De Vere Care Limited

Lehmann House Residential and Nursing Home

Inspection report

Lehmann House
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Suffolk
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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
Lehmann House Residential and Nursing Home is a residential care home providing personal and nursing care. The service can support up to 34 people. It is divided into four units over two floors. Two units were being used one upstairs and one downstairs. There were 16 people living in the service at the time of this inspection.

People's experience of using this service and what we found
There was a lack of clear governance in the service and the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant poor care was not identified and rectified by the provider. The provider had not effectively and consistently worked with professionals to ensure people's needs were met.

Risks to people's health and wellbeing were not consistently identified, managed or followed to keep people safe. Where advice had been received from health care professionals this was not always followed.

Improvements were needed to ensure incidents of suspected abuse were investigated and reported to the local authority when required. Improvements were needed to ensure people were consistently protected from the risk of infection and cross contamination.

The provider did not use a staffing tool to assess the number of staff required. There were not enough staff deployed effectively to provide care and support. Due to pressures on staff time, interactions with people were often task focussed. Staff told us the training was not of a high quality. We observed poor moving and handling practice during our inspection visit.

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. The service had obtained consent to people's care and support arrangements from relatives who did not have the required legal authority.

The activities co-ordinator had left the service and no alternative arrangements had been put in place for people's social engagement. We were told staff should be providing activities, but no extra staff had been employed to meet this requirement.

The service placed people at risk of physical harm and at the risk of significant emotional harm due to isolation, lack of engagement and the impact of poor care

Rating at last inspection

The last rating for this service was Requires Improvement (published 5 February 2019). At this inspection the service has deteriorated to Inadequate. Previous to the Requires Improvement rating the service was rated Inadequate at the inspection in July 2018.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lehmann House Residential and Nursing Home on our website at www.cqc.org.uk.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and care provided. A decision was made for us to inspect and examine those risks.

Enforcement
At this inspection, we identified breaches of regulation in relation to the management of risks, staffing levels and recruitment practices, people's emotional and physical needs not being met and the overall governance of the service. We placed an urgent condition on the providers registration and issued a Notice of Decision to close the service

Follow up
This service has now closed.

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 safe findings below.

Is the service caring?

Inadequate

The service was not always caring.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below

Lehmann House Residential and Nursing Home

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 by one inspector and a specialist advisor in nursing care.

Service and service type
Lehmann House Nursing and Residential Home 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.

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 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 three people who used the service and three relatives about their experience of the care provided. We spoke with five members of care staff including the cook. We also spoke with the service's nominated individual and a director of 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 seven people's care records and multiple medication records. We looked at three 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 continued to seek clarification from the provider to validate evidence found. We liaised with the local authority regarding action they had taken.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The service did not have effective systems and processes in place to protect people from harm.
- Following a substantiated safeguarding investigation, the local authority put a protection plan place to protect an individual from further harm. The service did not carry out the recommended actions and the abuse was repeated.
- Appropriate safeguarding referrals were not made to the local authority. For example, one person suffered an alleged theft, but this was not reported.
- Investigations into safeguarding concerns were not thorough. A member of staff who was suspended due to a safeguarding allegation was re-instated with no clear rational or analysis of the evidence gathered.

Assessing risk, safety monitoring and management

- The service used standardized risk assessments including Waterlow for pressure care and the Malnutrition Universal Screening Tool (MUST) for malnutrition. Where people were identified as at high risk a corresponding a care plan was in place. Care plans contained a staff signature to show they had been reviewed monthly, but they had not always been updated with new information. For example, a person had recently choked on their meal, but their care plan had not been updated to include actions to address the risk.
- Moving and handling techniques used by staff were not always safe. We observed a member of care staff supporting a person to walk. They did not prepare the person to stand with a clear explanation of what they were doing and when the person moved they became unsteady and distressed. Guiding the person holding their hands in front of them did not provide the required level of reassurance.
- A person who used a full body sling was left sitting in the sling after their transfer. They told us they did not like the arrangement. They felt the sling which was made of a synthetic material itched their head and messed up their hair and the straps between their legs uncomfortable. They had attempted to wrap a blanket around their legs to prevent the bare skin touching the sling fabric as they felt it rubbing. The person's care plan identified them as being at risk of skin breakdown, but it did not mention the impact sitting in a sling for extended periods may have. The care plan did not refer to leaving the person sitting on the sling or address any associated risks.
- Investigations into safeguarding concerns were not thorough. A member of staff who was suspended due to a safeguarding allegation was re-instated with no clear rational or analysis of the evidence gathered.

