

Crosscrown Limited

Granville House

Inspection report

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30 January 2020
07 February 2020

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Granville House is a residential care home, providing personal care and accommodation for up to 23 older people, including people living with dementia. The home was divided into three separate floors or units which were being used as residential accommodation. There were 22 people living at Granville House when we inspected the service.

People's experience of using this service and what we found

People did not always receive safe care and support, as individual and environmental risks were not always sufficiently managed to ensure people's safety. Medicines management required improvement to ensure people always received their medicines as they should.

People were not always supported to have maximum choice and control of their lives, as staff were risk averse, and told us they would prevent people from leaving the home alone. Where people required a DoLS to restrict their movements, these had not been put in place. The provider failed to ensure people received the right amount of nutrition to ensure they maintained their weight and health.

People using the service did not consistently receive support from a well led service. Quality monitoring systems and processes had failed to identify where the service needed to make improvements.

People felt safe at Granville House. Staff understood their responsibilities to protect people from the risk of abuse. The registered manager checked staff's suitability for their role before they started working at the home.

People received kind and caring support from staff. Staff respected people's private spaces. Overall, people and their relatives were involved in planning their care and support. The staff team worked to promote people's dignity and privacy.

The service was led by a registered manager who was supported by a deputy manager and senior care worker. People knew how to raise concerns and provide feedback about the service. The provider ensured people received care at the end of their life, which met their wishes.

Rating at last inspection

The last comprehensive inspection report for Granville House (published August 2017) we gave a rating of Good in all areas. At this inspection we found the service had deteriorated and have rated the service as requires improvement. We identified two breaches of the regulations in safe and well led.

Enforcement

We have identified three breaches of the regulations in relation to the safe care and treatment of people, whether people were supported in line with the mental capacity act and in the management of the service

at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Why we inspected

This was a planned inspection based on the rating at the last inspection.

Follow up

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement 

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement 

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good 

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good 

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement 

Granville House

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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.

Inspection Team

The inspection team consisted of two inspectors.

Service and service type

Granville House is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission (CQC). The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

The initial inspection visit took place on 30 January 2020 and was unannounced on the first day. We returned to complete our inspection on 07 February 2020.

What we did before inspection

We reviewed information we had received about the service since the last inspection. This included information received from the provider about deaths, accidents and incidents and safeguarding alerts which they are required to send to us by law. We also requested feedback from the Local Authority quality monitoring officers. We reviewed the information from the Provider Information Return. This is information we require providers to send us at least once a year to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection

We spoke with seven people living at the home. Some people, due to their complex care needs and disabilities were unable to give us their feedback about the home. We spent time with people to see how staff supported them.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed care and support being delivered in communal areas of the home.

We received feedback from seven members of staff including the registered manager and deputy manager. We also spoke with a visiting health professional.

We reviewed a range of records, including four people's care and medicines records. We also looked at records relating to the management of the service, including audits and systems for managing any complaints. We reviewed the provider's records of their visits to the service; and records of when checks were made on the quality of care provided.

We looked at three personnel records to check that suitable recruitment procedures were in place, and that staff received supervision and appraisals to continue their professional development.

Following our inspection

We received feedback from a visitor to the home and four relatives of people who used the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks were not always managed safely. Risk assessments and risk management plans were not always in place to instruct staff on how they should manage risks to people's health and welfare. One person was losing weight, but their food intake was not being monitored. A referral to a dietician had not been made to seek medical advice about how the person's weight loss should be managed. Their care records did not show clearly how much weight the person had lost, because weight records had been archived. We retrieved the weight records and found the person had lost 12kg in the previous nine months. The person had not been placed on a fortified and extra calorie diet to reduce the risk of weight loss. We brought this to the attention of the registered manager, who made a referral to the dietician following our visit.
- Another person had a diagnosis which cause them pain and swelling. We found it was not mentioned in the person's care records. There was no care plan or risk management plan in place, so that the condition could be monitored, and potential triggers avoided. Following our inspection visit we were sent information about the management of the condition which had been added to the person's records.
- Another person had a catheter in place (a soft hollow tube, which is passed into the bladder to drain urine) and required their fluid intake and output to be monitored. This was to ensure they remained hydrated and free from any infection. Records were not robust enough to demonstrate staff were monitoring their fluid intake and output to ensure the person did not become unwell. We raised this with the registered manager, who implemented improved catheter monitoring straight away.
- Environmental risks were not always managed safely. We found radiators around the home did not have radiator covers in place, to reduce the risk of people becoming burnt on hot radiators. We brought this to the attention of the registered manager on the first day of our inspection visit. The registered manager assured us that plans were in place to cover radiators following our visit.
- There was a lack of storage around the home, and mobility equipment such as hoists were stored in communal areas and lobby-ways at the home. This posed a risk of people walking into equipment and injuring themselves.

