Care Quality Commission

Eldercare (Halifax) Limited

Sun Woodhouse Care Home

Inspection report

Woodhouse Hill Road
Woodhouse Hill, Fartown
Tel: 01484 424363
Website: www.eldercare.org.uk

Date of inspection visit: 31 July 2015
Date of publication: 23/10/2015

Ratings

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

Overall summary

We inspected Sun Woodhouse on 31 July 2015 and the inspection was unannounced.

Sun Woodhouse provides accommodation and personal care for up to a maximum of 24 older people. At the time of our first visit there were 13 people using the service. The accommodation is arranged over two floors and there is a stair lift on the main staircase. There is one lounge and one dining room on the ground floor and bedrooms are all single occupancy.

At the time of our visit the home was being managed by a peripatetic manager employed by the provider to oversee management until a person to take the role of registered manager could be appointed. 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.

People who used the service told us they liked the staff and found them kind and helpful

We found standards of cleanliness and infection control in the home had improved since our last inspection but some areas required further improvement. Systems were in place to support safe management of medicines.

Summary of findings

Systems were in place to make sure staff were recruited safely but staff lacked training in areas such as maintaining people's safety, safe moving and handling, Mental Capacity Act and Deprivation of liberty safeguards and supporting people living with dementia.

Care plans did not always reflect people's current needs and people did not always have their care needs met.

People did not always have their nutritional needs met.

People had little access to meaningful activities.

Systems to monitor the quality of the service had been improved but further work was needed to make sure people who lived at the home were protected from unsafe or inappropriate care.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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.

Although people told us they felt safe, we saw that not all staff had received training in keeping people safe and did not always recognise potentially abusive situations.

Systems for managing medicines were safe.

Further improvements in relation to infection control were needed.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received the training they needed to support them in their work. Staffing was not well organised

Staff did not work in line with requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not always met.

People's health and welfare needs were not always met

Is the service caring?

Requires improvement

The service was caring in that staff were kind in their approach to people.

People told us the staff were good but we observed staff did not always interact appropriately with people.

People had not routinely been involved in the planning and review of their care.

Is the service responsive?

Requires improvement

The service was not responsive

Care was not always planned in a person centred manner although some consideration was given to people's preferred routines.

Care plans did not always contain up to date information about people's care needs.

There was a lack of meaningful activities.

Is the service well-led?

Requires improvement

The service was not well led.

The management of the home had been through a period of instability and there was no registered manager in post.

Summary of findings

Although some improvements had been made, the provider had not fully complied with the requirements made at the last inspection to establish robust systems for monitoring the quality of the service.

Sun Woodhouse Care Home

Detailed findings

Background to this inspection

When we inspected this service in January 2015 we identified a number of breaches of regulation and told the provider that improvements must be made.

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 had taken the actions identified as necessary to meet 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 31 July 2015 and was unannounced.

There were two Adult Social Care inspectors involved in this inspection. Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. On this occasion 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 eight people who used the service during our visit. Not all of the people we spoke with were able; due to complex care needs to tell us about their experiences at the home. We therefore used other methods such as observing how people spent their time, how staff supported them and looking at individual care records. We also spoke with the peripatetic manager and five members of staff. We also reviewed documentation to show how the service was run.

Requires improvement

Is the service safe?

Our findings

We spoke with three people who lived at the home about whether they felt safe. They told us they felt safe living there and if they had any worries they would talk to staff or the manager. One person said "Oh yes, the girls make sure I'm safe alright." The manager told us staff had received training in safeguarding and this was confirmed by one of the staff members we spoke with. However, when we looked at the training matrix, we saw the training in safeguarding for 11 staff members was out of date. They last had training in early 2014. The matrix showed eight staff had not received any safeguarding training and only one staff member had their safeguarding training up to date.

