Care Quality Commission

Bupa Care Homes (GL) Limited

The Kensington Nursing Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 7 and 10 August 2015 and was unannounced. The Kensington Nursing Home is registered to provide nursing care to 53 people. The home is arranged on three floors with lift access to each floor. People living at the home are generally older people, some of whom have dementia. Respite shorter stay care is also provided. There were 47 people living in the home at the time of our visit.

The service had a registered manager. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available at the time of our visit.

The service received referrals from Clinical Commissioning Groups and Local Authorities. People

Summary of findings

were also able to self-refer. Initial assessments were carried out by senior staff members to ensure that the service was able to meet people's specific care needs. People and their family members were invited to visit the home and meet staff before making a decision about moving into the home.

Care plans were developed in consultation with people and their representatives. People's risk assessments were completed and these covered a range of issues including guidance around personal care, moving and positioning, food and nutrition. Risk assessments were not always updated in line with the provider's policies and procedures.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (2005) (MCA) and DoLS, and to report upon our findings. DoLS are in place to protect people where they do not have the capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. Senior staff understood when a DoLS application should be made and how to submit one.

Nursing and care staff had received training in mental health legislation which had covered aspects of the MCA and DoLS. However, staff were not always able to demonstrate a clear understanding of how these issues related to the care and support provided to people living in the home. We noticed some incidences where people's movements were restricted and could not be assured that staff understood people's rights and that these decisions had been appropriately assessed as being in people's best interests.

Staff were able to demonstrate an understanding of safeguarding in relation to pressure wounds and told us they would report these concerns to senior staff. However, staff demonstrated less awareness of other forms of potential abuse and who, other than the manager, these matters should be reported to.

People were visited by a range of healthcare specialists and supported to attend health appointments as needed. There were protocols in place to respond to any medical emergencies or significant changes in a person's well-being.

The home had an activities co-ordinator and a schedule was posted in the reception area providing information about the range of activities on offer. These included exercise and music sessions, pet therapy, birthday parties, food tasting and themed events.

People's opinions as to the quality and choice of food on offer, was mostly positive although the provider was not always ensuring that people's individual cultural food preferences were available to them.

Daily menus were posted in the reception area. People were able to eat in designated dining areas, in their rooms and/or in the garden (weather permitting).

There were arrangements in place to assess and monitor the quality and effectiveness of the service. This included annual surveys and medicines administration auditing. It was not always clear whether learning took place and improvements implemented as a result of audit findings.

We found breaches of the regulations relating to person-centred care, safe care and treatment, safeguarding, complaints handling, notifications and good governance. You can see what action we told the provider to take at the back of the full version of this 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. People were not always being supported to take their medicines safely.

Risk assessments that identified risks to people's safety and/or that of others had not always been reviewed in line with the provider's policies and procedures.

Fire exit routes were not being kept clear of obstacles and not all staff knew the coded door pad number to fire exit routes.

Appropriate arrangements were in place to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had received training which covered aspects of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, staff were not always able to demonstrate a clear understanding of how these issues related to the care and support provided to people living in the home.

Care plans contained information about people's lives, past and present but were not always completed in full.

People were supported to maintain their health and to access appropriate healthcare appointments.

The service was not always able to meet people's requests for culturally specific diets.

Is the service caring?

Requires Improvement

The service was not always caring. Not all care plans had been completed in full and not all of the people we spoke with felt they had been involved in decisions about their care.

Staff were able to explain and give examples of how they would maintain and promote people's dignity, privacy and independence.

People told us they were happy with the care they received and that staff were kind and courteous.

Is the service responsive?

Requires Improvement

The service was not always responsive. Not all initial assessments had been completed in full and reviews of people's care and support needs were not always being reviewed in line with the provider's policies and procedures.

Activities were organised within the home but there was little opportunity for people to partake in events and activities taking place in the local community.

Summary of findings

The service had a complaints policy which was available for people using the service and their family members. Complaints were not always logged and responded to in line with the provider's policies and procedures.

Is the service well-led?

