Mrs H Green

Devonia EMI Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 1 and 2 March 2016. The first part of the inspection was conducted 'out of hours' because we had concerns about night staffing levels. We undertook this focused inspection to assess the level of risk to people's safety and welfare and to review whether the provider now met legal requirements. The provider had been in breach of regulations since September 2014 and had failed to respond appropriately to meet requirements. This inspection identified continued breaches of legal requirements and found that people were at continued risk of harm.

During this inspection we considered the domains of 'Safe' and 'Well-led' and reviewed seven of the nine breaches of regulations identified at our November 2015 inspection. Of the seven breaches reviewed, five remained unmet. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Devonia EMI Home on our website at www.cqc.org.uk

Devonia EMI Home is a family-run home that has been established for over 30 years. It provides accommodation and care for up to 12 ladies, over the age of 65, some of whom are living with dementia. At the time of our visit there were three people in residence and the provider had agreed to a voluntary suspension on new admissions due to on-going failures to meet requirements of the regulations.

The service did not have a registered manager and the provider was in breach of their registration conditions. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had deregistered with us in September 2014 and had not worked at the service since May 2014. The service did not have a manager at the time of this inspection and the day-to-date running of the service was being managed by the provider.

There was a lack of effective leadership. The provider had been in breach of regulations since September 2014. They did not have a system to assess, monitor and improve the quality and safety of the service or to respond to known risks.

People were at risk of harm. The provider had failed to assess risks to people's safety and to provide staff with the necessary guidance and training to meet their needs. Some people who used the service presented on occasions with behaviours that could be described as challenging. Staff had not been trained in how to support people with these needs and there was insufficient guidance on the use of medicines prescribed on an 'as needed' basis to manage behaviours. Where people needed support to move, some staff had not been trained in safe moving and handling procedures and staff did not always use mobility aids to promote safe practice. Records relating to people's care and to the management of the service were not always accurate.

There were enough staff on duty but some staff had not received training to enable them to support people

in a safe way. Although the staff on duty were able to describe how they would identify and respond to any allegation of abuse, some staff had not received training in safeguarding adults at risk.

The provider failed to notify the Commission of significant events as required by law. They had not displayed the rating of the service given at the last inspection. Services are required to display their rating so that people can easily understand the performance of the service.

Relatives spoke highly of the service and staff. During our visit there was a calm atmosphere. There was very little by way of activity or stimulation for people.

People received their medicines safely and staff followed clear procedures for the management and storage of medicines.

There were systems in place to promote safe recruitment decisions and to assess whether new staff were safe to work with adults at risk.

The provider had taken action to improve fire safety equipment and processes within the service following action taken by the Fire Service.

We found five continued breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. Two breaches from the inspection in November 2015 were not reviewed as part of this inspection.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC has now cancelled the provider's registration.

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 at risk of harm because risks to their safety had not been properly assessed or managed.

There were enough staff on duty but some staff had not received training to enable them to support people safely.

Staff on duty understood how to identify abuse and described the action they would take in response to safeguarding concerns but some staff had not been trained in safeguarding adults at risk.

Pre-employment checks had been completed for new staff before they started work.

People received their medicines safely.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance system was not effective. The provider had not taken action to mitigate known risks. Actions identified to make improvements in the service had not been completed. There was no system in place to monitor and drive improvements.

Action had not been taken to address previous concerns and breaches of regulations.

There was a lack of clear and stable leadership.

The provider had failed to display their rating received following our last inspection.

Relatives of the people who remained at the service spoke positively about the home and the staff.

Devonia EMI Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Devonia EMI Home on 1 March and 2 March 2016. The purpose of this inspection was to check that improvements to meet legal requirements had been made. The team inspected the service against two of the five questions we ask about services: Is the service Safe? and Is the service Well-led?

An inspector and an inspection manager undertook this inspection.

