Aura Care Living Ltd

# Stratton Court

## Inspection report

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23 May 2023
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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Stratton Court is a residential care home providing accommodation to persons who require nursing or personal care, for up to 84 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 48 people using the service. People are accommodated in 1 adapted building.

People's experience of using this service and what we found
People were not always protected from the risk of harm as incidents had not always been appropriately investigated to ensure appropriate action had been taken. This meant the provider and registered manager had not always ensured lessons were learnt and changes were made to the service to protect people from the risk of avoidable harm.

People's care plans and risk assessments had not always been updated following these incidents. However, care staff were taking action to protect people from the risks associated with their care. The provider had arranged for additional training for staff to assist them in managing the needs of people who can become anxious.

The provider and registered manager had not always informed CQC of notifiable events. The registered manager took immediate action to address this concern at the inspection.

People were at risk of not always receiving their medicines as prescribed. There were not always effective systems for staff to ensure people received their medicine as prescribed and to ensure people's medicines were administered in accordance with manufacturers guidance.

The provider and registered manager did not always operate effective systems to monitor, assess and maintain the quality of service people received at Stratton Court. While some improvements had been made to good governance processes in relation to the environment, infection control and falls, there were not effective systems in relation to the concerns we identified at this inspection.

People and their relatives spoke positively about the level of engagement and support their loved ones received. People throughout the home enjoyed a range of activities and were being actively supported to be engaged in the community. Since the last inspection, action had been taken to provide a dementia friendly environment and tailored activities on Highgrove (dementia care unit). People enjoyed 1 to 1 and group activities which were tailored to their needs.

Improvements had been made to ensure people's care plans were person centred, however additional improvements were required for people living on the Highgrove unit.

People and their relatives shared mixed feedback about the management of the service. Whilst the majority

of relatives were positive, some relatives raised concerns in relation to communication and their loved one's care. The registered manager was taking opportunities to engage with people, their relatives and seek their views.

Staff spoke positively about the support they received and discussed how the provider and registered manager were responsive to their ideas and requests. Staff told us they felt the service was improving, thanks to management support and a reduction in agency staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 January 2023).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found while some improvements had been made in relation to some of these actions, there were additional shortfalls and the provider was not meeting all of the relevant regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 21,22 and 23 November 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve person centred care and good governance.

Prior to this inspection we received concerns in relation to people's care and treatment and the service was involved in safeguarding processes with the local authority.

We undertook this focused inspection to check the safety of people's care and to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stratton Court on our website at www.cqc.org.uk

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance, safeguarding service users from abuse and improper treatment, safe care and treatment. We also identified breaches of Notification of other incidents and Notification of death of a service user of the Care Quality Commission (Registration) Regulations 2009.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Stratton Court

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three Inspectors and 2 Experts by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stratton Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

There was a registered manager in post at the time of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We considered the feedback from the local authority and professionals who work with the service. We used the information the provider sent us in December 2022 in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 12 people who lived or were staying at Stratton Court. We spoke with 12 people's relatives about their experience of the care and support provided by the service.

We spoke with 18 staff including the registered manager, deputy manager, clinical lead, lifestyle coordinator, 4 unit leads, 8 care staff and 2 housekeeper staff. We also spoke with a representative of the provider and the nominated individual for the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 8 people's care records. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We reviewed 4 staff recruitment and personnel files.

We continued to seek clarification from the management team to validate the evidence found. We sought and received feedback from 4 healthcare professionals involved with the service.

Requires Improvement

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed 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.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of avoidable harm. When incidents occurred, they were recorded by staff. However, there was not always a consistent approach as there was limited oversight from management to ensure appropriate action had been taken and the relevant authorities informed. This placed people at risk of harm as actions had not always been taken to manage or mitigate identified risks.
- Where incidents had occurred when people had become anxious, appropriate action was not consistently taken to ensure their care plans and risk assessments were updated. This meant care staff did not always have the information they required to assist people and take action if they became anxious.
- The registered manager and provider did not always ensure appropriate referrals had been made to the local authority as incident reports had not always been effectively managed. During the inspection the registered manager took immediate action to address this concern.

