Serenity One LTD

Dr Anderson Lodge

Inspection report

East Lane
Stainforth
Doncaster
South Yorkshire
DN7 5DY

Date of inspection visit:
02 December 2019
03 December 2019
10 December 2019

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21 January 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Dr Anderson Lodge is a residential nursing home. The home can accommodate and provide care to up to 60 people with varying needs such as older people, younger people, people with sensory impairments, physical disabilities and dementia. There were 41 people living at the home at the time of our inspection. The main building, called the lodge had 27 people, a separate building called the annexe provided care to 14 people living with dementia.

People's experience of using this service and what we found
Risks associated with people's care and treatment were not always identified or managed safely. This put people at risk of not receiving the right support to meet their needs and showed the registered provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

The systems to help identify where improvements were required had been ineffective. The systemic failings found at this inspection demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of potential and continued harm.

People were not effectively protected from abuse because some staff did not recognise their responsibilities to ensure people were safe. People told us they felt safe living at the service. However, practices were not safe. Changes to people's health needs were not routinely addressed in a timely way.

The level of activities and meaningful occupation did not meet the social needs and wellbeing of everyone living at the home, especially people living in the annexe.

People and relatives said staff were kind and caring. However, people's privacy and dignity were not always respected. People's medicines were not well managed to ensure people received medicines as prescribed.

People were not always supported by staff who were suitably trained, assessed and monitored to carry out their role safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
This service was registered with us on 10/10/2018 and this is the first inspection. The last rating for this service was good (published 24 October 2018). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the

rating at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dr Anderson Lodge on our website at www.cqc.org.uk.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified nine breaches in relation to person centred care, safe care and treatment, dignity and respect, consent, safeguarding, nutrition, premise and equipment, governance and staffing.

Following the inspection the registered manager submitted an action plan to CQC to inform us of the action they intended to take and placed a voluntary suspension on admissions to the home.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Dr Anderson Lodge

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 Care Act 2014.

Inspection team
The inspection was carried out over three days. On the first and third day two inspectors visited, and the second day was carried out by one inspector and 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.

Service and service type
Dr Anderson Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 2 December 2019 and ended on 10 December 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people who used the service and seven relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, nurse, care workers, the cook, activities coordinator and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. 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 reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We raised a safeguarding concern to the local authority safeguarding team after the inspection. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The provider sent an action plan giving details on how they were going to reduce the risks and ensure the service was safe.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The environment was not safe, and this posed a significant risk to people's health and wellbeing and lessons were not learnt from incidents. During a tour of the building on the first day of the inspection we found a window restrictor was missing from an upstairs window. The registered manager immediately reported this, and a repair of the window was carried out. On the third day of the inspection we found another window wide open creating a significant risk to a person who may be in a confused state.
- The provider had failed to identify that bedrails were being used that did not safely meet people's needs, risking entrapment and injury. These risks were discussed with the registered manager who was guided to use the latest health and safety guidelines.
- Risks associated with people's care and treatment had not always been identified and managed safely.
- Analysis of accidents and incidents was not effective, and lessons had not been learnt. One person had displayed behaviours which had caused staff to be injured but a lack of analysis meant that there had been no action taken to reduce these known risks.
- The registered manager's audit was not effective in identifying issues. We completed a tour of the service with the registered manager and found that a majority of the environmental risks we found, had not been identified on the manager's audit.

There had been a failure to robustly assess, monitor and manage the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely, and we could not be assured people received medicines safely in line with good practice.
- Medication administration records (MARs) were poorly completed and there were many gaps without explanation or investigation to check if people had received their prescribed medicine.
- Stock checks of several items found the amount in stock did not always tally with the administration records, this means people may not have received their medicines.
- There was no guidance on administration of 'as and when' required basis, known as PRN. There was a lack of records completed when PRN had been administered. It was unclear why the medicines had been administered, what dose had been given, or if the medicines had been effective.
- Where creams, ointments or drops were being administered they had not been dated when opened, so it was unclear if the medicines had passed their use by date.

