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Birch Holt Retirement Home

Inspection report

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Ratings

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

Overall summary

We inspected Birch Holt Retirement Home on the 3 and 5 November 2015. This was an unannounced inspection. Birch Holt provides accommodation, care and support for up to 26 people. On the day of our inspection 20 older people were living at the home. The service provided care and support to people living with dementia, risk of falls and long term healthcare needs such as diabetes.

A registered manager was in post. 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 and associated Regulations about how the service is run.

The provider had not protected people's safety by ensuring effective management of medicines. For example the provider had not followed best practice with regard to the management of storage, receipt and recording of medicines.

We found risks associated with some people who had a higher care support needs had not been supported in a

Summary of findings

timely manner to effectively manage their health. For example when they had lost weight. People's care plans did not capture or reflect an up-to-date picture of their changing health support needs.

We found areas of the home were not clean and equipment in use that was not suitable, for example wicker chairs which contained commodes.

Through reviewing records we identified some care staff had not updated their training in key areas for extended periods of time.

We found the provider had not made adequate provision to ensure people's social needs were met. People told us they would like more to do and be involved with. We found examples where the provider had not ensured people's choice and dignity had not been respected.

The provider had not routinely submitted statutory notifications to the Care Quality Commission, as required. Under the Health and Social Care Act 2008, providers are required by law to submit notifications of incident affecting people.

Although people and staff generally spoke positively about the registered manager, in their leadership capacity they had not identified the areas of concern we had during this inspection.

Staff had an understanding of the procedures and their responsibilities to safeguard people from abuse. Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People told us they had access to on-going healthcare support and were supported to access health professionals such as their GP when required.

People told us staff were kind and we observed positive interactions between people and staff.

People told us they felt there were sufficient numbers of staff deployed at the service to meet their care needs.

We observed various meals, people told us they enjoyed the food and looked forward to coming to the dining room to spend time with others.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

There were a number of breaches of the regulations. 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?

Inadequate

The service was not safe.

We found areas of the home were not clean and some equipment not suitable for a care setting environment.

Medicines were not consistently managed safely.

Risks related to some peoples care had not been adequately managed and recorded.

The provider had not taken steps to assure themselves that one member of staff was suitable to work within a care setting.

Is the service effective?

Requires improvement

The service was not always effective.

Extended periods had lapsed between some staff undertaking refresher training.

Staff supervision minutes were limited and provided limited feedback that was designed to develop staff's performance and capability.

Staff had an understanding of the Mental Capacity Act 2005 and consent issues.

Is the service caring?

Requires improvement

The service was not always seen to be caring.

Although we saw positive interaction between people and staff we found

people's choice and dignity was not consistently promoted.

Relatives and friends told us they were unrestricted as to when they able to visit people

Peoples care records were held securely.

Is the service responsive?

Requires improvement

The service was not always responsive.

We found the provider had not made adequate provision to ensure people's social needs were met.

Care plans we reviewed did not provide a person centred picture of their support needs. They lacked detail, personalisation and were not up-to-date.

A complaints policy was in place.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The provider had failed to establish quality assurance systems which were used to drive improvement.

Accidents were recorded however were not used to analyse trends and influence future staff learning.

Statutory notifications had not been consistently submitted to the Care Quality Commission

People spoke positively about the registered manager and staff told us they felt supported in their roles.

Birch Holt Retirement Home

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.

We inspected the service on the 3 and 5 November 2015. This was an unannounced inspection. The inspection team consisted of two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. We looked at care documentation and examined records which related to the running of the service. We looked at six care plans and four staff files, all staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Birch Holt. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. 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 were unable to talk to us.

We looked at areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with five people who live at Birch Holt, one visitor, five staff, one visiting health professionals and the registered manager.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and members of the public. We spoke with a representative from the Local Authority's contracts and monitoring team. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

People who were able to communicate with us said they felt safe living at the Birch Holt. However despite peoples' comments they felt safe we found aspects of the service were not adequately protecting people.

On arrival at the service there was no answer from the home's door bell. The front door was unlocked so we entered the service. We waited in the reception for several minutes until a staff member acknowledged our presence. We raised our concerns with the registered manager regarding people's safety and security. A risk assessment had not been completed and the registered manager was unable to identify what steps had been taken to ensure people were protected by adequate security measures.

People who had been assessed as at risk of possible skin damage were provided with specialist mattresses. These mattresses are designed to provide relief to skin pressure areas. It is important this equipment is set correctly and in line with a person's weight and manufacturer's instructions. We found two people's mattresses were not set correctly. This placed these people at greater risk of skin pressure damage. The registered manager told us they did not have a system to routinely check and record whether settings were correct.