The service was not always well-led. The service monitored the quality of the service via audits and surveys. However, audits failed to identify or address some of the shortfalls we found during our visit.

The provider conducted a residents and friends survey on an annual basis.

Staff meetings were held on a monthly basis but staff did not feel there were opportunities to feedback ideas and make suggestions about how the service was run.

Requires Improvement

The Kensington Nursing 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.

This inspection took place on 7 and 10 August 2015 and was unannounced. The inspection was carried out by an inspector and two specialist advisors. We were also assisted by an expert-by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who supported this inspection had experience and knowledge about caring for older people and people living with dementia.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC within the past 12 months.

During the inspection we spoke with nine people using the service and three relatives. We spoke with a home manager who was registered with the Care Quality Commission to manage another service provided by Bupa Care Home (GL) Limited in North London. The home manager was providing part-time cover in the absence of the home's own registered manager. We spoke with a deputy manager, an area manager and four nurses. We also spoke with a visiting health professional, four members of care staff, two kitchen chefs, a domestic staff member and an activities co-ordinator.

The records we looked at included 12 people's care plans, six staff records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not always protected from the unsafe management of medicines. Some people living in the home had opted to self-administer their medicines. Where this was the case, care plans outlined the support required to complete this task safely. However, on the day of our visit, one person had self-administered an incorrect dose of medicine. Staff were unable to ascertain which medicine had been taken and at what dose. The incident was reported before 9.00am but at 10.30am, no significant action had been taken. A GP and family members were later contacted but we saw no evidence in the interim period that this person was being monitored for any signs of adverse effect or deterioration to their health. We noted this person was registered blind and on many medicines including diazepam.

This person's care plan stated that they should be supported by a nurse to ensure they were taking the correct medicine at the right time and at the right dose and that their ability to self-administer should be regularly assessed. The only copy we were able to locate of a self-administering medicines assessment plan was dated 24 July 2011. This was clearly an error as this person moved into the home in 2013. We also noted that this person's medicines were stored in an unlocked drawer.

We noted that copies of the British National Formulary (BNF), a pharmaceutical reference book containing information and advice about the correct dosage, indication, interactions and side effects of medicines were dated 2013-2014, and were therefore out of date.

The issues above indicate that people were not always protected against the risks associated with the unsafe storage, management and administration of medicines**.** This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where staff were responsible for administering people's medicines, we saw that medicines administration records (MAR) were completed appropriately. MAR charts contained photographic identity pictures and recorded people's names, date of birth, details of medicines and any known allergies. Records were initialled by staff qualified to administer medicines safely in line with the provider's policies and procedures. Staff had access to disposable gloves and aprons and were required to wear a uniform and name badge. The clinical room was well organised and items were clearly labelled.

Where risks to people's health, safety and welfare were identified, management plans were developed to minimise them. We looked at care plans which showed individualised risk assessments were carried out addressing areas such as personal care, diet and nutrition and falls prevention. However, we found incidences where risk assessments had not always been reviewed and updated in line with the provider's policies and procedures.

We noted that call bells were not always connected to the appropriate electrical sockets and when connected, were not always within people's reach. One person told us they didn't know how to use their call bell and another person told us staff were too busy to answer their calls. We reviewed one person's care plan and noted they had been identified as being unable to use their call bell. The care plan stated that staff should 'pop into [their] room and check on [them] when passing by.' However, the care plan did not indicate how often this should happen and there was no documentation to evidence that checks were being made on a regular basis.

Fire risk assessments and personal evacuation plans had been completed for people living in the home. These considered the needs of the individual in conjunction with their physical and mental capacity and the environment. The fire alarms were tested on a weekly basis and we saw that fire equipment had been serviced appropriately. However, not all staff were able to tell us the number to coded door entry systems leading to the main stairs and fire exits. We noted hoists were stored along corridors, one of which was partially blocking a door to a person's room. We also saw a mattress leaning against a wall which may have made access problematic in the event of a fire.