Prior to our visit we reviewed four previous inspection reports, , safeguarding information received from the local authority and notifications received from the provider about a failure of the home's boiler and Deprivation of Liberty Safeguards (DoLS) that had been authorised. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we addressed potential areas of concern.

We observed care and 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 looked at care records for all three people living at the home, medication administration records (MAR), monitoring records of people's weights, accident and activity records. We also looked at two staff recruitment files, four staff training files, staff rotas, staff handover records and audits of the service.

During our inspection, we met with all three of the people who lived at the service although only one person was able to provide detailed information about their experiences. We also spoke with one relative, the provider and five care staff. Following the inspection, we contacted a Community Psychiatric Nurse (CPN) who had involvement with people at the service to ask for their views and experiences.

Inadequate

Is the service safe?

Our findings

When we inspected in September 2014 and April 2015 we had concerns that the system for identifying and assessing risks was not fit for purpose and that staff lacked information on how to mitigate risks. The provider failed to take action and by September 2015, we found that the lack of a system to assess, monitor and mitigate risks to people was having a direct impact on their safety. We issued a warning notice to the provider. At our next inspection in November 2015 we found that the provider remained in breach of this regulation and that people were at risk. At this visit we found that the provider had not taken action to minimise risks to people and remained in breach of this regulation. We will publish information about the action we have taken in response to continued breaches of regulations once this is completed.

Although there were fewer people living at the service, they remained at risk because there was a lack of consistent information on how to manage people's behaviours that might challenge and place them and others at risk. Staff told us that two of the three people who lived at the home could present with behaviour that challenged. Care plans and risk assessments for these people lacked information on what might trigger known behaviours, how to support them and how to keep others safe. One person's care plan stated, 'Can become agitated and lash and kick out during the process (washing and dressing)' and, 'Does tend to hit out and shout when frustration sets in'. Although there was guidance such as to talk to the person calmly and not too quickly there was no detail on what might trigger these behaviours and how staff should respond to keep the person and others safe.

From the daily notes, it was clear that there had been episodes of behaviour that challenged. One person had reportedly thrown their drinks, the remote control and cushions, screamed for help and been, 'Very, very agitated'. A staff member told us, "Just after tea sometimes she gets worked up". During February 2016, we read that another person had been 'agitated' at different times on 13 days. On one occasion the GP had not been able to see this person as they were too agitated. Although these people had a known history of behaviours which may challenge there was no care plan in place to describe how staff should support them and the behaviour monitoring charts were blank. The lack of behaviour monitoring information meant that patterns in behaviour may not be identified. Staff had not been trained in supporting people with behaviours that might challenge which put people and staff at risk of harm.

At our last inspection we identified that the guidance on when 'as required' medicines should be used to help ease people's distress and manage behaviours that challenged was unclear. One person was prescribed medicine to be taken on an 'as required' basis to help calm them. The protocol which should describe how and when to administer the medicine had not been updated since our last inspection and still lacked detail. The reason for the medication was given as 'agitation' and under the heading, 'How the decision is reached about how and when to give' it stated, 'When (name of person) becomes distressed'. This person had been given this medicine on two occasions in the last month. On these days it noted that the person, 'Appears agitated' and was, 'Agitated first thing this morning'. On other days staff had recorded that the person was, 'Very agitated all day' or, 'Very agitated,' but the medicine had not been given. One staff member told us that if the person's behaviour was not under control within 20 minutes they tended to give the medicine but this was not recorded as guidance to ensure a consistent approach. It was, therefore, not

clear how the decision to administer the 'as required', medicine was taken. The lack of information and guidance for staff on how the person would present could mean that the medicines were administered inconsistently or inappropriately.