People were not always protected from the risk of avoidable harm as there were ineffective incident management processes. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the registered manager provided an action plan on how they planned to protect people from immediate harm. This included changing their daily meeting to review accidents and incidents and notifications. The registered manager confirmed that, where necessary, people's care plans and risk assessments have been reviewed and updated.
- Management carried out monthly falls analysis at Stratton Court to identify changes which could be made to people's environment. Analysis indicated people's falls had reduced since January 2023. However, concerns were identified at inspection in regards to post falls observations. Please see Is the Service Responsive for more details.
- People and their relatives told us they felt Stratton Court was safe. Comments included: "Oh yes, they keep me safe" and "I feel he's safe and they're really good caring for him."

Using medicines safely

- People did not always receive their medicines as prescribed. We identified 5 people who had been placed at risk of not receiving their medicines as prescribed in May 2023. When we counted people's individual medicine stocks against medicine administration records, we found more or less doses than we expected to find.
- Staff had not always identified when people had not received their medicines as prescribed as they had not accurately checked people's medicine stocks in accordance with daily medicine checks set by the

manager.
● Staff did not always ensure people were protected from the risk of receiving prescribed medicines against manufacturers guidance. Two people were prescribed liquid medicines which, in accordance with manufacturer guidance, required removal after a specified date. The service did not operate an effective system to check and manage these medicines. Neither person was impacted by this concern.
● Some people were prescribed medicines that where to be administered 'as required' when they experienced anxiety or distress. We reviewed 3 people's 'as required' protocols for these medicines. There was not always clear guidance for staff to follow, including when to administer or how to review the effectiveness of their prescribed medicines.

People were not always protected from the risks related to their prescribed medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had implemented effective systems to assist people living with diabetes. For people who received insulin, there were effective systems to manage assisting people with this medicine, as well as ensuring their health and wellbeing was maintained and protected.

Assessing risk, safety monitoring and management
● People's clinical risks were assessed and known by care and nursing staff. However, where people could be anxious or challenging there was not always clear detailed risk assessments on how to best support them.
● One person was living with diabetes. The person had a clear care plan which staff followed. Nursing staff kept a record of the person's blood sugar levels. Staff sought the advice of healthcare professionals and worked with the person to manage any health-related risks.
● Where people required textured diets or thickened fluids, clear guidance was in place for staff to follow. We observed staff supporting people in line with their assessed dietary needs. Staff were able to discuss the individual support people required.
● Where people required support to maintain their skin integrity, there was clear guidance in place to support nursing and care staff. This included supporting people with dressings and repositioning.
● People were protected from the risk of their environment. Appropriate checks had been made to ensure the environment was safe. The provider had systems in place to improve and maintain records in relation to environmental risk. On the day of our inspection work was being undertaken where faults had been identified with fire doors.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. One person was receiving care and support which increased the risk of them being deprived of their liberty. The registered manager ensured an updated application was made in relation to this person immediately following our inspection.
● Where the service had applied to deprive someone of their liberties, they kept a tracker to follow the

progress of the application and ensure that any DoLS conditions were acted upon.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes
The provider was following current government guidance in relation to visiting at the time of the inspection.

Staffing and recruitment
● Staff were recruited safely. All required checks were made before new staff began working at the home. Disclosure and Barring Service (DBS) checks were completed alongside seeking references from staff's previous employers. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Recruiting managers kept a record of when they had sought references and not received a response. This enabled them to ensure appropriate checks were carried out and whether it was necessary to seek additional references.
● Suitable staffing levels were in place to meet the needs of people using the service. The registered manager explained that staffing levels were based on people's needs and dependencies. They told us staffing levels had remained consistent despite a decrease in the number of people living at Stratton Court. Since the last inspection the registered manager and provider had recruited new staff to Stratton Court and had reduced agency usage.
● People and their relatives told us there were enough staff to meet their loved ones needs. They spoke positively about staffing, including the reduction of agency. Comments included: "Waiting doesn't happen very often. Carers are very good" and "There are enough staff."
● Staff told us there were enough staff and they had the time they needed to provided people's care. Comments included; "Staffing has improved. We have less agency [staff] and we have a clear plan. Even when we have sickness, we are always safe" and "There are enough staff, we have enough time to spend time with the residents, we do more 1 to 1 activities."

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. This meant people's needs were not always met.

At our last inspection people's care records were not always current and reflective of people's needs. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the registered manager and provider had made improvements however further action was required to meet the regulation.