Following our inspection we requested information relating to the last fire evacuation drill. We were told that the provider had not carried out a fire drill this year but would arrange for this to happen as soon as possible. The shortfalls identified in this and the above three paragraphs indicate that the provider was failing to continually assess the risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

The service had policies and procedures in place for safeguarding adults which were available and accessible to members of staff. We had received a number of safeguarding notifications in the past six months relating to pressure wounds. We asked the area manager about strategies in place to prevent and/or reduce the risk of people developing pressure wounds. We were told, staff had completed training in pressure area care and completed turning charts, fluid and nutrition charts. We saw that referrals to tissue viability nurses had been made but noted that there were sometimes significant delays in this process. A nurse told us, “Pressure sores developed through poor care” and “training in pressure sores is needed but it feels like [the provider] is not listening to us.”

Staff told us they had completed safeguarding training as part of their induction. Staff were able to demonstrate an understanding of safeguarding in relation to pressure wounds and told us they would report these concerns to senior staff. However, staff demonstrated less awareness of other forms of potential abuse and who, other than the manager, these matters should be reported to.

We discussed staffing levels with the deputy manager who told us that normal staffing levels during the day were three or more care staff and one nurse for each floor. During the night, one nurse covered each floor with the assistance of two care staff. Staffing numbers were based on people’s dependency levels and were continuously reviewed to ensure numbers were adequate. Staff rotas indicated that the minimum staffing levels requirement was being met.

We found robust recruitment and selection procedures were in place and saw appropriate checks had been undertaken before staff began work to help ensure that staff were suitable to work with people using the service. Staff files contained references, proof of identity and criminal record checks demonstrating that staff had been recruited safely.

Staff we spoke with were aware of the provider’s whistleblowing policy and were able to explain how they would raise any concerns about the service to the management team and to external authorities, if necessary.

The home environment was clean and free from odours. Staff wore uniform and most had name badges. Staff and people visiting the service had access to hand gels.

Requires Improvement

Is the service effective?

Our findings

The provider was not always ensuring that people's individual cultural food preferences were available to them. People's opinions as to the quality and choice of food on offer, was mostly positive although we were told by kitchen staff that they were unable to cater for one person living at the home who had requested a halal diet. The chef told us "Bupa won't pay for Halal food just for one person."

We observed that people were assisted to return to their rooms by 4.30pm. We asked the nurse in charge why the communal areas were not in use at this time and were told, "it was toileting time." We also noted that the evening meal was being delivered to the floors at around 5pm. The chef told us, "We have to prepare all the meals by 5.00pm because some staff leave at 5.30pm." The chef also told us, "There's only one option available at dinner time because I'm on my own. But if people don't like it they can have and omelette or a sandwich." The area manager informed us she was aware of this practice and that they had tried to change this routine by ensuring senior staff were on duty later to monitor staff and break these patterns. However, this and the above paragraph indicate that the care and support provided to people living in the home was not always flexible or effective and did not reasonably consider people's individual choices and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each floor had a small kitchen where people and their relatives were able to prepare snacks and drinks whenever they wished to. One person told us, "We can help ourselves from the kitchen. There is always tea and coffee, yogurts, orange juice, biscuits, bananas, ice cream available." Drinks and snacks were served throughout the day.

Daily menus were posted in the reception area. We observed staff supporting people to make their meal choices and were told the kitchen was able to provide alternative options if people did not like what was on the menu. We observed the lunch time meal being served on the ground floor and noted that proceedings were well organised and different choices of meal were available.

For people who wished to eat in their rooms, food was placed in a heated trolley and plates covered before being delivered. People who required prompting and/or support to eat their meal received the appropriate support and assistance. We saw staff ensured that spilt food was cleared up and people were assisted to have their hands and mouths wiped clean (where appropriate) and napkins were replaced. A choice of fruit juices, water and wine was available.

People's names and photographs were displayed on some of the doors to their rooms and rooms contained personal items which supported people's sense of identity and/or aided memory. Calendar charts displayed the correct day and date and weather conditions. However, we noted that some menu charts were displaying menus for previous days rather than the actual day.