People were not protected from avoidable harm due to a lack of written guidance for staff and the use of inappropriate moving and handling techniques. One person was unable to stand without assistance and required a wheelchair to transfer. This person's care plan for mobility read, 'Depending on mood will stand with two carers and take weight well'. There was no guidance on how staff were to assist this person if they could not take their weight. This concern was raised with the provider in our last two inspection reports but the care plan had not been revised since May 2015. At our last inspection the provider confirmed that they used a 'drag' lift to help this person stand if they were unable to take their weight. The 'drag' lift is any method of handling where the care staff placed a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders, wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. On this visit a staff member told us that on occasions when the person could not bear weight, "We (the staff) take her weight", which could place staff or the person at risk of injury. Although the provider had purchased a full body hoist, staff had not been trained to use it and told us that it was not used.

For another person the support plan stated they needed one or two staff depending on their mobility at the time. There was, however, no description of when they were able to manage independently and when staff should intervene to ensure their safety. In the daily notes, we read that this person was, 'Very unsteady on her feet' and, 'Very wobbly on feet'. They had also had an unobserved fall in the dining room during December 2015. During our inspection the two people who were able to mobilise were walking in socks and not wearing slippers or shoes. This presented a risk of slipping, especially on hard, non-carpeted floors such as that in the dining room. Staff training in moving and handling was out of date for 40% of staff. Twenty percent of the staff who were recorded on the rota as delivering care to people had no recorded training in safe moving and handling procedures. Therefore not all staff were suitably trained to support people safely with their mobility and the guidance in place to mitigate the risk of falls or injury related to mobility was missing or unclear.

At our last inspection we raised concerns over the fact that one person was supported to eat their lunch whilst sitting in a reclined position with their feet elevated. We raised these concerns with the provider and highlighted that the person's support plan lacked detail on how they should be positioned to reduce the risk of choking. At this visit the person was fed in the same way. We observed that the person craned their neck forwards to take the food from the spoon. The person coughed when given a drink and was at an increased risk of choking due to their reclining position. The support plan for 'food intake' had been revised in January 2016. It stated that food should be cut into small manageable pieces but made no reference to postural support.

Where risks had been identified there was a lack of monitoring to ensure people's safety. One person used bed rails to prevent them from falling out of bed. These had been assessed in November 2015 and the form indicated that the safety of the equipment should be checked on a monthly basis. There had been no further checks to ensure that the rails and padding, used to protect the person from bruising and to minimise the risk of entrapment in the rails, were safe. Where people were supported to use the toilet, staff maintained a record of their bowel movements. Staff told us that this was to ensure they were, "Regular". We looked at the bowel monitoring charts and found unexplained gaps, including in one case a gap of 14 days. It was not clear whether this was a recording error or whether this reflected 14 days without a bowel movement. There was no evidence in the care plans that people's risk of constipation had been assessed, or what action staff should take if a person did not have regular bowel movements. Therefore it was unclear how people's bowel

health was being monitored and responded to when changes arose.

The provider's failure to assess risks to people's health and safety and to take action in response to known risks was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken action to improve fire safety at the service. The provider had been issued with an enforcement notice by the West Sussex Fire and Rescue service in November 2015 because deficiencies in fire safety arrangements at the home had not been remedied. In December 2015 the provider had commissioned a complete audit of fire safety via an external company. This company had drawn up an action plan which included specific timescales. The provider had made progress and had prioritised completion of those actions associated with the highest risk. Some actions had a deadline of June 2016 and the provider had a plan to address these. Fire training had been provided to staff in December 2015 and an evacuation drill had been completed. One staff member told us, "We've had fire training; it covered evacuation and putting fires out. We're bang up to date with all that". They also said, "We've got all new fire doors".

There were sufficient staff on duty but gaps in staff training meant that some staff lacked the skills to carry out their duties safely. Two staff members who supported people with personal care tasks such as bathing, toileting and mobility assistance had not received appropriate training to carry out these tasks safely. According to the provider's training matrix sent to us in January 2016 these staff had not been trained in moving and handling, infection control, basic first aid, dementia awareness or the Mental Capacity Act 2005. Refresher training for some other staff was out of date as well. This could mean that staff did not have the skills or experience to support people safely.

