Mrs Brenda Tapsell

The Granleys

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
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

This inspection took place on 23 and 24 September 2015 and was unannounced. The Granleys provides accommodation for up to 17 people with a learning disability. At the time of our inspection there were 17 people living there. People had a range of support needs including help with their personal care, moving about and assistance if they became anxious. Staff support was provided at the home at all times and people required supervision by a member of staff when away from the home. Each person had their own room; they shared a bathroom and shower rooms as well as living and dining areas. The home was surrounded by gardens which were accessible to people.

There was a registered manager 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.

We found a number of breaches 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 this report.

People were put at risk when their needs changed and their risk assessments were not updated to reflect

Summary of findings

accidents or incidents which had occurred. For one person the risks of them having further falls had not been prevented. There was no analysis of accidents or incidents to monitor and respond to repeated accidents. Referrals to health care professionals were made and their recommendations followed. However, these were not always being followed up to reduce risks further.

People's capacity to consent had not been assessed in line with the Mental Capacity Act and best interests' meetings had not always been held to discuss why decisions were taken. Medicines were not being administered safely and in line with national guidance. Safeguarding alerts were not always being raised when needed and the Care Quality Commission was not being notified as required by law.

Robust procedures were not in place when appointing new staff to make sure all information, required by law, had been obtained. Staff were busy and at times there were not sufficient staff to make sure people's care and support was being delivered safely.

People and those important to them knew how to make a complaint or raise issues. Complaints were not being recorded and there was no evidence of how the provider had responded to these. People and staff expressed their views as part of the quality assurance process but were not involved in quality audits carried out by the provider. Quality assurance systems did not drive through improvements.

People enjoyed an active lifestyle accessing resources in their local community such as places of worship, clubs, leisure centres and colleges. People had opportunities to do voluntary work. They had a range of activities provided at home including music and dance. People said they were happy living at the home and it was "amazing". They said they liked the food and made choices about what to eat. They had just changed the menus to include cooked breakfasts.

Staff said they were well supported and had access to training relevant to the needs of people they supported. They were able to develop professionally and were completing the diploma in health and social care. People and staff spoke highly of the registered manager who was open and accessible.

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. People were not being protected against the risks of possible harm or injury. Robust systems were not in place to manage risks they faced.

People were not always supported by sufficient numbers of staff to keep them safe and to meet their individual needs. Recruitment and selection procedures were not robust and did not make sure all the necessary checks were being completed.

People's medicines were not being managed in line with national guidance.

People felt safe and staff understood how to raise concerns about potential abuse, although this was not consistently applied.

Is the service effective?

Requires improvement

The service was not always effective. People's capacity to make decisions was not being assessed in line with the law, when they were unable to consent to their care and support. There was no evidence decisions were being made in their best interests.

People who were being deprived of their liberty, to keep them safe, did not have the appropriate authorisations in place.

People were supported by staff who had access to training to equip them with the skills and knowledge to meet their needs.

People were being supported to have a healthy diet. Their health and well-being was being monitored and referrals were made to health professionals to help them to stay well.

Is the service caring?

Good

The service is caring. People were supported with kindness and respectful interactions were encouraged.

People talked to staff about their views and made decisions about their daily lives.

People were helped to be independent.

Is the service responsive?

Requires improvement

The service was not always responsive. People's complaints and those of others involved in their care were not recorded or responded to. People said they would talk to staff or the registered manager if they had concerns.

Summary of findings

People's care plans were mostly kept up to date with changes in their needs and reflected their wishes and preferences. People had the opportunity to be involved in activities outside of their home in their local community. Activities they enjoyed were also provided in their home.

Is the service well-led?

Requires improvement

The service was not always well-led. Quality assurance processes were not robust. Risks to people were not consistently managed and there was no effective system for driving through service improvements.

The registered manager did not always submit notifications as required by law, to the Care Quality Commission about accidents or incidents.

People, those important to them and staff voiced their views about their experience of care. The registered manager was open and accessible to people and staff.

The Granleys

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.

The inspection took place on 23 and 24 September 2015 and was unannounced. One inspector carried out this inspection. Before the inspection, the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including past inspection reports and notifications Services tell us about important events relating to the service they provide using a notification. Information had been shared with us by a local authority quality assurance team.

As part of this inspection we talked with eight people living in the home. We spoke with the registered manager and seven care staff. We reviewed the care records for four people including their medicines records. We also looked at the records for three staff, quality assurance systems and health and safety records. We observed the care and support being provided to people. After the inspection we contacted two social care professionals.