The Care Quality Commission is required by law to monitor the operation of The Deprivation of Liberty Safeguards (DoLS). The service had policies and procedures in place that ensured staff had guidance if they needed to apply for a DoLS authorisation to restrict a person's liberty in their best interests. Senior staff understood when an application should be made and had attended training which had covered aspects of the Mental Capacity Act (2005) and DoLS. Appropriate assessments had been undertaken for people living in the home and DoLS applications submitted to the relevant agencies. However, we noted that care plans did not always indicate where people had been assessed for a DoLS authorisation and the relevant capacity assessments had not always been completed in full.

Some of the people living in the home received one to one care and support which had been requested by family members and which was provided by the service at an extra cost. There was no indication that staff were aware that this type of supervision was a deprivation of a person's liberty. Neither were staff aware that tables placed permanently infront of people could also be perceived as restrictive practice. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a member of care staff who was providing one to one support and noted they offered very little in the way of meaningful or stimulating activity other than occasionally looking at pictures in a magazine and playing with some small plastic animals. We asked this member of staff what they knew about the person they were supporting. It was evident that this member of staff knew very little about this person or the care plan that was in place.

Requires Improvement

Is the service effective?

People's care records included the contact details of family members, GPs and other health care professionals and/or relevant representatives. There was some information about people's lives prior to moving into the home, for example; people's life histories, hobbies and interests. However, this information was not always completed in full.

We saw that people were visited by a GP who came to the home on a weekly basis and more often if required. People told us they were able to get to appointments as needed and were accompanied if required. We saw that assessments by various healthcare professionals such as tissue viability nurses, occupational therapists and physiotherapists had been completed and visits recorded in people's care plans. We spoke with a healthcare professional who was visiting the home on the day of our inspection. They told us that "staff mean well" and "[the service] has potential." However, we were told that staff did not always respond well to advice given.

Staff were required to complete a two week induction which covered areas such as medicines administration and first aid awareness. Staff then completed both classroom and e-learning and shadowed other members of staff before they began working with people on their own.

Staff had group and individual supervision which meant people were supported by staff who were trained to deliver care safely and to an appropriate standard. We saw records of supervision sessions where issues such as catheter care and infection control had been discussed.

A training matrix showed the training all staff were required to undertake to meet the needs of people they supported such as safeguarding, first aid and infection control. Some staff we spoke with told us they wanted more training and more opportunities to develop their skills and knowledge.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care they were receiving. One person told us, “Everything is magnificent. It is comfortable, good food, very courteous and very helpful staff.” We saw staff interacting with people using the service, explaining their actions and offering reassurance when needed.

However, we heard from some staff that people were neglected and that the care and support was, “reactionary, we wash, dress, feed and change.” Care staff told us about two people living in the home who they felt were neglected due to staff not having enough time to take care of people’s needs. We spoke to the deputy manager about these people and were told that a safeguarding concern relating to care standards had been raised for one of these people and was in the process of being investigated. We were also informed that care reviews would be scheduled immediately for both people in light of staff concerns.

We looked at people's files which included their care planning documentation, risk assessments, healthcare documentation and other records. Care and support records we read contained information outlining people’s normal routines and activity preferences, details about the ways in which people preferred to communicate and strategies for supporting health and well-being.

Care plans showed evidence that end of life decisions had been discussed with people when and where appropriate. Documents indicated whether people wished attempts to be made to resuscitate them in the event of cardiac or respiratory arrest were fully completed, had a review date and had been signed by the appropriate parties.

Staff told us they entered daily information in people’s daily logs. Information included a brief overview of the support given, activities participated in and details regarding people’s well-being. We noted an entry for one person which read that “[They] were well behaved.” This type of reporting could be perceived as inappropriate and lacking in sufficient detail to act as a useful record of how this person spent their time during the course of the day. Relatives were kept updated about any changes in the health and welfare of their family members.