We found medicines were not effectively and safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●We identified some infection control issues. We found cracked tiles and dirty seals around toilets. We found several areas where wood was porous and could not be suitably cleaned to prevent the spread of infection. We discussed these concerns and the registered manager told us they didn't have anyone employed to carry out maintenance tasks and they were currently advertising to fill the role; however, they would take action to address the issues.

● Staff told us they had no protective equipment to protect them when supporting people who displayed challenging behaviour and could spit at them. We discussed this with the registered manager who told us there were face mask available, however staff were not aware of this and were not using this protective equipment.

● We observed poor food hygiene practices during the service of a meal which left people at risk of the spread of infections.

The provider had failed to ensure people were protected from the risk of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider was failing to always protect people from abuse. One person who was being regularly restrained without suitable safeguards in place, which was a breach of their human rights.

● Staff were not always recognising and responding to abuse. We saw one incident where a person who was confused grabbed hold of another, staff had not reported the incident to the registered manager, so it could be reported to the local authority safeguarding team.

● We asked the registered manager to report two concerns to the local authority safeguarding team, so they could look into them.

The provider had failed to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not sufficient numbers of staff available to meet people's needs.

● Staff were not always deployed effectively so that people received care when they required it.

● People told us the staffing levels were not suitable and we observed staff were often task orientated.

● A number of people living in the annexe were seen to be distressed, however staff were busy carrying out tasks and their time was not responsive to reassuring and engaging with people.

The provider had failed to ensure there were sufficient staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider carried out comprehensive background checks of staff before they started work to ensure their suitability. These checks included details on their qualifications and experience, their employment history and reasons for any gaps in employment, references, a criminal records check, and proof of identification.

Inadequate

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law;

- People were not always referred to health professionals in a timely manner to ensure their health needs were met.
- One person had been consistently refusing medicines for a number of weeks. This had not reported to the GP for a review of the persons medicines.
- Care was not always suitably assessed or being delivered in a person-centred way.
- We found instances where there was key information missing from people's care plan which was essential to support them, and we found instances where information was conflicting, so it was unclear which information was current. For example, we found conflicting information on how to hoist people, which put them at risk of harm. One person's care plan stated they had difficulty communicating and could get upset but no information was available on how to effectively communicate with the person when they were distressed.
- Initial admission assessments were completed and listed people's health problems such as epilepsy, or diabetes. One-person's initial assessment stated they had epilepsy, however there was no further information on the support they needed to manage their epilepsy, or consideration of any of the risks associated with the condition.
- Restraint was being used, but there were no specific guidelines in place for staff to follow or behaviour monitoring being carried out to enable analysis of incidents. This goes against National Institute of Clinical Excellence (NICE) guidelines on Violence and Aggression.

The provider had failed to ensure they were delivering person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Feedback from relatives was they had been fully involved in developing their relative's care plan. One relative said, "I've been involved from the word go in the care plan."

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

- Specific advice from professionals was not always followed. Risks associated with eating, such as choking, were not managed safely. We found several examples where staff failed to follow professional guidance. This placed people at risk of aspirating or choking. Aspiration happens when food, liquid, or other material enters a person's airway and eventually the lungs by accident. It can happen as a person swallows, or if food comes back up from the stomach.

● People that had lost significant amounts of weight, had no record to ensure they were having enough dietary intake. Referrals had not been made to health professionals. This posed a risk of people losing further weight and not receiving adequate nutrition and hydration.
● The meal time experience was poor. We found people had been served food which was cold, and no temperatures were taken of the food before service. People were not offered a mid-morning snack, despite them requiring regular snacks to maintain weight. When food was pureed or blended it was not presented in an appealing way and second helpings of food was not always offered to people on pureed diets.
● People's specific food needs were not being met. One person was allergic to eggs and cheese. We spoke to the cook who told us, "One person who is allergic to cheese and eggs, I just don't offer them to [the person]. I still give the person cakes, because the eggs in it don't seem to bother them."