Medicines not requiring a refrigerated environment were stored appropriately, however medicines which required refrigeration were stored in the main kitchen refrigerator, on the bottom shelf in an unsealed container. This meant there was a risk medicines could be adversely affected by either liquids or other food stuffs entering the container from food stored above. We identified this issue to the registered manager and on the second day of our inspection a sealed container was being used.

Medicines were dispensed from a nearby GP practice. The registered manager told us the GP practice did not issue medicine administration records (MARs) when they picked up people's medicines. The registered manager created people's individual MAR on the service's computer.

We found one discrepancy in the recording of controlled medicines. One person's controlled medicine record stated they should have one dose remaining however their box was empty. The registered manager stated this was an administration error. We found a number of staff signature omissions (identified as gaps) in MAR. Staff are required to sign on the MAR that the prescribed medicine had been administered to the correct person after it had been taken. These omissions (gaps) had not been identified by the staff administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. Staff when asked could not confirm whether the medicine had been administered. One person's whose diabetes was controlled by insulin had a different amount recorded on their MAR and their diabetic recording book. The registered manager told us the correct dosage was the number in the diabetic recording book however staff had continued to sign the MAR for a different and incorrect amount.

There were two staff signatures missing from the sample signature sheet. It is good practice to record the name and signature of all staff authorised to administer medicines.

On the first day of our inspection we saw a staff member who was responsible for medicines demonstrated poor practice. For example we saw this staff member leave a person's medicines on their spoon and then walk away without observing them take it. This meant the staff member could not be certain the person had taken their medicines.

Risk assessment within people's individual care plans identified support care needs had been considered for areas such as mobility, nutrition and people's skin condition. Although they were seen to be reviewed monthly they provided limited guidance for staff on how to safely support people. We found one person who had been at the home on respite care since 20 October had no risk assessments in place to guide staff.

Some people living at Birch Holt required support managing their diabetes via insulin injections. Care staff were responsible for supporting people with this. Although care staff told us they felt confident to support people there were no specific diabetes care plans in place. This meant there was no formal guidance for care staff on how to recognise and manage the risk of possible changes in these people's physical or behavioural demeanour as a result of their diabetes. A diabetes 'monitoring diary' was kept in these people's rooms. This was used to record the time and site of an injection and a person's blood sugar readings. However there were no numeric 'normal range' readings

Is the service safe?

available for staff to determine if a person's blood sugar level was within safe levels for that person. This meant that staff would not be able to easily identify if a person's readings were a cause for concern.

The issues above issues related to people's safety were a breach in Regulation 12 HSCA (RA) Regulations 2014.

We found areas of the home were not clean. There was a strong mal odour in the home's entrance hall and other parts of the ground floor. A visitor said, "It really hits you as you come in." Close to this area was a small room which had been previously, but longer, used as a bathroom. We saw and staff told us the bath was now used to 'soak' commodes pans once they had been cleaned in another area of the home. This room had a strong damp odour. This room was within close proximity to people's rooms and a damp smell was apparent in the corridor outside this room. The wooden flooring was not covered and areas of the floor were visibly damp. The room was also being used as a storage area for various items such as a gazebo and a carpet cleaner machine. There were people's clothes in this room however the registered manager stated these awaiting to be taken to a local charity.

The main bathroom on the first floor had linoleum flooring which was curling up in several corners and did not provide a seal. There was an accumulation of hair on the floor in one corner; this was left from when the hairdresser had visited. Sections of grouting were missing around the bath and enamel had worn away in places on the toilet. All toilet brushes in communal toilets were stained and grubby. The extractor fans in the communal ground floor toilets were not working.

The registered manager informed us that responsibility for cleaning was shared between the domestic cleaner and care staff. The care staff cleaned sections of people's rooms on the corridor they had been allocated to work on. The domestic cleaner worked between 8am and 2pm Monday to Friday, this meant that communal living areas would not be cleaned at weekend.

We saw several people had commodes chairs in their rooms which were made from a wicker type material which are more difficult to effectively clean.

The home had two pieces of mechanical lifting equipment, these were used to assist people to move who were unable to do so independently. Staff were using slings for multiple people. This meant there was an increased risk to equipment not being clean for people.

These issues identified with the premises and equipment were a breach in Regulation 15 HSCA (RA) Regulations 2014.

