Conquest Care Homes (Norfolk) Limited

The Oaks & Woodcroft

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
The Oaks & Woodcroft are two residential bungalows registered as one location and provide personal care for up to 12 people with a learning disability, mental health need, physical disability and/or autistic people. The service had 6 people living at The Oaks and 6 people living at Woodcroft at the time of our inspection.

People's experience of using this service and what we found.
Right Support: Some facilities were shared which did not maximize people's choices and independence. For example, both bungalows had their own kitchen but the fridge in Woodcroft was almost empty, and inspectors were told staff could take food from The Oaks fridge which did not enhance choice for people, as they were reliant on staff to anticipate their needs and needed support to access the kitchens. We observed people and staff walking through each other's bungalows without using the front door and waiting to be invited in. At least 1 person living at Woodcroft was using the bathroom at the other bungalow. This should be considered in terms of the rights and privacy of everyone using the service. One bungalow was for men and the other for women and there had been sexual safety concerns in the past which needed careful consideration.

Staff did not support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's access to parts of their home were restricted and we found other restrictive practice and limited choices for people around their daily routines and activities.

Some key aspects of people's lives had not been reviewed for a long time, for example: control and support people needed to manage their finances and medicines and support with day-to-day tasks which would maximize people's independence. People were supported to discuss their wishes and have goals and objectives in place to show how they would like to spend their time and what they would like to do. For example, go on holiday.

Right Care: Staffing was not consistently safe to ensure people's needs were met. A high number of incidents had resulted in more staff being employed across the day shift. We had concerns about shift patterns as there was a reduction of staff from 7pm which could impact on people's choices of activities and routines.

Staff needed additional training to help ensure they understood how to support people safely and in the least restrictive way. People's records required improvement to help guide staff as to the actions they should

take to reduce incidents and know how and what to record. Staff showed a limited understanding of the function of behaviour, possible triggers, and consequences.

Right Culture: We found cultural changes were necessary to ensure people had their rights upheld and people were treated with dignity and respect. We found some of the terminology used in people's records, such as 'challenging behaviour' was not person centred and staff did not address people in a dignified or person-centred way.

Audits and surveys were used to identify areas for service improvement and development, but these were not yet fully effective as we identified areas of concern which could compromise people's care and treatment. Staff worked in conjunction with other professionals and families to ensure the care was as holistic as possible, but health care professionals and family members stated the service could be slow to act on their concerns.

Several incidents had not been reported to CQC to ensure we could assess if appropriate actions had been taken. During our inspection we found information governance was poor but accepted that the provider was migrating records from paper to electronic systems which should improve accessibility. However, we found information was not always up to date, accessible or known by all staff. This could compromise people's care.

The registered manager, the regional manager and the senior team were working hard to improve the culture of the service and ensure staff through training, supervision and induction had the right skills and attitude.

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

Rating at last inspection and update –
The last rating for this service was Requires improvement (published 22 December 2020.)

Why we inspected.
We undertook this focused inspection to follow up on concerns raised by the Local Authority and in response to a recent coroner's inquest which required the provider to take certain actions.

The provider submitted us their report. We initially looked at Safe and Well-led but opened the inspection up to look at Effective as well due to some concerns about the performance of the local medical practice and the potential impact this might have on people using the service. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains Requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and recommendations.
We have identified breaches of regulation 11 consent, regulation 12 safe care and treatment, regulation 17, good governance regulation 18 staffing.

For more serious breaches of regulation 12 Safe care and treatment and regulation 17 we have served Warning notices.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

The Oaks & Woodcroft

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
The Oaks & Woodcroft is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Oaks & Woodcroft is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the 13 June 2023 and announced on the 2nd visit 19 June 2023.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We spoke with the local authority and reviewed information about the service including enquiries and share your experiences. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people using the service but used observation as our main frame of reference. We had discussions with 3 care staff plus the team leader, the deputy manager, the registered manager, and the regional manager.

We reviewed 3 people's care records, risk assessments and medication record and continued to request specific documentation. We looked at the environment and reviewed 2 staff recruitment records, training records and other records relating to the management and safety of the service.