One member of staff was able to give us their understanding of the different types of abuse and what they would do if they had any concerns. However another staff member we spoke with could not recall having done any training in safeguarding and was unclear in their understanding of what it meant. During our visit we saw one person who lived at the home displaying behaviour that other people found irritating. We heard one person shouting at them to shut up, staff were nearby but did not intervene. When we spoke to staff about this they did not recognise this as a potentially abusive situation from which the person needed to be safeguarded.

This meant that the provider had not established effective systems to ensure the safety of people who lived at the home and is a breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people who used the service had difficulty communicating their needs. We asked staff what they would do when people couldn't tell them something was wrong or they felt unsafe. One staff member told us they would recognise if people were in distress through their body language and the way they acted with other people. Although staff we spoke with could tell us what they would do if they had any concerns about people's safety, the service had not taken the necessary steps which ensured all staff had the necessary training to identify people at risk. This meant people who used the service were not being protected from possibility of harm because the service had not ensured its entire staff received training in safeguarding vulnerable people.

We saw that a system had been put in place to make sure that any accidents within the home were recorded and analysed on a monthly basis to see if there were any trends or patterns which would identify key times or situations when accidents were more likely to occur

We saw from rotas and from speaking to staff that staffing levels were arranged at three care staff during the day and two at night. A cook worked 8am to 2pm and a member of cleaning staff worked 9am to 3pm daily. The manager worked mainly 8am to 4pm weekdays and was not included in the care staffing hours. At the time of our visit there were 13 people living at the home. None of the staff or people living at the home we spoke with raised concerns about staffing levels. However we noted that staff were not always deployed in a way which made sure that people in the lounge area could easily attract staff's attention if they were in need of assistance.

We looked at three staff files and saw the recruitment procedure was robust to ensure staff were checked before being able to work with vulnerable adults. Staff files contained evidence of interviews, two references, Disclosure and Barring Service (DBS) checks and identification checks. This meant that staff were recruited safely.

We looked at the systems in place for the receipt, storage and administration of medicines. Staff told us that a new system had been put in place for medicines and they felt a little unsure of it as they had not yet received training relating to the new system. We found that medicines received into the home were being recorded and stored safely and appropriately. We saw from Medication Administration Record (MAR) sheets that staff were signing appropriately when the medicine had been administered and that any omissions were recorded as necessary.

We saw that staff recorded stock levels of medication after each administration. We checked a sample of these and found them to be correct.

Medicines were stored safely and at appropriate temperatures.

When we last inspected Sun Woodhouse we found serious issues in relation to cleanliness and infection control and said that improvements must be made. On this visit we found the home to be much cleaner but there were still some areas of concern. For example we found dirty toilets in a communal bathroom and in one person's ensuite. We

Requires improvement

Is the service safe?

found one person's bed had been made with soiled sheets and another person had soiled underwear in the drawer. In one person's ensuite we found dirty and clogged disposable razors and saw black slimy mould inside the person's denture pot. The manager took immediate action to address these issues.

Inadequate

Is the service effective?

Our findings

We asked people who lived at the home about how they spent their time. One person told us "I get bored sometimes." Another person told us "I just sit here doing nothing." We also asked people for their opinion of the food at the home. One person told us "It's ok" and another said "The food is alright." None of the people we spoke with were able to tell us what they thought about the abilities of the staff.

Staff we spoke with confirmed they had received supervision. One staff member told us they had supervision every 6-8 weeks and another one told us "I had supervision a few weeks ago but it's not a regular thing." None of the staff we spoke with had an annual appraisal. However, they felt the training they received helped them to do their job.

Staff training records showed that not all staff had received the training they needed. For example only half of the staff team had received training in supporting people living with dementia, six did not have up to date moving and handling training and only nine staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

This meant that staff had not received the training they needed and this is a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities)

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) is part of the Mental Capacity Act (MCA) 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. Some of the staff we spoke with had received training but it was clear from our conversations that they didn't understand how to implement their learning. For example, some people who smoked had to ask staff for their cigarettes because they were kept in the office. People could not walk freely into the garden because the doors were locked and they had to rely on staff to take them out. Staff did not understand these two examples were a deprivation of people's liberty.