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

- The care plans for people living with dementia did not always support person centred care, as they were not always an accurate reflection of people's individual needs and preferences. For example, for 3 people living with dementia there was limited information on how staff should support them, including when they may be anxious and require reassurance. Staff were able to discuss people's interests and the things that they liked to do, although these were not always consistently recorded on their care assessments.
- The care plans for people living on the dementia unit were not always reflective of their current needs or contain the required detail. For example, staff discussed that 1 person liked the company of staff and liked to access the garden and the wider community. There was no care plan or guidance for staff to follow on how to support this person and protect them from any avoidable harm.
- One person's care and support had changed following an incident in the home. Whilst staff and management could discuss these changes, there was no record of this change in the person's care plan to reduce the risk to the person.

People's care plans were not always current and reflective of their needs. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service did not use nationally recognised tools to support staff to identify when people's health changed or deteriorated. The home had recruited a deputy manager who had identified concerns around the lack of these systems. Healthcare professionals shared mixed feedback on how staff responded to people's changing needs. One professional felt staff did not always recognise when people's needs changed without support from professionals.
- When people suffered a fall, post falls protocols were not always effectively followed. The deputy manager told us and we saw that, following a fall, staff had not consistently followed the providers post fall policy.

The service did not always operate recognised systems to ensure people received safe and effective care. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

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

At our last inspection people had not always received care which was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the management team and provider had made improvements around people's person-centred care and were no longer in breach of the regulation.

● Improvements had been made to ensure everyone living at Stratton Court received access to effective and meaningful stimulation. People living with dementia now had access to activities which were tailored to their needs. For example, people were engaged in lively activities such as singing, dancing and ball games. People told us they enjoyed this interaction and benefited from enjoying different activities.
● People spoke positively about the activities they received at Stratton Court. Comments included: "I enjoy it here" and "I think there is always something for [relative] to do."
● People were supported to access the homes grounds and to be comfortable in their environment. On Hygrove new soft furnishings had been provided along with dementia friendly items, such as fiddle boards and artificial plants. One person liked to use the soft furnishings as a bed. On 1 day of the inspection people requested to have their lunch in the courtyard to enjoy the sunny weather which staff acted upon.
● Since the last inspection the lifestyle co-ordinator had focused on community engagement to support people living at Stratton to feel as part of the community. This included engagement with local groups, churches and schools. The service had also started an intergenerational project by supporting a parent and toddler group which people really enjoyed.
● The lifestyle co-ordinator kept a record of special events at Stratton Court. They also kept a record of people's stories, including 1 person who had donated their pictures to the home. Where requested, staff shared pictures of people enjoying activities and events at Stratton Court. One person's relative told us, "[Relative] had her birthday last week and they totally spoilt her. She likes word games on a Monday and goes to church services, [lifestyle co-ordinator] brings a sheet to go through the service with her and the vicar also comes to see her in her room. It's a very friendly place."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were identified, assessed and recorded in care plans. They referred to how people communicated their needs and any support they required.
● Two people living at Stratton Court did not speak English as their first language. Staff worked with people and their relatives to ensure effective communication. One relative spoke positively about the home, how they had been involved in meetings and supporting their relative with communication. They told us, "Since the first day, the stuff of the care home has provided above and beyond support, helping my grandad to settle in the most comfortable and convenient for him way."

Improving care quality in response to complaints or concerns
● People and their relatives told us they knew how to make a complaint to the service. People shared mixed

feedback on how their complaints were acknowledged and responded to. Comments included: "If I was unhappy I would let someone know"; "We waited a while for an acknowledgement and response, which wasn't good" and "Any concern I mention to staff and they're on the ball."

● The management team kept a record of complaints and concerns they had received. The provider had arranged for an independent consultant to assist with the complaints process. Prior to the inspection this had been communicated to people's relatives as part of a relatives meeting.

End of life care and support

● People were cared for at the end of their life through partnership working with health professionals. Staff spoke positively about end of life care and ensured people received the care and support that was important to them, including being visited by their loved ones. One person was being supported with end of life care. Nursing and care staff spoke compassionately about the support they were providing and how they were working with professionals to ensure people were comfortable and free from pain.

Requires Improvement

# 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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care

- The provider and registered manager had failed to consistently send the required notifications to the Care Quality Commission without delay since January 2023. This impacted on the ability of the CQC to effectively monitor the safety of people as information was not available at the time of the events. CQC monitors important events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

The provider did not always notify the Commission without delay of the incidents which occurred as a consequence of the carrying on of the personal care to people. This was a breach of Regulation 18 (1) and Regulation 16 (1) of the Care Quality Commission (Registration) Regulations 2009 respectively.