We completed a second half day inspection and observed activities taking place. We continued to review information and received feedback following the inspection from 6 health care professionals and 4 relatives.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Risks were not effectively documented or managed. Changes in people's needs were not always well communicated and records were not clear as to how staff should respond to people's changing needs. For example, 1 person's care plan stated they had lost weight recently and we observed their clothes were ill fitting. There was a staff recommendation in the care plan that the GP should be notified but there was no evidence in the care plan that this had been followed up or their diet altered.
- Written guidance for staff about how to support people when they were anxious was not clear and this exposed people and staff to potential harm. The provider had not engaged with other professionals in a timely way and staff were not sufficiently trained to support people in a positive way to reduce the likelihood of incidents occurring.
- Health care professionals told us the service did not always share information adequately or inform them of people's changing needs and risks to enable them to respond appropriately. Equally the provider raised frustration about the timeliness of health care professionals responding to their referrals.
- There had been 74 incidents in the last 6 months and the analysis looked at where and why these incidents had occurred but did not tell us how staff were supported to reduce the number of incidents by de-escalation.
- A health care professional told us that staff referred to daily incidents with one person which were not clearly documented. For example, one month 13 incidents were recorded and the previous month no incidents were recorded. We carried out a records audit and found conflicting information and spoke with staff who were not all aware of people's needs. We were therefore not confident that people's needs were clearly known, and risks managed.
- Incidents where people had become agitated around mealtimes put people at risk and these risks had not been sufficiently assessed and explored. For example, 1 person grabbed at other people's food and was at risk of choking. A high number of incidents were recorded to have taken place in the dining room and it was unclear what strategies were in place to reduce the level of incidents.
- People were not fully supported to maintain a healthy diet, in line with their needs. Risks associated with choking were not consistently managed placing people at risk of avoidable harm. Lessons from a recent coroner's court had not been firmly embedded although improvements were noted.
- Repeated incidents did not assure us adequate processes were in place to ensure lessons were learnt and clear steps were taken to reduce the likelihood of further risk.

Our findings meant the provider had failed to prevent persons receiving unsafe care and treatment and to prevent unavoidable harm or risk of harm. This was a breach of regulation 12, (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●Processes were in place to reduce the risk of cross infection. However, we were not assured that audits were always effective at identifying shortfalls in the levels of cleanliness. On the day of the inspection, we found areas of the service to be dirty, including the kitchen in Woodcroft: the fly screen, work surfaces and flooring needed replacing as did the fridge / freezer. There was also an unpleasant odour in the kitchen at Woodcroft which at the time of our inspection had not been investigated and could impact on people's health and safety.

● A family member had concerns that during their regular visits there were not always toilet rolls, or soap in the toilets for people and staff to wash their hands. They also suggested incidents of continence were not well managed. During our observations we did not observe staff encouraging people to wash their hands before a meal. Poor hand hygiene can spread infection.

Our findings meant the provider had failed to adequately prevent and control the spread of infection. This was a breach of regulation 12, (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

● The service followed current government guidance relating to visitors.

● People told us their relatives visited them.

Using medicines safely:

●Medicines were not always managed safely. We found several creams out of date. We noted a medication error which had not been identified by the provider and 1 medicine had been out of stock for 4 days.

●Medicines were reviewed by the GP and other specialists, but we found some people were taking a lot of medicines with no clear evidence that the provider was following the principles of (STOMP) Stopping over medication of people with a learning disability, or autism or both. For example, we saw 1 person's medicines were reviewed and increased due to changes in their behaviour before any clear analysis was completed as to the possible causes of their raised anxieties.

● The provider had protocols in place for medicines that were prescribed to be given as required but we found 1 protocol that had not been completed and had no guidance for staff as when to administer this medicine and another which stated review monthly but no evidence it had been reviewed since the date of implementation in the last year.

●One person was receiving medicines covertly and a best interest decision was in place, but we were unable to see how the staff had supported the person to understand why they were taking medicines and the possible benefits and adverse effects of not taking it as prescribed. The GP had advised staff that they should take medicines in tea, without specifying which medicines. The risk of taking medicines in tea had not been adequately explored. For example, if they did not finish their tea, if someone else took their tea and crushing tablets and putting them in liquid could change the effectiveness of the tablet.

Our findings meant we were not assured that the provider was managing medicines safely. This was a breach of regulation 12, (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were enough trained staff who had received medicines training and had their competencies checked. Medicines were kept in people's rooms and were mostly administered in line with the prescriber's instructions.

Health and safety checks were being completed and arrangements for fire safety were in place.

●Improvements had been made to documentation in response to people's dietary needs and associated

risks, we also found staff were recording what people were eating and drinking and this was monitored to ensure people did not suffer from dehydration.

Systems and processes to safeguard people from the risk of abuse

●The provider did not have robust systems and processes in place to protect people from the risk of abuse. Staff received training to help safeguard people, however, they were not supported adequately to implement good practice to care for people when they became distressed and in the least restrictive way possible.

●We were not assured that people were protected from the risk of poor care, abuse or neglect as not all incidents were documented and reported appropriately, and there were not always lessons learnt. For example, information was received from health care professionals about their concerns, but this was not always available at the service to show how the provider had acted on the concerns to improve people's care and prevent neglect.

●Where risks arose when some people expressed agitation or aggression, staff were not adequately trained to support those people and others from the risk of neglect, harassment and abuse.

Our findings meant we were not assured that the provider was adequately safeguarding people. This was a breach of regulation 13, (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●Enough staff were employed to meet people's needs. Staffing at the service had recently improved after agreed additional funding was awarded. Some people had 1-1 core hours; others had shared support with some people attending set activities during the day.

● We reviewed several people's records which showed them going to bed before 8pm each night and very little variety in their evening routine. Reduced staffing after 7 pm meant there were no regular evening activities, and we could not see how people's choices were promoted around their preferences.

●Staffing vacancies were being actively recruited to and although there were a lot of newer staff there were some existing staff who knew people's needs well.

