with the sensory room in the home. The manager responded by taking the person to a local store to choose furniture and decorations, and then had the maintenance team install new flooring, cupboards, lighting and redecoration.

A copy of the complaints policy and procedure was available, and where this was not in an accessible format for people, staff told us they had sat and explained it to people. Where people had raised a complaint, we saw that these were managed appropriately and a response given to the person explaining the actions taken. One person's relative confirmed to us they were aware of how to make a complaint and told us, "We would take it up with the house first, if that wasn't forthcoming we would go to the county council."

Requires improvement

Is the service well-led?

Our findings

People, one relative, staff and visiting health professionals were all positive about the management of the home. One person's relative told us, "If I phone I speak to the manager, they give me a good overview of what [Person] has been up to for the week and any concerns. The Manager is very good; they seem to know how to manage people."

People told us that the manager was hands on in their approach. Staff told us they promoted an environment that was caring and inclusive, putting people first. We observed that all staff ensured that these values were demonstrated when supporting people.

There was not a registered manager in post at the time of our inspection. The current manager had been employed at the home as manager during two separate periods. They left their management role in 2011 and deregistered as the manager. However, when they later resumed this post in March 2013 they did not submit an application with CQC to register as the manager. They had not informed the provider that they had deregistered.

The manager and provider carried out a range of management audits to monitor staff performance and keep people safe. We saw areas such as medication, health and safety, food hygiene and cleanliness. However, these were not always effective. Where audits had identified gaps or concerns these had been recorded, however no action plan was in place to record how and by when these issues would be resolved. For example, The manager told us that care plans were reviewed three monthly or when people's needs changed. The provider carried out an audit of the home on 08 July 2015. They identified that one person's care plan had not been reviewed since November 2014. There were no actions recorded for when this would be completed, and by whom.

Issues identified in audits were not always followed up the following month. For example we saw in April's audit that a weekly schedule was required for one person's summer activities, and railings for the stairs were required. When we looked at July's audit there was no suggestion these areas had been reviewed to ensure they were completed. We also saw that the provider had identified in previous audits areas such as risk assessments not being reviewed and care plans not updated. At the time of our inspection no action had been taken to address these issues.

We asked the manager if they had their own development plan that they used to identify issues or concerns and improve the quality of service provided. They told us they had not developed one. We saw that an Annual Development Plan for 2015/16 had been produced by the provider. This plan was not specific to Brent Cottage, and did not address many of the concerns identified by our inspection. Where plans for Brent Cottage were included these were in relation to environmental improvements, however did not include the stair railings as identified in the April audit.

People's records were not up to date and sensitive information was kept and stored safely. Care records that we looked at were easy to review, and legible with no gaps or omissions. However where changes had been made to a person's care, or when the provider's policy required the care plan to be reviewed this had not been completed. The record clearly and accurately noted this. This meant an accurate record of a person's care needs had not been maintained.

Night monitoring visits that had previously been carried out by the manager had ceased. The last visit carried out was in October 2014. The purpose of the visits was for the manager to carry out an unannounced review of the service at night to ensure staff supported people safely and appropriately and carried out their functions as required. When the manager was asked they did not provide a reason why they had ceased these quality checks.

We saw that annual reviews were completed by both people with support from staff. These were presented in an accessible format so that the person could be supported by the staff member to complete them together. The manager told us that they reviewed the comments, and the results of the surveys we reviewed for 2014 were mostly positive. However where people had indicated areas that could be improved the manager had not sought to understand what needed to change. The views of people's relatives and healthcare professionals had not been sought; however this was an area the manager said they were developing and would send out surveys to people in the near future. They told us that people's relatives frequently commented positively and constructively about the service; however they did not document this.

This meant that quality assurance systems were not always effective in identifying, monitoring and improving the quality of care that people received.

Requires improvement

Is the service well-led?

We found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the accident and incident reports for the service and saw that where a notification was required to be sent to us, these had not always been completed. Incidents people had placed others at risk due to their behaviour had not always been submitted as legally required. We asked the manager if they reviewed incidents in the home to understand and respond to any trends, patterns or themes. They told us they did not.

We found that the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 1(a) (b) (c) 3 (c)** **Care and treatment was not always appropriate and did not always meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (3)** **The legal requirements of the Mental Capacity Act 2005 had not been followed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (g)** **People medicines were not managed safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (4) (b)** **People were not protected from improper treatment.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) There was not an effective system in place to assess, monitor and improve the quality and safety of the services provided , and mitigate risks to service users and visitors to the service. There was also not an accurate record maintained in respect of each service user.
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 (2) (e) Notifications of incidents had not been made to the Care Quality Commission when required.

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.