The above demonstrates breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staffing and recruitment
● Appropriate recruitment checks were not always made on staff. Recruitment files did not contain staff employment history and checks had not always been carried out to ensure they were suitable to be employed in the care sector.
● Where checks had revealed concerns, for example, criminal convictions on a Disclosure and Barring Service Check (DBS) appropriate risk assessments had not always been carried out.

The above demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper person.

●There was no process in place to assess the number of staff required to meet people's care and support needs.
● There were not always sufficient staff on duty to meet people's needs. We observed one person who was still in bed at 10.30am because staff had not had time to support them to get up. The person told us they would have liked to get up, "If at all possible."
● On the first day of our inspection the night nurse had to stay on duty to cover the beginning of the day shift as no nurse had arrived to cover the day shift. A nurse was found from one of the provider's other services to cover the day shift.
● We observed periods of up to 45 minutes during the day when no member of staff was available in a unit as they were supporting staff in the other unit.

The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Using medicines safely
● Medicines were not always given as prescribed. One person consistently refused their lunchtime medicine prescribed for Alzheimer's disease. They had refused doses at lunchtime but had taken their medicine at other times of the day. It was not clear whether alternative strategies such as changing the time of the medicine had been considered to support the person to receive their medicine. No GP referral was recorded.
● One person repeatedly missed some morning medicines due to being asleep. It was not clear how staff supported them to receive their prescribed medicines on the days they slept through the allocated medicine administration times. Records did not demonstrate that the medicine had been given later.

The above demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.
● Medicines were stored securely.

Preventing and controlling infection
● The service did not follow appropriate infection control procedures. No infection control audits had been carried out since February 2019.
● We observed wet mops drying on top of a clean clothes storage unit, which was a risk of cross contamination.
● There was limescale build up on pipes in the sluice room and the floor in the laundry was stained with limescale. Limescale can harbour infection.
● We observed sheets and towels with brown stains. These could also harbour infection.

The above demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014, Safe care and treatment.

Learning lessons when things go wrong

- There were no systems in place to learn from accidents and incidents.
- On the first day of our inspection visit we observed five accident forms on the desk in the office. There was confusion by staff as to who should be putting these on the provider's computer system. A director of the provider said it should be the administration assistant. The administration assistant said they did not have access to the system. This meant that accidents and incidents were not being reviewed and investigated.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- Care plans identified risks to people but did not show how the risk was managed. For example, one person was assessed as at risk of dehydration. They had a fluid chart in place. However, there was no information about how this was monitored. The fluid chart showed that the person consistently failed to meet their identified target, but no actions had been recorded.
- People's preferences and choices were not always completed in their care plan. For example, the sections in one person's care plan which recorded their religious and cultural believes, how they communicated, how they preferred to sleep, and their hobbies and interests had been left blank. This meant that care and support decisions may not meet the person's needs and preferences.
- An occupation health (OT) assessment for one person recommended they were approached from their right hand side due to issue with their sight. This was not reflected in their care plan and we observed staff approaching and sitting to the left of the person throughout our inspection visits. The OT assessment also recommended, where possible staff should eat a meal alongside the person. This was not reflected in the care plan which said, 'Occasional support needed at mealtimes.'