Inadequate

Is the service safe?

Our findings

People confirmed they felt safe living at the home. One person told us they had "been picked on, but it's all alright now." There were inconsistencies in the way in which safeguarding concerns were responded to and dealt with. Concerns had been raised about how people were treated by some members of staff. This had been raised by community professionals and a safeguarding alert was raised in response by the provider. This had been investigated and the registered manager said they had addressed the issues with staff as a team and individually in meetings. People told us they were not shouted at or spoken to rudely. Although some staff indicated at times this was still a problem. This alert had not been shared with the Care Quality Commission (CQC). Another safeguarding incident had been notified to the local safeguarding authority as well as CQC. There was evidence the appropriate action had been taken in response to this.

People were not always being protected against the risks of abuse. An incident had been recorded which described how a person had allegedly been assaulted by another person living in the home. There had been no witnesses but an injury had been sustained and the person had described how this had happened. No further action had been taken by the registered manager to investigate this or to escalate a safeguarding alert.

People did not have access to information about safeguarding and how to stay safe. They told us they would talk to staff if they had any concerns. Staff understood how to raise safeguarding concerns and had completed training in safeguarding. Although they had access to a local telephone number to ring they did not have a copy of the local safeguarding procedures.

People were not being protected against the risks of harm or abuse. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People had support to manage their finances if needed by the provider and the registered manager. Records were kept of any income and expenditure and receipts were kept to evidence items they had purchased. People were charged towards the costs of running the bus allocated to The Granleys. One person did not use the bus due to access difficulties and their contribution was used towards the cost of using a taxi. The registered manager said they had analysed receipts to assess whether this was cost effective and were considering if this was the most appropriate way to pay for travel expenses.

People were not being protected against risks and action had not been taken to prevent the potential of harm. Accident and incident records had been kept when people had falls or slips or trips. Although the registered manager monitored these, there were no systems in place to analyse, assess and record on-going risks to people. The actions taken in response to accidents and incidents were not robust and whilst referrals were made to community professionals for some people to prevent further harm this was not consistent.

One person had been referred to health care professionals due to falls in their shower. There was no risk assessment in place to describe the risks to them or what support staff should provide to prevent a fall happening. Their care plans indicated at times two staff would be needed to support them if they were feeling under the weather. Staff commented however that due to the person's condition, which came on quickly and with no warning, it was not always possible to assess when two staff were needed. Despite trying out a chair in the shower which proved unsuccessful and a change in medicines, they were still at risk of falls. Over a space of nine months they had a further five falls in their shower.

In addition, a night report indicated the person's legs had to be moved back into their bed. This incident had not been followed up as a near miss and no risk assessments were in place to describe the sleeping arrangements or the support needed by staff overnight. A hospital bed had previously been provided which was lowered to minimise possible harm.

People were protected against the risks of fire. Each person had an individual evacuation plan in place describing how to help them to leave the building in an emergency. People had taken part in drills to evacuate the building and knew where they should go. On-call systems were in place should staff need help or support out of normal working hours. They said they could rely on the registered manager. There were systems in place to monitor fire, water temperatures, legionella and portable appliances to make sure the environment and equipment were maintained safely.

Inadequate

Is the service safe?

People's medicines were not managed safely. Arrangements for the supply of medicines had been changed due to previous concerns about the safe administration of medicines. Medicines were supplied each week and the medicine administration record (MAR) recorded stock levels for medicines delivered in blister packs. No clear stock records were being kept, at the time of the inspection, for medicines kept in boxes or given to people as needed. There was no evidence of authorisation from the GP or pharmacist for the use of homely remedies.

Most people had given their consent for staff to administer their medicines. One person's care plans stated they were being given their medicines with a drink. Their drinks had to be thick and easy to swallow, so their medicines were given to them on a spoon with a thickened drink. This had not been discussed with their GP or pharmacist. There was no evidence this way of giving medicine was being done in their best interests or was the safest way to administer their medicines. A decision or action taken on a person's behalf must be made in their best interests where a person had been assessed as lacking capacity to make a decision.

The risks associated with people receiving unsafe care and support were not being assessed. This potentially put people at risk of harm or injury. The administration and management of medicines was not following current national guidance, potentially placing people at risk of harm. **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People were supported to manage their own medicines. One person was given their medicines daily which they kept locked in their room. Staff had completed training in the administration of medicines and were observed to assess their on- going competency.