Staff files contained photographs of staff, employment histories were checked, suitable references obtained. However we found one member of staff did not have a Disclosure and Barring Service check (DBS) in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The member of staff was a contractor who regularly undertook work at the service. There had been no assessment undertaken to mitigate the risks of this person working within the premises unsupervised. This staff member had access to all areas of the service and therefore required a DBS. Following our inspection the registered manager provided evidence they had begun the DBS application for this staff member. This is an area that requires improvement.

Care staff were able to identify their responsibilities to keep people safe from harm or abuse. They had an understanding of the different types of abuse. Care staff told us they had confidence senior staff would take appropriate action if they raised concerns relating to potential abuse. One member of staff told us, "I know they (senior staff) would take my concerns seriously." Care staff told us if they were not satisfied with the response from senior staff they would refer issues to the local authority or the CQC.

People told us there were sufficient staff available to assist them. One said, "I stay in my room a fair bit but I see they are about." During our inspection staffing levels matched what was planned on the staff rota. During the night there were two care staff on the premises. The registered manager predominately worked in an administrative function and was based in their office; however staff told us they were visible throughout the day. Staff told us they felt there were adequate numbers of staff to keep people safe. Call bells were seen to be answered promptly and people were supported safely by care staff whilst moving around the home.

Requires improvement

Is the service effective?

Our findings

Despite peoples' comments they felt well cared for we found shortfalls in aspects of the service which were not effective in meeting people's needs.

We reviewed a document that listed the mandatory training all staff had undertaken. This included areas such as medicines, safeguarding and fire training. We identified that some staff had not updated their training in some areas for extended periods of time, for example one staff member had not undertaken infection control training since 2006 and another three not since 2012. The importance that staff attach to infection control and cleanliness can be refreshed through training. We found areas of the service were not clean. Two members of night staff had not updated their safeguarding training since 2009. To determine what other 'supplementary training' staff had undertaken it was necessary to look at each staff member's individual file. This meant it was not easily identifiable which staff had undertaken what training and when it required refreshing. Accessibility to this information could be used for senior staff when planning rotas so staff skills sets could be best matched up to support people effectively.

We saw examples of staff not adhering to best practice principles they would have be shown in training. For example we observed a staff member bring a person a plate of food from the kitchen whilst they were undertaking medicines. It is good practice for a staff member responsible for undertaking medicines to be undisturbed whilst they administer medicines so as to reduce the risk of errors.

However staff we spoke to were clear on their roles and had experience to support the needs of older people living at the home. For example some staff had undertaking training in diabetes and falls prevention.

Staff files evidenced supervision was undertaken once every two months. The registered manager undertook the majority of these. Meeting minutes we reviewed were brief and provided limited feedback that was designed to develop staff performance and capability. For example one staff member's recent supervision notes from August 2015 stated, 'No problems, all well.' Staff supervision is an opportunity for senior staff to encourage staff to reflect on learning from practice, offer personal support and identify professional development opportunities. The issues related to training and supervision require improvement. However staff told us they felt supported and saw the registered manager regularly and could approach them about their roles.

The registered manager was aware of their requirements with regard to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to support people who do not have capacity to make a specific decision. There was one DoLS applications awaiting approval from the authorising body. Staff demonstrated knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Policies and procedures were available to staff on the MCA and DoLS. These provided staff with guidance regarding their roles and responsibilities under the legislation. Care staff understood the principles of the MCA and respected people's rights to make decisions. We saw people being asked for their consent routinely through the inspection. One person said, "They explain things as best they can."

Each person was registered with a GP and when they stated they did not feel well a doctor was called.One person told us, "My GP is very nice; they will come out when I need them." We saw other health services included an optician and podiatrist. People's daily notes we reviewed identified examples of where staff had liaised with health care professionals if concerns were identified, for example a with district nurse. We spoke with a visiting district nurse who had come to the home to dress people's wounds and check on people with skin pressure areas. They told us they felt the service met people's health care needs in regard to managing skin pressure areas and wound care. They said, "Care staff are good at keeping areas creamed that require it."

People spoke positively about the home's food. We observed three meal times during our inspection. The majority of people came to the dining room for their meals. One person told us, "I spend most of the time in my room but I like coming down for meals." Other people ate in one of the home's lounges using tray tables and others chose to eat in their rooms. There were drinks and condiments available. The days planned meals were identified on a white board in a corridor. Although there was no second choice of meal advertised, people told us they could request something else if they did not want the 'main

Requires improvement

Is the service effective?

option'. We saw one person had requested a sandwich for their lunch which was provided. The cook was able to describe how they catered for individual needs and explained, "You get to know their tastes and routines." Staff assisting people to eat were sat at eye level and engaged with them positively and offered encouragement. Background music was playing and people were seen to be chatting and enjoying the meal time experience in the dining room.