Using medicines safely

- The provider was not consistently following safe protocols for the storage and administration of medicines. We looked at four people's medicines and medicines records, and we observed medicines administration. We discussed the safe administration of medicine with the registered manager and a staff member responsible for administering medicines.
- Controlled medicines NICE guidance advises providers that staff should make appropriate records of controlled drugs that have been administered to people. The staff responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. Controlled medicines are at

risk of being misused, and so extra safety measures are needed to make sure they are prescribed, supplied, used and stored safely. We saw one person was given their controlled medicine by one member of staff. The member of staff did not seek the support of another staff member to witness the administration of the medicine. We checked the controlled medicines register, which is a log of who administers these types of medicines and checks the stock of each medicine when given. This medicines register had been signed by the registered manager and the staff member, to say they had both witnessed the medicine being administered. We brought this to the attention of the registered manager, who explained they had signed the register to confirm they had made a stock count, however, they confirmed they had not witnessed the staff member give the person their medicine. The safe procedure for the administration of controlled medicines was therefore not always being followed.

- Medicines were not accurately accounted for, as medicines records did not reflect the true amount of medicines that were in stock for each person. We counted three medicines for one person, there was a discrepancy in the total tablets in stock for all three medicines. These discrepancies had not been identified in medicines audits. This meant we could not be sure people were receiving their medicines as they were prescribed.
- Topical medicines such as creams were not always stored securely. We checked how creams were stored when they were kept in two people's bedrooms. We saw a total of five topical medicines were left out in their bedroom, which was accessible to people passing by. Where people had creams in their bedrooms, the area was not temperature controlled. We saw that two of the creams should be stored below 25 degrees centigrade, to ensure they were effective. The creams were not dated, to show when they had been opened, so that we could not be sure whether the cream could be used safely. Two of the products were flammable. We asked the registered manager whether there was a risk assessment in place for the use and storage of such creams, they told us there was not. Following our inspection visit the registered manager showed us evidence that risk assessments had been put in place for the use of flammable topical creams.

The registered person failed to protect people from the risks associated with the unsafe management of medicines. The registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

- People and their relatives told us they felt safe at the home. One person said, "They [staff] are there if I need them that's why I am safe. The staff always make sure my frame [walking aide] is nearby."

Staffing and recruitment

- People told us, and we saw during our visits, there were enough staff to care for people safely. One person said, "Staff look after me. There is a bell, but I usually call and someone comes."
- The provider used a dependency tool, to calculate the numbers of staff needed to support people, based around people's current assessed health and care needs. The management team were confident there were enough staff to keep people safe.
- In addition to allocated care staff, there were also a number of other staff that could be called on to support care staff at busy times, such as the activities co-ordinator, registered manager, deputy manager and the head of care. One staff member said, "I think there is enough staff. I feel like I have enough time to speak to people. If not the manager will come and help."
- Throughout our inspection visits we saw people's needs were met in a timely way. Staff were not rushed and had time to spend with people.
- The registered provider undertook background checks of potential staff to assure themselves of the suitability of staff to work at the home.