People were put at risk of receiving inappropriate care and support by poor recruitment and selection processes. Applications were submitted which asked for a full employment history. However there were gaps in employment history in the applications looked at. This meant the registered manager was not fully able to assess the competency and experience of new staff. Proof of identity was provided by new staff and for two this included a current photograph. A photograph had not been obtained for a third member of staff.

The registered manager had failed to carry out all the checks required by law when appointing new staff. **This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff were only appointed after a full disclosure and barring service (DBS) check had been received and references had been returned from at least two former employers. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. Staff confirmed they shadowed existing staff for at least two weeks prior to working on shift and this could be extended if needed. New staff completed an induction programme and were registered to follow the Care Certificate standards to assess their competency. The Care Certificate sets out the learning competencies, standards of behaviour expected of care workers.

People were being supported by three care staff and additional support from the deputy or registered manager when needed. One person's care plans stated they needed two staff when transferring from their chair, wheelchair or bed. This person also at times needed the support of two staff when showering. Staff feedback about staffing levels was mixed. They all said they were very busy and acknowledged the registered manager was "hands on" and would help out. A domestic/catering assistant was on long term absence and this post, although advertised, had not been appointed to. This meant staff had to prepare and cook meals as well as their other duties. Staff said the staff team also covered annual leave and sickness. Agency staff were not used. The provider information return recognised staffing levels needed to be reviewed. People were potentially put at risk of receiving inappropriate care and support due to staffing levels which did not reflect their individual needs. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Requires improvement

Is the service effective?

Our findings

Some people were not able to make decisions about their care and support. Medicines records confirmed this and stated staff could administer medicines on their behalf. There was no evidence of people's mental capacity being assessed in line with the Mental Capacity Act 2005. There were also no records detailing decisions taken in their best interests and who had been involved in these decisions. A decision or action taken on a person's behalf must be made in their best interests where a person had been assessed as lacking capacity to make a decision. For people unable to make decisions about their care and support their care plans did not evidence how their mental capacity had been assessed or when decisions were to be made in their best interests. For example, supporting a person with personal care, nutritional requirements or moving and positioning. There was no guidance for staff about how they should support people with fluctuating capacity to make choices or decisions. For instance, where people were living with dementia and were at times able to make choices but at other times needed help to make decisions in their best interests. There were some restrictions in place to keep people safe. One person used a lap belt to stop them falling out of their wheelchair and the front door was kept locked. There were no records to confirm the rationale for these restrictions as being in people's best interests. Staff had completed training in the Mental Capacity Act 2005 but did not always follow the requirements of the Act.

People's consent to their care and support was not always being recorded in line with the requirements of the Mental Capacity Act 2005. **This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

At the time of our inspection visit there had been one authorisation granted for a person relating to restrictions on their liberty. Although the registered manager was aware of the latest guidance in relation to the Deprivation of Liberty Safeguards (DoLS) no further applications had been submitted for other people living in the home whose liberty had been restricted to keep them safe. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom.

The provider was not acting in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People were encouraged to make choices and decisions about aspects of their care and support such as choosing what to wear, what to eat and what activities they would like to do. Staff were observed supporting people to make choices by offering them objects to enable them to choose between or giving them alternatives to choose from. One person had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place which had been discussed with their family and authorised by their GP.

People occasionally needed help to manage their emotions or feelings. Clear guidance had been provided about what might upset people, for example noise or people congregating together. Records also stated what staff should do to help people remain calm, such as suggesting the person went somewhere quieter or distracting them to make a drink or listen to music. Incidents affecting people's well-being were recorded and monitored by health care professionals. Staff said they did not use physical intervention and the provider information return confirmed this.

People told us they liked the food and were able to make choices about what they had to eat. People were observed having drinks and snacks when they wished. One person said they enjoyed helping in the kitchen. A menu had been put together with people to reflect their likes and dislikes. A new menu for the winter included brunch at the weekend and the option of cooked breakfast such as pancakes or poached egg. One person needed a soft diet and their food was pureed and presented in an appetising way. Staff supervised another person whilst eating and their food had to be cut up. If people missed a meal they had their food at a time to suit them. People's weights were being monitored. Social care professionals were concerned these were not always being followed up and the necessary action taken to fortify people's diet to prevent further weight loss. The registered manager confirmed they had not used butter or cream as additives for people losing weight but did encourage people at risk of weight loss to eat their meals.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. This included training

Requires improvement

Is the service effective?

considered as mandatory by the provider such as first aid, food hygiene, moving and positioning and infection control. Staff said they had also completed dementia training which really helped them understand people living with dementia and how to interpret their behaviour. A training spread sheet was kept to provide the registered manager with an overview of the needs of staff and to monitor when refresher training was needed. Staff said they were supported to develop professionally completing the diploma in health and social care at levels two, three and five. Assessors had been trained to carry out observations in line with the Care Certificate. New staff had been enrolled on this certificate and the registered manager intended to enrol existing staff as well. Staff had received professional support through individual meetings with the management team as well as regular staff meetings.