The above demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Staff support: induction, training, skills and experience

- Staff told us that the quality of the training was poor. One member of care staff described it as, "The worst training I have ever had."
- Particular concern was expressed by staff about the quality of the moving and handling training. They told us, "I had one hour manual handling training from a care assistant who read the legislation and used the hoist once for 10 minutes." We observed poor moving and handling practice during our inspection visit which demonstrated ineffective training.
- Staff told us they did not feel supported by the management team. One member of care staff told us they had received no supervisions during their induction period.
- The provider told us staff completed an induction booklet which should be signed off by the manager. Staff told us this was not carried out in practice and the booklet was signed by other members of care staff. This meant we could not be sure staff had attained an adequate standard on completing their induction.
- The service training matrix recorded the clinical lead and interim manager had not completed the service's safeguarding, risk assessment, pressure ulcer prevention, Mental Capacity Act 2005, malnutrition, infection control and health and safety training. This meant their knowledge in these areas may not be up to

date.

The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing

Supporting people to eat and drink enough to maintain a balanced diet
● Poor recording and care co-ordination meant staff were not effectively monitoring the intake of people who were diabetic. For example, a person with type two diabetes was offered sugary snacks by two different staff within minutes of each other in the morning and again in the afternoon.
● People in the downstairs lounge were offered drinks and snacks throughout the day. However, we did not people who remained in their rooms were offered the same access to drinks and snacks.
● Where people required their fluid intake to be monitored this was not done. For one person records demonstrated they had not met their assessed fluid intake for the six days prior to our inspection. No action had been recorded in the care plan to address this.
● The weight record for one person showed they lost 6.3kgs in four months. A nurse practitioner recommended a referral to the dietician in September 2019. There was no record in the care plan that this had been made. This person was not being supported to maintain their weight.
● People made menu choices the day prior to the meal. People we spoke with who lived with dementia could not recall what they had ordered but they told us the food was tasty.

Staff working with other agencies to provide consistent, effective, timely care
● Some care plans recorded people had received support from community services including podiatry, Speech and Language Therapist (SALT) and a GP.

Adapting service, design, decoration to meet people's needs
● The design of the service met the needs of those living there.
● Specialist or adaptive equipment was not always available when required. We were made aware of an occasion where an appropriate commode was not available and delay in obtaining a suitable commode had meant the service had used a washing bowl as a pot in a commode.

Supporting people to live healthier lives, access healthcare services and support
● Recommendations by other healthcare professionals regarding people's care and support needs were not always followed. For example, one person's records stated they could eat and drink independently. A letter in the care plan from the SALT made four recommendations regarding their eating and drinking. These were not reflected in the care plan.
● Healthcare advice from other healthcare professionals was not always sought promptly. For example, one person sustained a head injury following a fall. The 111 service was contacted and advised the person should be monitored overnight, and their GP contacted. There was no record in the care records of the person being monitored. The GP attended the following day. There was no record of discussions regarding the head injury. Following a general deterioration in the person's condition the GP attended four days later and the person was admitted to hospital. There is no record of the person being monitored in the days following their head injury. The service did not recognise the deterioration may be as a consequence of the head injury.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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

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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service had not made appropriate applications under DoLS for people living in service. For example, one person who lived with dementia had their movement restricted and did not have a DoLs in place.
- The service had a poor understanding of the MCA. This was demonstrated where a relative had given consent for a person to receive care but there was not an appropriate Power of Attorney in place.
- We observed some people required the support of restrictive practice interventions, such as lap belts on their wheelchair or bed rails. Mental capacity assessments had been completed for these activities. For example, one person had a capacity assessment in place which considered the need for bed rails the assessment found they had capacity to make this decision.

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to 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

- People who remained in their rooms were at risk of social isolation, there was no system in place to monitor their welfare or provide them with any cognitive or social stimulation.
- We observed staff treating people with kindness and compassion. However, pressure on them to provide care to the next person meant their ability to do this was limited.
- Due to pressure on their time staff were unable to respond to people's needs quickly. People were not always supported to get up in the morning when they wanted to. Staff told us they had not yet had time to get one person out of bed who told us they would have preferred to get up earlier.