Learning lessons when things go wrong

- Staff knew how to report and record accidents and incidents. The registered manager was responsible for analysis of accidents and incidents to identify patterns and trends and prevent a reoccurrence. Learning from incidents was shared with the staff team.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training and understood their roles and responsibilities in keeping people safe. Staff told us they would report any concerns if they suspected abuse and had confidence the registered manager would investigate.
- The registered manager and provider understood their legal responsibilities to protect people and share important information with the local authority and CQC. Notifications about specific events had been sent as required by the provider.

Preventing and controlling infection

- Overall the service was well presented, clean and tidy.
- Staff had received training in infection control and worked in line with NHS England's Standard Infection control precautions and national hand hygiene protocols.
- Staff understood the importance of using gloves and aprons to reduce risks of cross contamination.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The registered manager and staff demonstrated they understood people's capacity could change, according to their health. However, the registered manager and staff did not consistently understand all the principles of the MCA. We were concerned care staff were overly cautious in enabling people to take positive risks in their lives. For example, to make choices about leaving the home.
- On the first day of our inspection visit we found no DoLS applications had been made to the local authority, where people had restrictions placed on their movements. One person had a history of trying to leave the home, and care staff prevented them from doing so when they indicated they wanted to leave. This was because care staff felt the person was not safe to leave the home unless they were accompanied by staff. However, although we agreed the person might need support to access the local community, we were concerned they were restricting the person without the appropriate authorisations in place.
- On the second day of our inspection visit we saw the registered manager had made DoLS applications for four people who lived at Granville House, to gain the authority to restrict their movements. This was because four people would not be safe leaving the home unaccompanied by staff and lacked the capacity to make risk-based decisions about their own safety.
- However, care staff told us they would not let anyone leave the home alone, unaccompanied by staff. This meant there was a lack of understanding about how people with capacity to make their own decisions should be encouraged to make their own choices and remain independent.
- Mental capacity assessments that described what decisions people could make for themselves, and what decisions people needed support with, were not consistently completed. This meant it was difficult to understand which decisions people required support with, and which decisions should be made in the person's best interests, with the person, their representatives and health and social care professionals.

The registered person failed ensure care was provided with the consent of the relevant person. This was breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Need for consent.

Supporting people to eat and drink enough to maintain a balanced diet

- Where people were losing weight the provider was not always supporting them to access dietician's for advice and was not always providing people with an increased calorific diet where this was necessary. Following our visit, the registered manager ensured an appropriate referral had been made to a dietician. In contrast, one relative told us how the kitchen staff did cater for their relation's lactose intolerance, providing them with many different choices of food.
- Overall, people and their relatives told us they were satisfied with the quality of food provided. Comments included, "The chef is a good cook. It's the sort of food I like anyway", "There is a choice of two meals. There is plenty to eat and drink. I am never hungry or thirsty", "The food is excellent. Always good quality. Delicious puddings like cherry pudding and custard."
- People told us they were offered plenty to drink, to keep them hydrated. When we visited people in their rooms we saw people had drinks close by.

Staff support: induction, training, skills and experience

- The provider ensured care staff completed an induction that met the standards laid down by Skills for Care, a recognised organisation that provides care staff with training standards.
- Care staff received refresher training for their roles. However, staff did not always demonstrate they understood the principles of the MCA.
- Regular meetings with a manager, team members and individual performance reviews gave staff the opportunity to discuss training and practice, reflect on difficult or challenging situations, and identify areas of learning and development.
- The provider had an 'open door' policy, staff could raise any issues of concern or gain support from the deputy or registered manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs regarding their physical and emotional health were assessed in line with their wishes and preferences for their daily routines. Pre-assessments were carried out prior to anyone moving into Granville House and information regarding people's social and spiritual needs and their sexuality formed part of the assessments.

Adapting service, design, decoration to meet people's needs

- Granville House was divided into two floors.
- The home was not a purpose-built care home and had been converted to offer people a communal lounge area, dining room and outside garden space. Each person had their own bedroom.
- However, there was a lack of private space, or separate communal areas for people to meet with family and friends, as everyone shared the same communal lounge and dining room spaces.
- Signs were used around the home to direct people, to ensure people with memory problems or confusion could find their way.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People told us they were able to access health professionals and medical treatment when they needed to.
- Where people required assistance from a nurse, nursing professionals visited the home on a daily basis to support people with their treatment. The provider was improving the way they worked with health

professionals, to ensure any recommendation or changes to people's treatment plans were recorded.