The provider had failed to ensure people received adequate nutrition and hydration. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● There were shortfalls in training. A large number of staff had not received training in dementia care and this was reflected in some of their interactions with people who lived with dementia.
● Not all training was effective. Although records showed staff had training in keys areas, such as safeguarding and moving and handling, this had not always led to competency. For example, we observed poor moving and handling practices and staff failed to recognise all safeguarding concerns.
● Staff received regular supervisions and appraisals from the registered manager, however, there was a lack of direct observations of care taking place to ensure staff training and practice were suitable and sufficient.

The provider had failed to ensure staff were suitably skilled and competent to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment in the annexe was not suitably adapted to meet the needs of people living with dementia. The corridors were dark and narrow, and the environment felt oppressive.
● Best practice was not followed for people living with dementia. National good practice in dementia care, identifies that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors were not in a contrasting colour, nor were toilet seats.
● There was a lack of appropriate signage such as toilet signs and signs to show people where their bedrooms were, this did not effectively promote people's independence.
● In the annexe we found one bed that had broken bedrails and in another bedroom a broken bedframe was in use, neither were fit for purpose.

The provider had failed to ensure the environment was suitable and safe. This was a breach of regulation 15 (Premise and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the third day of the inspection the layout of the lounge in the annexe had been changed which made a small improvement to the atmosphere and available space.
●The part of the home called the lodge was appropriately adapted for people with large corridors, spacious bedrooms. People could spend time with relatives in the communal lounges, or in the reception area.
● Bedrooms were personalised with personal belongings and photographs.
● The registered manager told us there were plans to improve the environment in the home.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's rights under the MCA were not always respected. Care was provided against people's wishes.
● Where people were subject to restrictions, such as physical intervention, their capacity to consent had not been assessed. Consequently, there was no evidence that interventions were the least restrictive option or in their best interests.
● Staff we spoke with did not have a good understanding of the Mental Capacity Act. The registered manager wasn't aware which person's legal representative had a Lasting Power of Attorney (LPOA), to enable them to make decisions on the persons behalf. Relatives were being asked to make decision where they didn't have LPOA to make decisions.

The failure to respect people's rights under the MCA was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS were in place when required. None of the DoLS we viewed had any conditions imposed.

Inadequate

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care.

● Person-centred care was not embedded into the culture at the home. Although people were, overall, positive about individual staff, there was a lack of person-centred care, which was more evident in the annexe. ● Staff did not always communicate with people in a kind and compassionate manner. We heard staff regularly refer to people as "feeders and wanderers", this was not respectful.

● We spoke to staff about one lady who was quite energetic and in good humour. Staff replied, "You want to see them when they kick off. They're not always like this."

● The majority of interactions we observed in the annexe were task orientated and people's emotional needs weren't always met.

● Staff did not respond when people were in distress. We observed a person being involved in an altercation with another person. Staff redirected the person away but didn't give any comfort or reassurance to the person who was visibly upset by the incident.

● Care plans contained information about people's choices, likes and dislikes but care was not being provided in line with people's specific choices. We found that everyone was taken to the toilet at specific times in the annexe rather than when there was a need.

● Negative interactions were observed when staff were not caring or considerate to people. One member of staff assisted a person to eat their meal. Before feeding the person they took away a teddy the person had been holding, the person was reluctant to let go but it was taken away without any explanation. The staff, then just spooned the food into their mouth without talking to them.

Respecting and promoting people's privacy, dignity and independence

● People were not always provided with care that promoted their dignity. Staff did not always notice or attend to people's personal care needs. One person was reliant upon staff to maintain their personal appearance, however staff had not provided this support and they were left in an undignified state.

The provider had failed to ensure people were always treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives from both units were positive about the approach by staff. One relative told us, " [My relative] is warm, happy and clean." Another relative said, "The staff are fantastic, very kind."