- The provider and registered manager did not operate effective systems to ensure CQC were appropriately notified as per the regulations. The provider and registered manager were unaware that notifications had not been submitted and had no system to ensure notifications had been sent appropriately.
- The provider and registered manager did not operate effective systems to ensure that incidents were appropriately reported and investigated. There was no system in place to monitor incident reporting processes and ensure staff followed processes as required. This also included not consistently informing local safeguarding authorities of potential safeguarding concerns.
- The provider and registered manager did not have effective systems to ensure that people's care plans were current and reflective of their needs. This meant the provider and registered manager could not always be ensured that learning from incidents would be reflected in people's care plans.
- There were not always effective systems in place to ensure people received their medicines as prescribed. Management had a daily medicine check which required staff to check people's medicine administration records and check the stock of their prescribed medicines. Staff were not using this system appropriately and had not used these systems to identify the concerns we identified on inspection. The provider and registered manager had not carried out effective checks to ensure these systems remained effective.
- While shortfalls had been identified in relation to incident reporting, concerns around recognising deteriorating patients and post falls monitoring. There had not been an effective action plan in place to address this.

The registered provider had not ensured that the quality assurance and monitoring systems in place were robust and identified the breaches we have identified in this report. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately following the inspection, the registered manager implemented an action plan in response to the concerns we found at this inspection. Evidence was provided in relation to management systems, staff skills and people's care records.
● The registered manager and provider had implemented falls analysis since our last inspection. These systems had been effective at identifying the reason people fell and measures that could be implemented to support them. Analysis showed that the number of falls which occurred at Stratton Court had consistently reduced since January 2023.
● There were effective systems in place to ensure people were protected from the risks of their environment and the risk of infection at Stratton Court.
● The provider and registered manager sought the support and guidance of consultants to help improve staff support and training. Consultants carried out audits and checks of the service, focusing on observations and practices in the home. They had identified some actions at a visit in May in relation to medicine administration record and current photographs of people which had been acted on prior to our inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff spoke positively about the support they received from the registered manager and provider and the culture that had developed at Stratton Court. Comments included: "I feel things have really improved. I feel supported and the management really do listen to us" and "Things have improved. I feel the care we provide is better and we're being supported to learn and improve."
● The registered manager had supported staff to reflect on their work at Stratton Court. This had been implemented to understand the pressures staff felt and to foster a positive, caring and inclusive work environment. Where staff had suggested ideas or raised concerns these had been acted upon. For example, staff had requested additional training in relation to dementia as well as some informal dementia training sessions for people's relatives.
● People and their relatives views were sought. The registered manager carried out meetings with people and their relatives to seek their views and involve them in developing the service. These meetings were used to discuss changes in the home, support being provided to the home by consultants as well as listen to any concerns. Families discussed ideas around communication and activities.
● People and their relatives mainly spoke positively about the care staff and believed there was a kind, caring culture at Stratton Court. Comments included: "Everybody's very kind and professional. They're very friendly and a very good team" and "Everyone's very approachable and helpful and if I need to I can always talk to someone about it."

Working in partnership with others
● At the time of our inspection the service was involved in safeguarding processes with the local authority. As part of this process professionals were visiting Stratton Court to review people's needs.
● The service received support from medical professionals to support people living at Stratton Court. Processes were being implemented to ensure important messages were being recorded and communicated to the staffing team.

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<br><br>Treatment of disease, disorder or injury | Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services<br><br>The provider did not always notify the Commission without delay of the incidents which occurred as a consequence of the carrying on of the personal care to people. Regulation 16 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider did not always notify the Commission without delay of the incidents which occurred as a consequence of the carrying on of the personal care to people. Regulation 18 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service did not always operate recognised systems to ensure people received safe and effective care. People did not always receive their medicines as prescribed. Regulation 12 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not always protected from the risk |

of avoidable harm as there were ineffective incident management processes. Regulation 13 (1)

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 | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The registered provider had not ensured that the quality assurance and monitoring systems in place were robust and identified the breaches we have identified in this report. Regulation 17 (1) |

**The enforcement action we took:**

The Care Quality Commission (CQC) has issued a warning notice for breach of Regulations 17 in relation to the care provided at Stratton Court.