- Regular staff handover meetings shared key information about people's needs, accident and incidents, hospital admissions, any changes in their health, and whether follow up referrals to other health professionals were needed.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Most of the people and relatives we spoke with told us staff were kind and caring and treated them with respect. Comments included, "I have been extremely kindly treated here", "Staff are very patient... It is 24 hour' care and I am amazed at how cheerful they are at 2am in the morning", "There is a kind and caring set of people." However, two people raised concerns with us regarding a member of staff, who they described as being abrupt with them at times.
- There were caring interactions between staff and people who used the service. Staff regularly checked on people in the communal areas of the home, to make sure they felt well. Staff spent time in the communal areas of the home and involved people in what was going on around them.
- Staff were quick to respond to people's requests and used non-verbal communication such as touch and smiling for people who struggled to communicate verbally.
- Staff felt confident they could support people to maintain their individual beliefs and respect their diversity.

Supporting people to express their views and be involved in making decisions about their care

- The activities co-ordinator used regular feedback from people when planning group activities and trips out, so these were responsive to people's preferences. For example, where people wanted to play games or liked jigsaw puzzles, staff assisted them to follow these pursuits.
- Records showed people, or their relatives, were involved in planning their care when they came to the home.

Respecting and promoting people's privacy, dignity and independence

- Staff were observed protecting people's dignity. For example, staff knocked before entering people's rooms. When people required personal care, staff offered to support people discretely.
- Staff could explain what they did to protect people's privacy during personal care routines.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records described people's life history, their likes and dislikes, so staff knew people's cultural needs and preferences. However, there was a lack of information in care records about how people should be supported to make every day decisions such as accessing their local community.
- Care records were reviewed monthly. The provider planned to introduce a new format of care records at the home, to provide staff with more detailed information about people's support needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Overall, people and their relatives gave us positive feedback about the organised activities at Granville House. People told us staff knew them well, and knew what they liked.
- Group activities were organised daily by the dedicated activities co-ordinator based on people's feedback and what people enjoyed. Each person was informed about the scheduled activities in a weekly planner and posters displayed.
- When an activity was taking place, staff approached people to see if they wanted to join in. Where people did not want to participate in group activities, staff told us they organised one-to-one time with them. Some people chose to spend most of their time in their bedroom. One person who was cared for in bed told us, "Just sitting here day after day gets boring. I don't think staff can be bothered to get me out. ... it would be nice to try and sit out." We raised this feedback with the registered manager, as there was no care plan in place to direct staff how to support the person to get out of bed. The registered manager told us staff asked the person each day if they wanted to get up, and they would look at ways of improving the person's social engagement.
- Group activities included days out, bingo, singers, fitness can exercise groups and animals visiting the home through a local charity.
- On the second day of our visit we observed people singing along to music supported by a guest singer. This activity encouraged people to join in. People clearly showed their enjoyment in the activity.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carer.

- Staff demonstrated they knew people well and what support each person required to express their views. Where people had specific disabilities that affected their communication, the provider used a range of

techniques to communicate with people such as large print, electronic records and pictures.

Improving care quality in response to complaints or concerns

- People and relatives told us they knew how to raise concerns or complaints with staff and the management team if they needed to.
- The provider had a complaints policy and procedure on display in the reception area of the home. There was also a suggestion box in the reception area and people were encouraged to leave their feedback.
- The service had a complaints log to record all complaints. However, there had been no complaints at the service in the previous year.