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

- People were not involved in decisions about their care. Care plans did not demonstrate the people had been involved in writing or reviewing them.
- The week prior to our inspection the service had changed from having three units to two units. This had made it necessary for people to move rooms. This had been carried out with no consultation with people or their relatives. One relative told us how this had caused distress to their family member.

Respecting and promoting people privacy, dignity and independence

- People's care records were kept in unlocked cupboards in communal areas. This meant people who were not authorised could access them.
- Staff routines and preferences took priority over consistent care and people's preferences. For example, when the nurse left a unit to go for a meeting the two remaining care staff sat in the lounge with one person for 45 minutes. Four people who remained in their rooms were not checked in that time.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated 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

- Care plans did not demonstrate people or their relatives had been involved in their care planning and review.
- Care plans did not reflect people's social and emotional needs which meant those with higher needs spent the majority of their day disengaged with their surroundings. Whilst visits from the local Chaplain and a primary school had been organised, our observations during our visits demonstrated people were not engaged or orientated with their surroundings on a day to day basis.
- Care plans were not updated to reflect people's changing needs. For example, an incident form for one person recorded a choking incident. At our inspection 10 days after the incident their care plan had not been updated to include increased observation whilst eating.
- Staff told us care plans did not clearly reflect people's needs and they got little time to read them.

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.

- Care plans contained little information about people's individual communication needs so it was unclear how staff would communicate with people effectively. For example, one person's care plan recorded they were registered blind. Their care plan stated, 'I'm registered blind but I'm not, however, I have no awareness of space." The care plan named the type of dementia they lived with but did not give staff a full picture of how this affected the person and their communication needs.
- One person living in the service used a word board to support their communication.

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

- Where people's individual needs had been identified these were not always followed up. For example, one person's care plan highlighted their need for activities in the day to support their mental wellbeing, but no activities were recorded in their daily log.
- People who remained in their rooms were at risk of social isolation. One person who remained in their room said, "There's no point in getting up. I don't bother to go out of my room, why would I?" There was no system in place to monitor the welfare people who chose to remain in their room or provide them with any cognitive or social stimulation.

● The activities co-ordinator had recently left the service. We were told by the interim manager staff should be engaging people in activities. However, extra staff were not deployed on duty to ensure there was enough time for staff to spend with people. Staff told us they would do activities with people if they had time, but it was clear they did not feel this was an integral part of their role neither had they received any training in delivering activities which were meaningful.
●There was no interim plan to support people's mental and social wellbeing until a new activities co-ordinator was in place. In discussion neither the interim manager nor the nurse were able to identify how the home's practices contribute to people's growing apathy and boredom. When people felt there was no point in getting out of bed this was simply seen as a choice rather than a reaction to an environment which was not able to meet their needs.
● The consultant managing the service on the day of our inspection visit suggested at the morning meeting staff carried out some activities with people. We observed care staff offer to knit with people. However, this was unsuccessful as the carers could not knit. No other activities were observed during our inspection.
● We observed one person sat in their wheelchair in the lobby for over an hour just staring at the front door, no one asked them if they would like to do something else. Another person wanted to go for a walk, they told everyone who went near them, but no one responded by taking them out into the garden or wider community.
● Consideration had not been given to how people living with dementia could be meaningfully engaged to reduce their distress and the potential for behaviours staff found challenging. A relative told us they had been asking the service to put on more activities for their family member for the past two years with no progress being made.

The above demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Improving care quality in response to complaints or concerns
● The service complaints policy was available in the reception area. However, when we observed a person's relative come to the reception to make a complaint the appropriate form could not be found.
● A relative told us they had been making suggestions for improvements to the service for the past two years, but nothing had been done.
● The service had a system to input complaints on a computer system for monitoring purposes. Since the registered manager had left it was not clear who was responsible managing this system to ensure complaints were managed appropriately.

End of life care and support
● The service was not supporting anybody with end of life care during our inspection visits.
● Care plans did not always include people's end of life care decisions.

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to 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.