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People were at risk of harm and were not achieving good outcomes because the provider failed to ensure they received consistent person-centred care. Staff did not always know people's individual needs in relation to choking, moving and handling and challenging behaviour. This placed them at risk of avoidable harm.
- People's care needs were regularly reviewed, however not effective as action to address risks was not taken following review. Care plans were out of date and did not always sufficiently guide staff on people's current care, treatment and support needs.
- People were not always involved in the care planning process. One person was regularly displaying behaviour that was challenging. There was a care plan in place on how to deal with challenging situations but there had been no professional consultation that the method used was the least restrictive and other options had not been considered.
- Monitoring records were not completed correctly, or in line with people's assessed care needs. We saw at times there was incomplete or inconsistent information recorded in care plans. For example, one person had been assessed by the speech and language therapist (SALT) as needing a specific diet, however this information had not been transferred into the persons care plan to ensure staff had access to the most up to date information.

Meeting people's communication needs

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

- People had care plans in place on communication needs, however we found that they lacked person centred details to enable affective communication, specifically with people who were anxious or displayed challenging behaviour.
- Not all staff recognised effective communication as an important way of supporting people to aid their general wellbeing.

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

- There was an activities coordinator employed by the service. They provided activities to people living in both the lodge and annexe.
- We found that people were generally more involved in activities in the lodge, however we observed a lack

of stimulating and meaningful activates taking place in the annexe. We saw that people were left without stimulation for significant lengths of time. One person who lived in the lodge said, "We can get a bit a bored we are all one room, it's easier to put everyone together for the staff."
●Local school children visited the home and sang carols in the lounge in the lodge. We asked if people from the annexe would have opportunity to be involved and staff said, "No, [everyone is not going] because they can be quite noisy and vocal and it spoils it for everyone else."

The provider failed to ensure person centred care was delivered. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● Staff were not suitably trained to provide end of life care. According to the provider training matrix only two staff had received training in this area. No one was currently receiving end of life care.
● Final wishes were recorded in people's care plans and covered people's cultural and spiritual needs.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure which had been shared with people and their relatives. We saw the complaints procedure was clear in explaining how a complaint could be made.
● We saw complaints that had been dealt with in line with regulations, and measures had been put in place to address the complaint satisfactorily.
● People were confident they could raise concerns and their concerns would be acted upon.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The systemic failings detailed in the safe, effective, caring and responsive key questions demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of potential harm.
- The registered manager's quality assurance systems were inadequate, and the provider had failed to test these systems with their own quality assurance checks. The registered manager had not kept up to date with best practice and ensured high standards of care were maintained.
- The quality monitoring systems failed to promote and support the delivery of high-quality, person-centred care. Where audits had been carried out, they had not effectively identified safety and quality concerns.
- Systems for learning from incidents and near misses were not effectively implemented which meant lessons were not being learnt from incidents.
- Directly following the inspection, the registered manager sent to us an action plan giving information on how they intended to address concerns and make improvements.
- The provider agreed to work with CQC and placed a voluntary embargo on admissions to the service, until a time where sufficient improvements had been made. This mitigated the risk and meant we didn't have to take urgent enforcement action on the provider. However, the service will be closely monitored and is in special measures.

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

- Feedback from people living at and visiting the home was gathered during meetings and feedback surveys.
- We received mixed feedback about the quality of the service in both the lodge and annexe. Some people were happy, whilst others expressed concerns regarding staffing levels and lack of activities.
- Staff received regular formal supervision, but there had been a lack of observations of the staff practice. This had contributed to some of the examples of poor practice we observed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The provider had failed to ensure peoples equality characteristic of disability, in respect of dementia care,

were being considered and people were supported in line with their needs.

- Some staff did not take responsibility to address risk. For example, staff did not always make referrals to health professionals in a timely way.

There had been a significant deterioration of the quality of care since the new provider purchased the home. This was a breach of Regulation 17 (Good governance) 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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care in response to their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provide failed to ensure the care and treatment of people was provided with the relevant consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided in a safe way. The provider has failed to assess risks and ensure they were doing all that was reasonably practical to mitigate risks. The provider had failed to ensure the proper and safe management of medicines. The provider had failed to ensure people were protected from the risk of infections.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that systems and processes were effectively operated to ensure that allegations of abuse, specifically restraint, are necessary and proportionate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutrition and hydration needs of people were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that premises and equipment were suitable for purpose and properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not adequately deployed, or skilled and competent to carry out the duties they are employed to perform.