Requires improvement

Is the service caring?

Our findings

We saw people were treated with kindness in their day-to-day care. People stated they were satisfied with the care and support they received. One person said, "Nice staff here." Despite positive comments we found examples where the service was not consistently protecting people's dignity.

The home had only one bath with lifting equipment fitted to support people. Care staff told us the majority of people used this bath on the first floor. Although some people had ensuite rooms which had a shower, staff told us not many people were able to access the showers in their rooms due to their frailty and mobility limitations. The registered manager told us people were offered a bath in the evenings. We saw meeting minutes from a recent staff meeting which stated night staff were required to support two people per night for a bath. It stated, 'When a client declines a bath, take someone from another day, two baths must be done'. Staff told us the bath took a 'long time to fill' due to water pressure. This meant that if all people wished to have a bath in a specific week, night care staff would not be able to accommodate their requests.

We saw several people were using plastic double handed 'children's type' cups for their hot drinks. Staff told us this was to try to prevent injury from hot liquids. However individual care plans and risk assessments did not identify if using these were people's choice or the rationale for this decision and whether alternative specialist equipment had been explored.

We saw one person who had been assisted to eat their lunch had been supported to wear a plastic apron to act as a clothes protector. This person was still wearing this one hour after their lunch had finished before a staff member assisted them to remove it. We saw people were asked directly after lunch whilst still at the dining table what they would like for dinner.

Care plans were designed using a software package within the registered manager's office. This software allowed care plans to be populated with predefined text. We found some of the language did not protect people's dignity, for example one person's care plan stated, 'occasional unacceptable behaviour' and 'constantly interferes with others'.

Care plans contained limited information on people's preferences or choices regarding their end of life decisions. Some care plans identified comments related to preferences regarding burial or cremation and who to contact however there was no evidence people or their families had been involved in gathering views and choices. We spoke with the deputy manager regarding this issue. They told us although this was a sensitive area to discuss with people more work was required to capture people's wishes.

The above demonstrates a failure to respect people's dignity which is a breach in Regulation 10 HSCA (RA) Regulations 2014.

Staff knew people well. Records identified the home had a low staff turnover. We observed positive and kind interactions between staff and people. For example staff were seen to discreetly ask people if they required the toilet. We saw occasions where staff took time to explain to people and orientate them to the home's routines. We saw staff knocking on closed doors before entering. Care plans identified where people had made a choice regarding their staff gender preferences whilst being supported with personal care. One person said, "I don't mind who helps me but I know I could let them know and it wouldn't be a problem."

One person said, "I know I have got a care file, I know roughly what is in it but I'm not too bothered about the detail, but I could if I wanted to." Care records were stored securely. Confidential information was kept secure and there were policies and procedures to protect people's confidentiality.

We saw visitors were welcomed during our visit. Relatives told us they could visit at any time and were always made welcome. A visitor said, "I visit regularly and stay as long as I want, I am always offered a drink."

Requires improvement

Is the service responsive?

Our findings

People's care plans did not provide a person centred picture of their support needs. They lacked detail, personalisation and were not up-to-date. They did not capture why the person had come to live at the service, their medical overview, their background and life history had not been documented. There was limited information and guidance on people's preferred daily routines. One person presented behaviours that could challenge. There was no guidance for staff within their care plan on how staff should support them such as strategies or potential triggers. This person's care plan had been last reviewed on 24 September, their 'walking' care plan stated, 'X can walk unaided' however their daily care notes indicated on the 13 October they were being 'hoisted' for all transfers. On the day of our inspection we saw staff were assisting this person to move by using a mechanical lifting hoist.

The home had two lounges; we saw the majority of people spent their time in the ground floor lounge. A member of care staff had recently taken on additional responsibilities regarding coordinating activities within the home. They told us most activities were run, 'in house'. They told us they currently organised activities in the afternoon on a Monday and Thursday where they undertook games involving cards and dice. There was a regular external activity booking once a week on a Tuesday morning for a motivation session. People told us the registered manager accompanied some people to a nearby pub for lunch once a week. Staff told us that between two and seven people attended this. Other adhoc events such as an external music performer happened up to four times a year. One person told us, "A few of us go to an organised lunch at Herstmonceux once a month." Another person said, "I like to go for my daily walk, I just let the staff know I am going." A local religious leader visited the home on a monthly basis. However by using the SOFI observation tool we saw people had limited social interaction from staff whilst they were sat in the lounge. The primary focus was the television which alternated between radio and television. One person told us, "It would be nice to have bit more going on." Another said, "I enjoy the music man when they come in." A member of care staff told us there were no activities at the weekend as the home had more visitors. People who chose to remain in their rooms did not routinely have staff sit and talk with them on a one to one basis. One person said, "When staff are around they are here to help me get washed or dressed."