The records of staff training did not demonstrate that staff had received appropriate training to enable them to meet people's need safely. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the occupancy of the service had reduced from 11 to three. The provider had maintained their staffing level of three care staff in the morning, two in the afternoon and two at night. This was sufficient to meet people's needs as one person required assistance from two staff with most activities of daily living, and another required two staff to support them if their mobility was poor. The rotas received from the provider demonstrated that they planned a minimum of two staff on duty at all times. Since our last visit the provider had reduced the number of staff employed. We asked about contingency arrangements such as for sickness or annual leave. The provider told us that they did not use agency and that, "They are good staff". She told us, "It's all of us, we work as a team. There's always someone there to cover them".

At our last inspection we found that the provider had not taken robust action to protect people when a staff member's fitness to carry out their role was being investigated. We set a requirement in relation to fit and proper persons employed. At this visit the staff member in question was no longer employed and this requirement in relation to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met.

The provider was able to demonstrate only those staff assessed as 'fit and proper' were employed. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were

obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

At our last inspection we found people were not protected from abuse or improper treatment because staff had not taken prompt action to report concerns and were not always able to identify situations that constituted ill-treatment. At this visit the staff on duty were able to tell us about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. This included the action they would take if there was verbal or physical aggression between people who used the service. One staff member said, "I would report it if there was a slap or someone threw tea". This demonstrated that staff understood their responsibilities. The requirement relating to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was therefore met. We found, however, that there was no training in safeguarding adults at risk recorded for two staff members and that training for four staff members was out of date. This could put people at risk of harm as some staff may not identify of be aware of the action to take if they witnessed or were informed of an allegation of abuse.

Medicines were administered safely. Checks were carried out that staff were competent to safely administer and handle medicines. A record of the signatures used by staff when completing medicines records was maintained for purposes of auditing and checking. Daily checks were made to ensure that medicines had been administered correctly and were all accounted for.

The records of administration of medicines to people were completed, indicating if a medicine had been taken or refused. For medicines prescribed on a variable dose, such as for pain relief, the dose given and time of administration was clearly recorded. Staff maintained records of when creams and ointments were opened, how long the manufacturer recommended it could be stored after opening and when it should be disposed of. We checked the stocks of medicines and found them to be in date. Since our last visit the medicines trolley had been moved into a downstairs room. Staff maintained a record of the temperature of the room and of the medicines fridge. This helped to ensure that medicines were stored at the right temperature and maintained their effectiveness.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. The manager in post at the time of our last inspection was no longer employed by the service and there was no manager appointed to replace them. The provider was in breach of their registration conditions which say that they must ensure that the service is managed by a person registered as a manager. The previous registered manager had deregistered with us in September 2014 and had not worked at the service since May 2014. The provider explained that they had started to look for new manager candidates but that this had been put on hold due to uncertainty over the service's future.

In the absence of a registered manager, the provider told us that they were in day to day control of the service. When we asked about their systems and processes or to see paperwork such as updated training information, the provider was unable to furnish this information. The provider did not appear to have sufficient understanding of the systems and processes required to lead and run the service safely and effectively.

The provider demonstrated a lack of understanding of the requirements of the regulations and how to achieve and sustain compliance. The provider had been in breach of regulations since September 2014. From April to November 2015, the number of breaches identified had increased from two to nine. Although the provider had started to complete a self-assessment of their compliance with the regulations, this had not been finished and there had been no update since February 2015. One staff member told us, "(The provider) hasn't done a whole lot more to move things on because she's worried about it (the service) closing".

We asked the provider what had changed and what improvements had been made since our last inspection in November 2015. She told us, "It's no good me telling you, you'll have to look at the paperwork". Although we had requested a plan of action to describe how the provider would address the breaches in regulation, none was received. The provider did not have a system to record and monitor the progress of actions required to improve the quality and safety of the service.