People had health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A record of appointments and any action taken was kept. People had annual health checks with their GP. Each person had a health action plan and a hospital passport should they need to go to hospital in an emergency. The registered manager said they worked closely with learning disability liaison nurses at local hospitals to make sure a smooth transition was in place for planned admissions.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and they liked the staff. One person commented, “Staff help me do my hair, they are alright.” and another person said, “I love it here, the staff are so nice”. People were treated kindly and respectfully. Social care professionals had raised concerns about the way people had been treated in the past. The registered manager said she had discussed with staff about developing positive relationships and treating people with respect. People confirmed, “Staff don’t shout”, and “Staff are polite”. Staff reflected this had been a problem but was currently not an issue.

People’s religious beliefs were recognised and they were supported to attend their choice of a place of worship. People’s preferences for support from staff of a particular gender were checked with them each day and respected. Activities were age appropriate and reflected their choices. Staff commented some resources such as magazines, colouring books and puzzles were provided because people enjoyed having them. They said parents of one person who had recently moved to the home, had commented how pleased they were to see their relative dressing in clothes which reflected their age and how smart they looked.

People’s personal histories had been provided giving staff some context to their life experiences. People’s likes and dislikes were highlighted but assumptions were not made that people may change their minds. Staff knew and understood people well, helping them to manage their feelings and emotions. Distraction was used to help people become calmer using activities or resources they enjoyed.

People told us they chatted with their key workers about their life at the home. One person said, “I talk about what I like to do” and another person said, “[Name] helps me, we go shopping and do cooking”. People confirmed staff listened to them, “of course they do”. Staff talked with people at their own pace, giving them time to reflect on the information they had been given and waited for their response or decision. People attended residents’ meetings where they exchanged views about what activities they would like to do and the food they would like to have on the menu. They also chatted about changes they would like to the décor of the home. People had access to advocates if and when they needed them.

People’s privacy and dignity was respected. Their care records prompted staff to make sure personal care was delivered in the way people wished to receive it and to make sure staff knocked on people’s door before entering. Daily records had been written respectfully by staff acknowledging when people were upset and stating “as a team we are working together to try and get problems solved”. Staff were encouraged to prompt people to do things for themselves. People were encouraged to do aspects of their personal care and helped around their home with the cooking, clearing away and cleaning. Staff described to people what they were doing and why, such as when helping people with moving and positioning tasks.

People’s family and people important to them visited at times which did not impact on people’s daily lives. Visitors told us they were made to feel welcome and “it is a nice home” and their relative had “settled in well”.

Requires improvement

Is the service responsive?

Our findings

People told us they knew how to make a complaint about their care or other issues and would talk with their key worker or the registered manager. A relative commented, "If I have any concerns they do try their hardest to put it right." Staff said they would report concerns to the registered manager or provider and if they were not resolved they would contact the Care Quality Commission (CQC). Staff told us they had no concerns about people living in the home or the care provided. Relatives reflected complaints they had raised had been resolved but they had not always had feedback direct from the registered manager. There were no systems in place to record, monitor or to evidence learning from complaints received. A poster produced in an easy to read format for people living in the home was displayed in communal areas and in each person's rooms. This gave misleading information telling people to call CQC with their concerns. The complaints policy and procedure correctly listed the contact details for the local authority and the local government ombudsman who should be contacted if people were unhappy with the provider's response to their concerns.

A robust process was not in place for responding to or evidencing learning from people's complaints. **This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People said they talked to staff about the support they needed in their day to day lives. One person commented, "Staff are very helpful" and another said, "Staff are helping me to give up smoking". Inconsistent feedback was received from staff and relatives regarding communication about changes in people's care. Overall there was improved communication about changes in people's needs but there were still times when not all of the staff seemed to be kept up to date with changes. The registered manager was aware of this.

People's care records provided a personalised overview of how they wished to be supported, their preferences, likes and dislikes and routines important to them. Daily records provided a comprehensive record of how people were being supported and the risks they faced. Along with a monthly review of people's needs these provided evidence of changes in people's health or well-being. Some care plans had been reviewed to reflect these changes but this was inconsistent. For example, one person's eyesight had deteriorated and they had chosen to spend most of their time at home due to risks of slips and trips but their care records did not reflect this. Other care plans had been updated to reflect changes in people's needs and cross referenced with guidance provided by health care professionals such as eating guidance. There was evidence equipment needed to maintain people's independence and safety was being provided such as a commode or wheelchair.