Some people who used the service were living with dementia and had difficulty recalling information and making decisions. Dementia can impact upon a person's ability to make decisions regarding their health and wellbeing. This is because dementia is seen as an impairment of the mind and can affect people's ability to retain and recall information. The ability to retain information is important when decisions are made.

In order to support people living with dementia to make decisions, such as staying in the care home, staff need to establish whether the person has capacity to make decisions and identify when decisions need to be made on behalf of the person and in their best interests. In one of the care plans we looked at where the person was living with dementia, staff had recorded the person had capacity. We could not see the process of this assessment and did not see that the assessment had been made with regard to the person making specific decisions. There was no information about how the staff making the assessment had come to their decision. In another care plan, we saw a restrictive practice assessment sheet was in place. This had not been filled in with specific details but had been reviewed and dated.

This meant that staff were not working within the requirements of the MCA and DoLS and is a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the care plans we saw had been signed by the person which indicated that staff had sought their consent.

The cook at the home on the day of our visit had been in post since April 2015. We asked them how they would plan menus for people and how they involved people were in menu planning. They told us they would talk to people and find out what type of meal they liked and what they did not like. The planning of menus was not done in consultation with people. The cook knew who required pureed food and had pureed the meal at lunchtime all together and had served the food in a bowl. We asked what the meal was and were told it was fish, chips and peas pureed together. We asked whether they would ever separate food to be pureed to make it look attractive and to enable the person eating the meal to differentiate between the components of the meal, they said they didn't realize you could or should do this. They told us "I found out today (inspection date) about separating food in puree." When we asked the manager about this they told us that staff had said it was the choice of the person to have their meals served in this way. They provided us with care notes which read 'I like my

meals soft in a soup like consistency' This had been written by a member of care staff and there was no evidence of consultation with the person or evidence that they had been offered choice.

We did not see any evidence that the service had taken steps to ensure the cook had the skills and knowledge to carry out their role effectively. However, the cook was aware of how they would fortify food for people for example by using full fat milk in milkshakes and Complan for people identified as at risk of weight loss.

Staff felt the quality of the food had increased since the new cook was in place. They felt there could be more variety of meals at tea time instead of the usual sandwiches. Two people had specific cultural dietary requirements. One person told us they were a vegetarian and their family usually brought food in for them. On the day of the inspection, the main course was a choice of meat or fish, staff asked them if they wanted chips and peas for their lunch. We did not hear them offer an alternative vegetarian meal. In this person's care plan it stated they should be weighed monthly and the records showed they had not been weighed since May2015. In another care plan we looked at, we saw the person was on a food and fluid chart. We looked at their food and fluid chart for the last three days. We saw fluid charts had not been filled in accurately and in some cases had not been filled in at all. When the fluid charts had been filled in, they had not been totalled so it was difficult to establish how much fluid they had taken. In one of the daily records, we noted the person had three quarters of a cooked breakfast; they had no mid-morning snack and no lunch. This was described as a good diet. In the same daily record, the fluid and food chart on the 13/07/2015 had not been filled in to indicate any meals had been taken after breakfast.

We saw from another person's records that they had been seen by the dietician in March 2015. The dietician recommended the person receive food 'little and often' and to be given fortisip, a drink to increase their calorie intake. This was to be reviewed in two months. No review had been made. We noted from this person's records that they had lost over 10 pounds in weight between May and June 2015. The care plan said to weigh this person weekly. This had not been done and the person's nutritional risk assessment had not been updated since May 2015. We noted that this person was prone to pressure sores and was being treated by the district nurse for this. The poor management of this person's nutrition could put them at further risk of tissue damage and delay the healing process of current sores.