People were at risk of harm because the provider did not have an effective system to assess, monitor and improve the quality and safety of the service. The provider had been in breach of the regulations concerning good governance since September 2014. They had failed to meet two warning notices issued with deadlines of 31 August and 20 September 2015. At this visit, we found that the provider had failed to take action and remained in breach of the regulation. We will publish information about action we have taken in response to continued breaches of regulations once this is completed.

People remained at risk of receiving unsafe care because risks to their health, safety and welfare had not been assessed. The system of audits did not assess whether risks to people had been mitigated and monitored effectively. Although staff had completed monthly reviews of people's care, there had been no audit to ensure that they understood their responsibilities or to satisfy the provider that people were receiving safe care that met their needs. We found that care plans did not always include guidance for staff on how to meet people's needs, particularly with reference to managing behaviours that challenged and

moving and handling. The provider's audit of risk assessments from August to December 2015 recorded, 'No issues. All up to date'. For January 2016 we read, 'Risk assessments reviewed and updated' which was signed by the provider. We asked the provider which risk assessments had been reviewed but she was unable to answer this, saying that another staff member was responsible for updating the risk assessments.

Where incidents had occurred people's care plans had not been reviewed to ensure that they met their needs. We saw that one person had fallen from bed in February 2016. Their 'sleep' care plan was last reviewed in January 2016. There was no detail as to why the person may have fallen or on how to minimise future risk. Another person had fallen over in the middle of February but the review of their mobility care plan at the end of February 2016 made no mention of the fall and simply recorded, 'no changes'. The provider's monthly accident audit consisted of a summary of the incident and any action taken by staff. This had last been completed in December 2015. There was no evidence that accidents and incidents had been reviewed to help minimise risk to individuals or to identify any patterns in falls or injuries that had occurred.

Other audits also contained gaps or inaccurate information. The nightly cleaning rota contained gaps on two days in both the week we visited and the previous week. A notice in the office stated that this checklist must be completed daily and that staff would be asked to return and complete their paperwork if it was not done. The monthly cleaning audit had last been completed in November 2015. The monthly complaints audit had been completed in January 2016 but recorded that no complaints were received. This was incorrect as the provider had received a complaint from a relative dated January 2016 which they had copied to the Commission with their response. In a list of policies and procedures we read that the complaints policy had been rewritten in January 2016. We found, however, that the policy was dated September 2015 and directed people to the former manager as a contact.

Some audits did not appear to have been used effectively to identify areas for improvement or to record actions that were required. The provider had used a medicines audit template to review their practice in October and December 2015. The audit stated, 'If you have ticked any boxes shaded grey it means action needs to be taken'. Some questions such as, 'Is there signage that the refrigerator should not be switched off?' indicated that action was required but there was no corresponding action plan or note to indicate the provider's intentions. Although the audit had been completed there was no evidence that through it the provider had assessed their practice as safe or picked up any points for improvement.

Records in relation to each person's care were not always accurate and complete. In one person's records a mental capacity assessment dated November 2015 concluded that they did not have capacity. Since this time the person had been assessed under the Deprivation of Liberty Safeguards (DoLS) and it was determined they had capacity to consent to the care placement. The records relating to this person's capacity had not been updated and were in conflict with the most up-to-date capacity assessment. In the Personal Evacuation Plan (PEEP) for this same person we read that their hearing was 'poor' but this was not referenced in the person's support plan. Similarly a risk assessment for mobility had not been updated since they have moved from the first floor following a prohibition notice by the fire service. Their risk assessment still made reference to the stair lift. There were gaps in people's daily notes and in the handover records. We found that people's care plans were not entirely accurate and did not always reflect people's current needs and risks.

Records relating to the management of the service, such as staff training records, were not fit for purpose. The provider told us that staff training was up to date but was unable to provide updated records which demonstrated this. We gave the provider the opportunity to send this information following our inspection but she told us that these details were held by a third party and she was unable to obtain it. This lack of clear information meant that some staff did not appear to have been trained in key areas such as safeguarding or

moving and handling and that other training had been allowed to become overdue. For each of the ten courses listed on the matrix training was overdue for some staff and some staff had never attended. Planned staff rotas showed at least two staff planned on each shift, however the 'timesheets' for recording actual hours worked differed from the planned rota. This meant that there was no definitive record of staffing hours worked to verify the numbers of staff on duty.