Staff told us that respecting people’s privacy and dignity was an important part of their work and they always made sure they observed good practice such as asking people’s permission, telling them what they were going to do and making sure doors were shut whilst people attended to or were being supported with their personal care.

Relatives and friends told us they were able to visit their family members whenever they wished. Visitors could see people in their rooms or in the lounge areas and outside in the garden. People using the service told us, “We are very well looked after” and “The staff are lovely and we are treated very well.” We looked at the compliments file and noted that relatives had praised staff for their nursing skills, love and care, compassion and consideration.

Requires Improvement

Is the service responsive?

Our findings

People's concerns and complaints were not always listened to and responded to appropriately. We saw copies of the complaints policy displayed within the home. The policy explained how to make a complaint and to whom. We saw that the provider had received and logged two written complaints relating to information sharing since the last inspection in January 2014. There were no responses available to these matters so we were unable to ascertain how the provider had managed these requests/complaints. The area manager told us procedures for managing and responding to complaints was "not adequate."

A suggestion's box was available in the reception area and we saw that two comments had been made by visitors and family members. Again there was no evidence that these matters had been dealt with and we were told that the suggestions box was not used. People living in the home and staff told us they didn't always feel listened to when they made a complaint or raised a concern. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before moving into the service people's care needs were assessed by the deputy manager. Where people had not been involved directly in the care planning process, the deputy manager told us they had sought input and advice from family members (where appropriate) and social workers. Most people told us they had been involved in the assessment process although one person told us they would have liked to have more involvement particularly around end of life plans. We found that not all initial assessments had been completed in full.

The deputy manager told us they visited people in their homes or in hospital. People and their family members were encouraged to visit the service before arrangements were put in place for an overnight stay prior to moving in on an initial trial basis. Regular review meetings were held to monitor people's progress and welfare in order to ensure that people were happy and settling in well.

People's care and support needs had been assessed by the service and we were told that these were updated and reviewed as and when required. We found inconsistencies in the care records we looked at but noted that the majority had been reviewed, dated and signed appropriately.

People we spoke with told us they thought staff knew them well and knew how to support them if their needs changed. One relative told us, "[My family member] came in to the home with terrible sores, but they have all gone now, thanks to the special mattress she has." We were told that staff always accompanied this person to their regular healthcare appointments.

The service had a part-time activities co-ordinator. Activity programmes were displayed around the home and we were told that people were given a copy of the schedule prior to events taking place. We observed an organised activity taking place which involved a visit from a wild science group and a talk about small reptiles. People were encouraged to handle frogs, lizards and geckos if they wished to. Earlier in the day people had been visited by Chloe the cat and her owner, who visited people in their rooms and similarly encouraged people to stroke and play with the cat. We were told by the activities co-ordinator that they also organised themed events, birthday parties, singing and exercise sessions. People told us they had recently been visited by the children's farm and that the corridors of the home had been filled with small farm animals such as miniature ponies and sheep.

The home had a large well-maintained garden with a water feature, a vegetable patch, different seating areas with shade provided and a well-stocked sensory garden. We saw people seated under a shaded gazebo enjoying the weather. We observed another person busy pruning plants and helping the home's gardener. One lady told us, "I'd like to go into the garden more often. The staff have taken me there once or twice. I can't get there alone." Some people living in the home told us they would like to be able to go out into the community more often. The activities co-ordinator told us that this didn't happen because staff were not available for this. People's activity levels were recorded in their daily logs although we noted that one to one sessions lacked information as to what the specific activity had been.

Requires Improvement

Is the service well-led?

Our findings

At the start of our visit we were informed that the registered manager had been absent from his post since 1 July 2015 and the home was being managed by a part-time home manager and a deputy manager. As part of the provider's and the registered manager's registration requirements, they must notify the CQC of any continuous period of absence of up to 28 days and over and provide information as to the arrangements for managing the service during their absence. We had not received this notification at the time of our visit and were unaware that the registered manager was absent from the service. This was a breach of Regulation 14 of the Care Quality Commission (registration) Regulations 2009.