There were some pictures of food for people to look at when choosing food from the menu. The pictures were in black and white and the pictures were difficult to see. The cook had not received any training in managing and understanding dietary requirements for people with dementia.

At lunchtime we saw one person struggling to cut through their fish. The fish was pre frozen bread crumbed and had been oven baked, the chips were frozen oven chips and the peas were from a tin. The person said "It's horrible" and left their meal. When it was established the person would not be returning we looked at the fish. We found it to be extremely hard and of poor quality. We showed it to the manager who agreed with us.

This meant that staff had failed to meet people's nutritional needs and is a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's care plans and daily records to see how the service recorded visits from other health professionals. Visits from other health professionals were being recorded in the daily records but not always in the care plans. It was difficult to find the information we needed in order to establish whether the service was recording health professional visits.

We saw in one person's records dated February 2015, they had said they would like staff to make them an appointment with an optician 'So I am able to have glasses for reading.' This had been signed by the person. We asked a member of staff if this had happened and they said "Not that I know of."

We saw other examples of people not having their healthcare needs met. In one of the care plans we looked at we saw staff should be recording change of position to prevent the development of pressure ulcers. In the bedroom we saw positioning charts were in place but we could not see any entries after 16 June 2015. We asked the manager about this. They told us repositioning records were routinely kept with people's daily records. We looked at the reposition charts for one person and found they had not been completed on a daily basis and when they had,

they had not been fully completed. This meant the person was at risk of development of pressure ulcers because staff had not been following the care plan which stated the person should be repositioned every three hours.

We saw from records that one person was receiving care from the district nurse for a sore. When we looked at this person's care records we saw that their skin assessment (Waterlow) had not been updated for two months and there was no indication they had a sore. We also saw an entry on the person's skin assessment to say they had a skin tear on their buttock. This had been recorded a month prior to our visit and no update had been recorded.

Whilst a care plan for this person's skin care included some good detail it was not up to date and therefore did not reflect their current needs.

One of the care plans we looked at stated the person required the use of a pressure cushion when they were sitting down in a chair or a wheel chair. This was to prevent the development of pressure ulcers. When the person was supported to move from their chair to a wheelchair, staff did not put the pressure cushion in place. The person then sat in the wheelchair for the rest of the morning. We brought this to the attention of staff. They thought a pressure cushion was in place on the wheelchair and, without talking to the person, put their hand underneath them to check whether the cushion was in place. This action did not demonstrate respect for the person concerned.

We saw in one person's daily records that they had been complaining of 'a lot of pain' in their leg during the night. We asked the senior care assistant what was being done about this. They said they had not seen any communication about this person and therefore did not know about the pain.

We saw from one person's daily records that they had sustained a fall. There was no record to indicate whether the person was assessed for injuries and there was no record of other professionals such as GP having been contacted. There was no record the person had been assessed during the rest of the day and the fall had not been mentioned in the night records.

The next day it was recorded staff noticed they were still in pain and contacted 'telemed', a service where care homes can get medical advice from healthcare professionals. Staff spoke with a nurse who advised them to give the person Paracetamol. The nurse advised no further investigations because 'If they'd cracked their ribs, the hospital wouldn't help.' The service did not know whether the person had cracked their ribs because no investigations had been carried out on the day of the fall. We could not locate the daily records for the date of the fall. We asked the manager where the records might be and they were not able to locate the records for us.

Another person's records included detail of when they had been found on the floor of their room. Records showed that the person had been assessed for injury by the staff on duty and no injuries had been noted. This had been recorded in the person's daily record. During late afternoon of the following day records showed that staff became concerned about the person and they contacted 999. We did not see any records to indicate staff had completed observations of the person between the time of the fall and the following afternoon. Records showed that the person had sustained a fracture of the hip during the fall.

This meant that staff had failed to meet people's healthcare needs and is a breach of regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

We asked people if they thought the staff were kind and helpful. One person said "Yes I think so" and another said they were "Darlings."