People told us about their daily lives and what they liked to do. They enjoyed activities outside of their home but also whilst at home too. People went to local day centres, colleges and leisure centres. People also took part in volunteering opportunities such as a butterfly garden project. People had busy lifestyles and showed us their activity schedules. During our inspection people went to an organ playing group at a local church, skittles and out for coffee. Activities when at home included games such as bingo or arts and crafts. They also had music and dance sessions provided. The provider information return (PIR) stated, "Service users maintain relationships with others inviting them to coffee mornings and to skittles". People from their local place of worship joined them regularly at the home and they met with friends at social clubs.

Requires improvement

Is the service well-led?

Our findings

Allegations of abuse had been raised and investigated on behalf of people. The provider had discussed these issues with the appropriate authorities and social care professionals. The safeguarding authority had been notified of these incidents. The Care Quality Commission (CQC) had not been notified of all allegations of abuse. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers. **This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.**

The provider did not have effective systems in place to monitor the quality of care and service that people received. Quality audits were completed at three monthly intervals and a checklist had been produced to evidence systems and processes looked at. Some actions had been carried forward for several audits such as replacing new carpets and employing replacement staff for maternity cover. Feedback from people living in the home and staff had not been included in this audit. Audits of care records had not identified a lack of risk assessments. Medicines audits had failed to question the administration of medicines with food. The registered manager had not analysed accidents and incidents to look for any developing trends. There was no recorded evidence of action taken in response to these. There was no system in place to record complaints or evidence what action had been taken. An annual report had not been produced to reflect the feedback from people or staff and improvements made as a result. There were no systems in place to review the delivery of care against current best practice and to drive through improvements. People were not being protected against the risks relating to their welfare or health and safety because the systems to monitor and assess these risks were not robust. **This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People, their relatives and staff had taken part in an annual survey giving feedback about their views of the service.

People were able to talk to the registered manager on a daily basis about issues or concerns and more formally at residents' meetings. People told us "It's amazing here" and "I like living here". Staff commented, "People are really happy, glad to be working here" and "We communicate well with people".

People benefited from staff who understood and were confident about using the whistleblowing procedure. Staff said they would be listened to and action would be taken to address their concerns. The registered manager said she had not always given staff feedback about issues they had raised and was addressing this by improving communication through team and individual meetings. Relatives commented about better communication with them but said there was still room for improvement.

The registered manager was accessible to people. Staff commented people really liked the registered manager and it helped that she worked alongside the team. The registered manager said her door was always open and people liked to spend time with her in the office. The registered manager said her vision for people was to ensure they "get everything they want and their wishes are achieved". Staff mirrored this saying, "The extra five minutes we spend with people individually is important" and "We are good at being there for people". The registered manager recognised the challenges of managing a staff team with mixed skills and knowledge of care and had plans to offer a wider range of training courses. The registered manager said resources were available for her to manage the home. Staff felt supported by the registered manager and were able to develop professionally. The registered manager had challenged poor practice and was clear about her expectations of staff and their responsibilities. She kept her own professional development up to date through membership with a local care providers' association and was completing a diploma in health and social care at level five. Feedback about the registered manager included, "She is very good" and "She has a good approach, she responds to issues".

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 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 with respect to people who lacked mental capacity to make decisions or give informed consent about their care. Regulation 11(1)(2)(3)

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 People who use services were not protected from abuse and poor systems were operated to investigate allegations of abuse. Regulation 13(1)(2) People who use services were being deprived of their liberty for the purpose of receiving care or treatment without the appropriate authorisations in place. 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Regulation 16(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not have systems to assess, monitor and improve the quality and safety of the services, such as regular audits. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured there were sufficient staff employed to meet people's care and support needs. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not operated effective recruitment procedures to ensure all information about staff was obtained before they were employed. Regulation 19(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay of allegations of abuse which occurred whilst services were being provided in the carrying on of a regulated activity. Notifications had not been submitted when standard authorisations had been granted to deprive people of their liberty. Regulations 18(1), (4A,B) (5) (b)(ii)

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 People who use services were not protected against the risks of receiving unsafe care and support. Risks had not been assessed to prevent avoidable harm. Regulation 12(2)(a) People were not protected against the risks associated with the unsafe management of medicines. Regulation 12(2)(g)