We saw that quality monitoring was undertaken to assess compliance with local and national standards. Monthly audits looked at areas such as care plans and medicines administration. We looked at medicines auditing records for April and May 2015 and saw that these had been completed and that findings/action points had been recorded appropriately. However, timescales for the completion of action points were not recorded.

There were processes in place for reporting accidents and incidents. We noted that a number of minor injuries, skin tears and unexplained bruising had been reported. We asked the management team how they reviewed these incidents and what action they took to understand and learn why these incidents were occurring. The regional manager told us that she felt the incidents may be related to moving and positioning technique. We noted from the latest training matrix dated 23 July 2015, that only 40% of staff had completed mandatory training in moving and handling of people. Over 30 members of staff were included on the list which indicated that refresher training was planned for August 2015.

The provider conducted a quarterly metrics report. This looked at areas such as the number of GP reviews carried out, hospital admissions, infection rates and customer feedback. The report for the last quarter dated April 2015, we noted that none of the comments boxes had been completed by the home manager and there were no action points recorded. We saw no evidence that any learning had taken place following the publication of the report's findings.

We were told that the provider conducted a residents and friends survey on an annual basis. We looked at the results of the last survey carried out in May 2015 and noted that only six people had completed the survey. Areas of strength suggested that the respondents were happy living in the home whilst areas for improvement indicated that the quality of care was poor. The survey did not contain any information as to how people's concerns would be addressed as a result of the survey findings.

We were told by the area manager that family meetings no longer took place as historically, they had been poorly attended. We were informed that relatives were able to speak with senior staff or email the registered manager or deputy manager whenever they wished to raise a concern or discuss their family member's care.

The manager told us that staff meetings were held on a monthly basis but staff told us they did not feel they were given opportunities to feedback ideas or were listened to when they made suggestions about the running of the service. We read the minutes of staff meetings held in June and April 2015 and saw that issues such as care documentation, people's dietary needs and mealtimes had been discussed.

We saw that manager's weekly walk around checklists had not been completed beyond 29 June 2015. This checklist provides an overview of the service and looks at areas such as, the cleanliness of the home environment, people's activity levels, staff approach and satisfaction with their employer.

We heard many complaints from staff ranging from low salaries to lack of training opportunities. We noted an overall dissatisfaction with the provider particularly in regards to communication, leadership and lack of opportunity to be involved in the way the service was run. We also found evidence of incomplete records and records where reviews were required. This indicated that systems in place to monitor the quality of service provision were inadequate and that feedback was not effectively evaluated in an attempt to improve service delivery. The above issues relate to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014** **Person-centred care** **People who used the service were not always receiving care and treatment that reflected their preferences and met their individual needs.** **Regulation 9 (1) a, b, c (3) a, b, c, d, e, f, g, h, i**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014** **Safe care and treatment** **People who used the service and others were not protected against the risks associated with the unsafe storage, management and administration of medicines. In addition, the provider was failing to adequately and continually assess the risks to people's health and safety.** **Regulation 12 (1) (2) a, b, c, d, f, g, i**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014** **Safeguarding service users from abuse and improper treatment** **People who used the service were not always being protected from abuse and improper treatment in accordance with the regulation.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 13 (1) (2) (4) c, d (5) (7) b

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence **Regulation 14 of the Care Quality Commission (registration) Regulations 2009.** **Notifications – notice of absence** **The service provider and the registered manager had failed to notify the Commission of a period of continuing absence of 28 days or more.** **Regulation 14 (1) a, b (2) a, b, c, d, e (5)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 HSCA (RA) Regulations 2014** **Receiving and acting on complaints** **The registered person was not operating an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons.** **Regulation 16 (1) (2**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014** **Good governance** **Systems and processes were not always being operated effectively to assess, monitor and improve the quality and safety of the service provided. In addition, records were not being completed or maintained accurately in**

This section is primarily information for the provider

Action we have told the provider to take

respect of each service user. People who used the service were not always receiving care and treatment that reflected their preferences and met their individual needs.

Regulation 17 (1) (2) a, b, c, e, f