We observed the interaction between staff and people who lived at the home. We heard one person ask a member of staff a question, as they answered, the staff member walked away from the person asking the question. There was little interaction between staff and residents in the lounge. For fifteen minutes, people were left in the lounge with no staff available to them. One staff member, writing up their daily notes in the lounge had their back to people sitting in the lounge.

We observed staff speaking about people rather than to them. For example we saw a member of staff say to another "Is it warmer outside yet because he (pointing at a person) wants to go out but he can't until it's warm." We also observed staff assisting a person use the hoist without speaking to them at all. Another person using the hoist was only spoken to when they initiated conversation to ask where they were going. On other occasions we saw some positive interaction but this was limited to when tasks were being carried out.

On one occasion we observed a member of staff drop the paperwork they were carrying. They swore loudly at this without any apparent regard for the people sitting in the vicinity.

From the care plans we looked at, it was clear people had not routinely been involved in their development and review. Although the service sought consent for specific issues such the use of photographs and the development of care plans, people hadn't always been asked to consent to the use of personal care.

Staff we spoke with told us they enjoyed working at the service. One staff member told us "I love working here; I love the residents and develop a good relationship with them." Another staff member told us "There is a real homely atmosphere here."

Staff told us they understood the need for dignity and respect, for example, they understood people's personal care should be carried out in private with the door closed. People we spoke with told us they felt staff treated them with respect.

None of the plans we looked at had recorded people's end of life wishes. There were no 'Do not attempt cardio pulmonary resuscitation' plans in place (DNACPR). In May 2015 the service had requested staff talk to relatives about people's DNACPR wishes but there was no evidence staff had discussed this with families or with people who lived at the home.

We asked people if they thought the staff were kind and helpful. One person said "Yes I think so" and another said they were "Darlings."

We observed the interaction between staff and people who lived at the home. We heard one person ask a member of staff a question, as they answered, the staff member walked away from the person asking the question. There was little interaction between staff and residents in the lounge. For fifteen minutes, people were left in the lounge with no staff available to them. One staff member, writing up their daily notes in the lounge had their back to people sitting in the lounge.

We observed staff speaking about people rather than to them. For example we saw a member of staff say to another "Is it warmer outside yet because he (pointing at a person) wants to go out but he can't until it's warm." We also observed staff assisting a person use the hoist without speaking to them at all. Another person using the hoist was only spoken to when they initiated conversation to ask where they were going. On other occasions we saw some positive interaction but this was limited to when tasks were being carried out.

On one occasion we observed a member of staff drop the paperwork they were carrying. They swore loudly at this without any apparent regard for the people sitting in the vicinity.

From the care plans we looked at, it was clear people had not routinely been involved in their development and review. Although the service sought consent for specific issues such the use of photographs and the development of care plans, people hadn't always been asked to consent to the use of personal care.

Staff we spoke with told us they enjoyed working at the service. One staff member told us "I love working here; I love the residents and develop a good relationship with them." Another staff member told us "There is a real homely atmosphere here."

Requires improvement

Is the service caring?

Staff told us they understood the need for dignity and respect, for example, they understood people's personal care should be carried out in private with the door closed. People we spoke with told us they felt staff treated them with respect.

None of the plans we looked at had recorded people's end of life wishes. There were no 'Do not attempt cardio pulmonary resuscitation' plans in place (DNACPR). In May 2015 the service had requested staff talk to relatives about people's DNACPR wishes but there was no evidence staff had discussed this with families or with people who lived at the home.

Requires improvement

Is the service responsive?

Our findings

None of the people we spoke with could tell us about their care plan or whether they were involved in any reviews of their care. One person we spoke with told us "I don't know what a care plan is." When we asked people about what they did to pass their time one person said "Not a lot, just the telly really."