End of life care and support

- People and their relatives were supported to make decisions and plans about their preferences for end of life care. Some people had a DNAR CPR form in place, which meant staff and emergency services knew the person should not receive resuscitation in the event of a sudden cardiac arrest.
- No-one, at the time of our visit, was receiving palliative care. Advance planning took account of people's wishes to meet their individual cultural and religious preferences.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- We found auditing and quality assurance procedures had not identified care records were not always up to date. Risk management plans were not always in place to advise staff on how they should manage the risks to people's health and wellbeing.
- Quality assurance procedures had not identified staff were not completing the required charts and daily records, to ensure people received enough fluid to maintain their health.
- Auditing procedures had failed to identify environmental risks at the home, which put people at risk of injury.
- Medicines administration procedures had failed to protect people from the risk of receiving too much, or too little medicines.
- Quality and safety guidance for the monitoring of controlled drugs was not always followed, to ensure drugs were administered by two members of staff.
- A lack of good records management meant people's records did not contain information about their weight loss or gain, for staff to identify where referrals to health professionals were required.
- The provider had failed to ensure care was provided in line with the consent of the relevant person or authority.
- The PIR did not reflect the issues we identified during our inspection visit.
- The provider did not share learning and improvement actions across their services, to mitigate some of the risks we identified during our inspection. For example, a lack of radiator covers and the risks this posed to people had been identified at another services. This meant the registered manager lacked key information about how their service could have been improved.

The provider had not established effective quality assurance systems to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Good Governance.

- The provider had recently recruited a quality assurance manager to undertake regular audits and quality assurance checks at their services, to improve their current auditing procedures.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At the time of our inspection visit there was a registered manager at Granville House five days per week.

The registered manager explained they had previously been responsible for the management of two homes, however, this had recently been changed, and they were now at Granville House each day. This meant the registered manager was able to focus on the improvements required at the home.

- The registered manager was supported by a deputy manager and a senior care worker. Staff told us they were listened to by the registered manager. Comments included, "[Registered manager] listens to us. She will take action with things".
- People, relatives and staff consistently told us the management team were approachable. Comments included; "[Registered manager] is astonishingly good. She has time to talk to us when we have questions."
- The provider undertook regular quality assurance surveys, and asked people for their opinion about the service through meetings and suggestions boxes at the home. In the most recent quality assurance survey we saw 98 per cent of people were satisfied with the care they received.
- People and their relatives told us they enjoyed living at the home, one person said, "I feel well looked after here. They provide everything I need. They are there for me when I need them. I like everything about it here. My room is lovely."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The management team held regular staff, team and departmental meetings, to provide staff at all levels an opportunity to give their feedback about the home and any ideas for improvement.
- The registered manager organised daily handover meetings between staff, at every shift change.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Senior staff worked alongside staff. For example, during weekly shifts they assisted people and staff to help them develop relaxed, positive relationships with people, and discreetly observe staff's support of people, so performance was continuously reviewed.
- The registered manager understood their regulatory responsibilities. For example, they ensured that the rating from the last Care Quality Commission (CQC) inspection was prominently displayed in the home and on their website and, there were systems in place to notify CQC of incidents at the home.

Working in partnership with others

- The service had links with external services, such as government organisations who provided links to renewed best practice guidance, charities, commissioners of services, nurses and health professionals. For example, the home had joined the 'red bag scheme' where the service prepared information to go to hospital with a patient, to provide the hospital with clear information on how to support the person.
- The registered manager sought opportunities to work with other bodies to increase people's enjoyment in life. For example, local charities to increase people's opportunities for social interaction in the local community.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and provider understood their responsibilities to share information under the duty of candour regulations.
- Relatives told us they were kept up to date with any concerns with their relations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 11 (1) Care and treatment of service users was not always provided with the consent of the relevant person(s) in accordance with the Mental Capacity Act 1983.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (2a,2b, 2c) The provider had failed to ensure systems and processes were operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Systems were not effective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>12(2a,2b,2d, 2g) The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment, and doing all that is reasonably practicable to mitigate any such risks;</p> <p>The provider had failed to ensure that the premises used by the service are safe; The provider had failed to ensure the proper and safe management of medicines.</p>

The enforcement action we took:

We issued a warning notice to the provider.