The lack of regular meaningful activities which met people's social needs was a breach in Regulation 9 HSCA (RA) Regulations 2014.

A satisfaction survey was undertaken annually. The registered manager told us this was aimed at residents, people's family and visiting health care professionals. A questionnaire form was left in reception for visiting health care professionals. Surveys were not posted out to peoples relatives. The most recent survey produced a total of ten returns. The feedback was seen to be positive and there were no suggestions identified for the home as to how or where they could improve.

The home's complaints log showed there had been no recent complaints recorded. We saw historic complaints had been responded to and the actions had been taken to resolve them were recorded. We spoke to people about how they would raise concerns if they had any. Most people said they would speak to the registered manager. One person said, "They (the registered manager) are about most of the time and I would tell them." Another person said, "I would speak to a carer if I was not happy about something." A visiting relative said they would 'pop their head' into the office to raise issues that needed resolving.

Inadequate

Is the service well-led?

Our findings

Birch Holt is the only service the provider operates. Although the provider is a partnership the registered manager told us that in recent months only one had been actively involved in the running of the service. The registered manager also informed us the provider, due to personal reasons, had recently been unable to routinely support them. As a result the registered manager had been required to take on additional responsibilities regarding the administration of the service. The registered manager was supported by a deputy manager.

Our inspection identified the provider and registered manager had failed to establish effective quality assurance processes that highlighted the areas of concern the inspectors found. For example there were no routine audits undertaken for medicines, infection control, care plans or health and safety. These can be used to identify shortfalls and drive improvements. The provider and registered manager had not established clear oversight of the areas that required attention. For example identifying issues such as the home having one bath with a hoist for twenty people, or there being no domestic cleaning in communal areas at the weekend.

The provider and registered manager were unable to evidence a planned approach to prioritising improvements to the home from a maintenance perspective. For areas of the home and furniture that required updating the provider and registered manager were unable to provide a timeline as to when works would be undertaken.

When people had an accident staff completed an accident form, once reviewed by a senior member of staff this was placed into people's individual care plans. The registered manager told us if a person had fallen then a tick was placed next to their name on a list in their office. This served as a visual indicator as to the number of falls people had. However information from these accidents had not been analysed to identify potential patterns, trends or for future staff learning.

The above issues and the concerns identified through the inspection directly relate to the service's leadership. Examples include failing to recognise the shortfalls with cleanliness and infection control, extended gaps in staff members training, one person having no care plan or risk assessments, not assessing the security risks associated with the front door and a member of staff not having adequate recruitment checks.

The above concerns are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified the CQC regarding some but not all notifiable events at the service, for example the number deaths. Under the Health and Social Care Act 2008, providers are required by law to submit statutory notifications. A notification is information about important events which the provider is required to tell us about. As part of the inspection process we identified information which had not been notified to us. We discussed the CQC notification templates which can be used to submit information however the registered manager was unaware of these documents or where to locate them on the CQC website.

By inconsistently notifying the CQC of notifiable events is a breach in Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

Following our inspection the registered manager notified the CQC that they had begun or had made some improvements in light of the feedback they had received from Inspectors.

The most recent staff meeting had been in October 2015. Six staff attended, this included the registered manager. These occurred on a six monthly basis. Staff meetings provide an opportunity for staff to share operational information and provide updates on individual people. Staff told us although they considered the communication between them generally worked, one said, "I have to admit I haven't been to a staff meeting for a while."

Staff told us they felt supported by the registered manager and they were available if required. One member of care staff told us, "It is straight forward to raise things with the manager or deputy." People told us they felt the home generally 'ran smoothly' and their comments and suggestions were usually listened to. One person said, "This is a nice place to live, the staff are kind." People said the registered manager was approachable and available.

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 **The registered provider had failed to ensure peoples care was meeting reflecting their preferences.** **Regulation 9(1)(b)(c)**

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured peoples autonomy and choice and dignity was respected.** **Regulation 10(1) 2(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered provider had not fulfilled their statutory obligations to the CQC with regard to notifications.** **Regulation 18(2)b(ii) 2e**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g) The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk and mitigating the risk. 12(2)(a)(b)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered provider had not taken steps to ensure the premises were clean. 15(1)(a)

The enforcement action we took:
Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(2)(a)(b)(c)

The enforcement action we took:
Warning Notice.