Staff we spoke with told us they didn't write the care plans and said the more senor staff did that. They felt the care plans were easy to read and gave them a good understanding of the needs of people who used the service. However we noted that some care plans were not up to date and therefore did not reflect the current needs of the individual concerned. For example, one person had a fractured limb but their care plan had not been updated to detail the changes needed to meet their personal care needs.

We looked at the care records for a person who had been admitted to the home two days before our visit. We found very little information in the records. For example the person's date of birth and GP had not been recorded. There was an instruction for staff to promote mobility and encourage with daily exercises but no information about what these were. No daily records had been made from the day or night of admission or the following day. Nothing had been recorded about the person's preferred routines, their abilities, their preferences or any risks associated with their care such as moving and handling.

We saw that some care plans had been written from the point of view of the person and there was evidence within the care plans of people's preferred routines. Care plan headings, for example, 'How I communicate' suggested a person centred approach However, there was little evidence of the person having been involved in the care planning process. Some care records included a life history, however we noted one of these was very short and gave little detail.

We did not see any activities planned for the day. Staff we spoke with told us activities for people were poor. One staff member told us "I think there is an activities co-ordinator but I don't know who it is."

The manager told us that there was not a programme of activities in place but that outside entertainers occasionally came to the home. People we spoke with told us they didn't do very much during the day. Some people told us they enjoyed going out but relied on staff to support them. On the day of inspection, we saw some people had been taken to sit outside in the sun but there were no staff available to sit with them for any meaningful interaction. Another person asked to go out for a walk in the garden with staff. They had to wait for over an hour to do this because staff were busy. In two of the care plans we saw it had been recorded that the individuals concerned enjoyed rugby and supported the local team. There was a televised game involving this team on the evening of the inspection but staff were not aware of the game and no plans had been made to ensure the two people would be able to watch and enjoy the game. This meant people were not being supported to follow their interests.

This meant that staff had failed to plan care in a person centred manner and is a breach of regulation 9(1) and 3(a), (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a system in place for responding to complaints made about the service. The manager told us there had not been any complaints since our last inspection.

Requires improvement

Is the service well-led?

Our findings

None of the people we spoke with made any comment about how the home was managed but staff we spoke with told us they had seen some improvements in the service. They felt the current manager was doing a good job. They acknowledged there had been problems with the service in the past and were hoping the improvements would continue.

The person in charge at the time of our inspection was a peripatetic manager employed by the registered provider to take on the managerial role until a registered manager could be appointed. The peripatetic manager had been working at the home for six weeks at the time of our visit. The registered provider had kept the CQC informed of managerial changes at the home since the last inspection.

When we last inspected this service we told the registered provider that actions were necessary to regularly assess and monitor the quality of services provided to make sure that people who lived at the home were protected from unsafe or inappropriate care. On this inspection we were able to see evidence of some improvements, however further improvements were still needed.

The manager told us they had recently started a system of daily audits within the home but this was in its early stages and there was no documentation available to support this. However the manager did show us a recent quality audit conducted at the home which had identified some issues. We saw that the issues identified had been addressed.

We saw that audits such as safety of equipment including bedrails, mattresses and wheelchairs had been completed. Fire safety checks and accident and incident analysis had been completed. Other audits had been completed but actions identified as needed had not been addressed. For example a care plan audit dated June 2015 had identified that care plans were not being reviewed as required and we found this to still be the case.

We saw the registered provider had installed a new laundry room since this had been identified as an issue at our last inspection.

We saw there had been two staff meetings since our last inspection and a meeting with the people who lived at the home and their relatives. This showed that some action was being taken to involve people in the home and give them opportunity to express their views.

The manager told us that they recognised further improvements were needed to ensure a robust system of auditing and improvement and said they were working toward this.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Staff were not working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards**

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 **Staff had not received the training they needed to enable them to carry out their roles effectively.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People did not always have their nutritional needs met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not always have their healthcare needs met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care was not always planned in a person centred manner.**

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure the safety of people living at the home.