The provider had requested feedback from relatives and professionals who had involvement with the service. We received copies of six feedback questionnaires dated from December 2015 to February 2016. In each case the feedback was positive. Where suggestions had been made, such as for additional activities or physio support, we asked the provider how these would be addressed. The provider told us that she had no plans to introduce new activities and said that people enjoyed watching television, listening to music or reading. The provider had not used feedback received to evaluate and improve the service.

The absence of an effective system to assess, monitor and improve the quality and safety of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken steps to improve the safety of the service in some areas. Action had been taken in relation to fire safety which included the fitting of new fire doors, staff training and an updated risk assessment for the service. The electrical wiring had also been assessed and deemed safe to use by an external company in January 2016. Rucked lino in one person's bedroom had been addressed which reduced the risk of trips and falls. The provider had also suggested that a staff member visit other care homes in the local area to see how they run their services. The staff member told us that this had been a useful exercise and that they had received advice on care planning and making improvements to the service.

Relatives told us that they felt able to raise concerns with the provider and expressed that there was an open culture within the service. One staff member told us, "I love it here. I love these ladies, they're family. They know they can talk to me, for any little worries". At our last inspection we raised concerns that there was no system to deal with verbal complaints made about the service. The provider had not updated their complaints policy and people could not be assured that verbal complaints would be handled appropriately.

The provider had agreed to a voluntary suspension on new admissions to the service due to our continued concerns about the failure to meet requirements. She advised that they were still showing people around but would speak with the Commission if she wished to take a new admission. The provider had not displayed their rating received following our inspection in November 2015. From April 2015, providers are required to display performance assessments by law. This should be conspicuous and in a place accessible to people who use the service. It should also be displayed on the provider's website. The provider told us that she would tell prospective residents and relatives to read the report and to look at feedback received by the home. A staff member said, "There's no point in hiding it. We would explain to them what our ratings are".

The provider did not understand her responsibilities in ensuring the rating was posted conspicuously on the premises and on the home's website. At the end of the second day of our inspection, after we noted the failure to display their rating, the provider posted the ratings summary near the front door and stated they would add this information to their website. However, a further review of the home's website following the inspection confirmed that the rating was not displayed there.

This was a continued breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At our last inspection we set a requirement relating to the notification of incidents. The law requires that services notify the Commission of specified incidents without delay. Following our last inspection, we received notifications of DoLS that had been authorised but we were not notified of an allegation of abuse made in January 2016, which was being investigated by the local safeguarding team.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

During our visit the atmosphere was calm, other than a minor disagreement between two people at the start of lunchtime. There was very little activity, with people generally sleeping in armchairs or watching television. We asked one person what kind of things usually went on in the home. They told us, "Nothing really, it's just like this". In the provider's feedback survey one friend had written, 'Very cosy and homely. A quiet, comforting atmosphere'.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay of the incidents specified. Regulation 18 (1) (2)

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care and treatment was only provided with the consent of the relevant person or that staff acted in accordance with the 2005 Act. Regulation 11 (1)(2)(3)

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not provided in a safe way for people because risks to their health and safety had not been assessed or mitigated. Regulation 12 (1) (2)(a)(b)

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system to record, handle and respond to complaints.

	Regulation 16 (2)

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the quality and safety of the services provided were not operated effectively. Risks to the health, safety and welfare of service users and others were not effectively assessed, monitored or mitigated. Records in respect of each service user were not always accurate or complete. Regulation 17 (1) (2)

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the rating received in its performance assessment by the Commission.

The enforcement action we took:

We have cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support and training to enable them to carry out their duties. Regulation 18 (2)(a)

The enforcement action we took:

We have cancelled the provider's registration