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

- Relatives told us they did not feel involved in the running of the service. They had raised concerns but did not feel listened to and told us no action had been taken in response to their concerns.
- Staff told us they did not feel the service was well-led and had little confidence in the management team. One staff member said, "I just turn up on the day." Another said, "I don't really know what's going on. There is no strategic oversight or leadership for individual shifts or the home as a whole." Another member of staff said they carried out their duties, "With little purpose."
- Staff told us they did not feel listened to by the management team. They said they had raised concerns regarding training with the manager and had, "Not got a positive response."
- The management team did not promote a person centred approach to care. For example, one person spent their time either in the lobby or in a downstairs lounge. We observed a director of the provider required them to leave the lounge and go to another part of the building as they wished to use the lounge for training. This was despite there being two empty units in the service which could have been used for training.
- Reporting of incidents in the service was inconsistent and unreliable. We were told of an incident where a person had exhibited behaviour which may be seen as challenging, and this was recorded. However, a relative told us of another incident with the same person but we could find no record of this.
- Where incidents had been recorded delays in recording and multiple records meant the records were unclear. For example, where a person had had a fall it was recorded in their fall's diary at 11am. A further record was made in the accident log, but no time was recorded. A third entry was made in the mobility care plan at 3.40pm. It was not clear if this was the same incident or two falls, as the recorded times suggested. There was no record of the fall in the daily log and no mention of how the person would be observed or supervised following a potential head injury.

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

- Relatives were not always informed of incidents in accordance with the duty of candour. One relative gave us an example of not being told about a fall and another instance where they found their relative with a bruised eye. They told us they had approached the manager about this but had been told they would not be informed unless an ambulance was called.

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

● There had been no registered manager in post since April 2019. The provider had been unsuccessful at recruiting to the role.

● The service was first inspected in July 2018 when it was rated as Inadequate with breaches of legislation. It was inspected again in November 2018 and rated as Requires Improvement. At this inspection we found the improvement had not been sustained. Some failings from July 2018 were being repeated. The provider had failed to bring about sufficient and sustained improvement to ensure people received good care that consistently meet their needs.

● There was no clear audit system, tools or procedures in place in either this service or by the provider. The interim manager said this was being worked on but there was no audit tool available for review on the day of our inspection. There had been no infection control audits since February 2019, and no pressure ulcer audit since March 2019.

● The provider's quality assurance systems had failed to identify audits were not taking place. Failing to carry out effective quality assurance measures contributed to the failings identified in this report.

● Staff were unclear about their roles. Some staff told us they did not have a job description.

Continuous learning and improving care

● There was ineffective monitoring of the performance of the service.

● The provider did not have a process in place which identified audits had not taken place. Without effective identification and monitoring of incidents the service was not able to identify and learn from mistakes.

Working in partnership with others

● We had concerns raised with us by the local authority about the providers ability to work with them to bring about improvements in the service.

All of the above demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred. Advice from health care professionals was not always followed. People were at risk of social isolation.

The enforcement action we took:

Vary a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred. Advice from health care professionals was not always followed. People were at risk of social isolation.

The enforcement action we took:

Impose a condition on the providers registration.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people from receiving care and support were not safely managed. Records were not stored securely.

The enforcement action we took:

Varied a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people from receiving care and support were not safely managed. Records were not stored securely.

The enforcement action we took:

Imposed a condition on the providers registration.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of clear governance and established procedures to ensure the quality of the care provided.

The enforcement action we took:

Vary a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of clear governance and established procedures to ensure the quality of the care provided.

The enforcement action we took:

Varied a condition on the providers registration.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate recruitment checks were not carried out.

The enforcement action we took:

Varied a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate recruitment checks were not carried out.

The enforcement action we took:

Imposed a condition on providers registration.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs. Staff were not recruited safely. Appropriate infection control procedures were not followed. Staff did not receive appropriate training and

support.

The enforcement action we took:

Varied a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs. Staff were not recruited safely. Appropriate infection control procedures were not followed. Staff did not receive appropriate training and support.

The enforcement action we took:

Imposed a condition on the provider registration.