● Recruitment checks were in place and satisfactory for both permanent and agency staff. Staff records demonstrated staff had received the appropriate training, had the right to work in the UK and had a completed check from the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●Records did not clearly demonstrate how decisions had been made in people's best interest and in the least restrictive way. Kitchens were locked and one kitchen could be accessed by a key, the other by a keypad which not everyone could use meaning some people could only access the kitchen with staff support. One person was not able to access the kitchen due to risks to their safety. Other options had not been considered which might be less restrictive for them. A best interest decision was not in place at the time of the inspection for the person who had no access to the kitchen.
●Two people had moved bedrooms. A decision taken by staff to help them carry out more observations without disturbing others. Staff told us one person had verbally agreed to this, the other was supported through a best interest decision. However, the person who verbally agreed had been considered by staff as not having mental capacity in other key areas of their life, so it was not clear how staff supported them to make a decision and if they understood the impact of the move.
● One person had a limit on the number of cigarettes they could smoke as agreed in their best interest's assessment. However, it was not clear how the person was supported to make decisions and understand the health risks associated with smoking or what alternatives such as patches could be considered.
●Incident management did not always show how staff acted in people's best interest and promoted their choices in a positive way which could reduce incidents occurring across the service. .

Our findings meant the provider had failed to always act in people's best interest and act lawfully. This evidence supports a breach of Regulation 11(need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills, and experience

●Staff did not have the necessary skills to meet people's needs particularly around managing people's anxiety and being able to use clear positive strategies to reduce the level of incidents which could place staff and people using the service at harm of injury.

Our findings meant the provider had failed to ensure staff were adequately trained to meet people's needs safely. This evidence supports a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The lack of staff training was being addressed by the service. We viewed the training matrix which showed most training was up to date, although a few training courses showed a low uptake by staff. The registered manager told us overdue training was booked.

●Staff told us they felt well supported and could raise issues as required. Induction was provided and appropriate to staff's previous experience. Staff new to care would complete the care certificate which is a nationally recognised induction course covering all the fundamental standards required for care staff.

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

● People's information did not provide clear guidance to staff on how to meet people's needs, safely, lawfully and in a person-centred way. This meant we were not assured staff understood people's needs or what actions they should take to support them in a positive way and reduce the likelihood of incidents occurring. Clear strategies were not in place to inform staff how they should react in different situations.

●People's health conditions were documented but not regularly reviewed to show changes in health or actions taken. The regional manager explained all information was being uploaded onto a new electronic system. This would help ensure all information was in one place and easily accessible. However, information was not fully accessible to all staff on the day of our inspection.

●Person centred care and support was not evident from the documentation we reviewed. People's choices of daily living were restricted from the daily notes we reviewed which showed limited activity taking place in the community. A family member raised frustration of the limited amount of activity and a person we spoke with confirmed they had not done any of the activities their care plan said they enjoyed. This was verified by looking at their daily notes and speaking with staff. This was not in line with right care, right support, right culture.

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

●People's choices about what they would like to eat, and drink were recorded in their care plans, but staff did not support people consistently to make choices about what they would like to eat and drink or consider ways in which people communicated their choices. People had limited options. For example, all but 1 person had crisps and a sandwich at Woodcroft, and this was the case for most lunch times. Staff told us that people chose their meals, but we did not see this in practice and were not assured that this was in line with their dietary needs.

●One person's record showed they liked a variety of drinks, but we only observed them drinking tea. We also noted staff were not supporting people to have drinks, including water on the day of inspection which was a hot day. Hot weather guidance was in place but the fridge/freezer in one bungalow did not contain any cold drinks or ice creams.

The fridge in Woodcroft only contained yogurts and sausages and the freezer was empty. A food order was placed later that day and people could go to local shops, but the lack of food meant that people's choices to meals were restricted.

●Tables were not appropriately set, so people could enjoy pleasant surroundings to have their meals in and to enhance people's dining experience.

Adapting service, design, decoration to meet people's needs.

●People's rooms were appropriately decorated and suitable to meet their needs and some recent refurbishment had taken place. We found however the kitchen in Woodcroft needed urgent refurbishment and this was being planned. There was a malodour in the kitchen and staff could not determine where it originated from.

●There was suitable equipment in the home to help meet people's needs. An adaptive bath was available for people with a physical disability and those needed support with bathing and people could choose to have a bath or a shower. One bungalow had less equipment than the other to promote people's independence and this was being addressed by the service. A sensory room was being utilised by people during the inspection.

●People also had access to external gardens which were being improved with the addition of raised flower beds.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care.

● Changes in people's health had not been adequately addressed to promote their wellbeing.

●The registered manager had made a few health care referrals to the learning disability team but had not provided them with an update when people's needs had changed. This would have helped ensure that health care professionals could respond more urgently as necessary.

●People's records were not always updated in a timely way to ensure staff had relevant information and were able to meet people's needs in a consistent way. This increased the risks of people receiving unsafe care.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The service was not effectively managed which meant poor outcomes for people using the service. Improvements were being made but were not firmly embedded. Since the last inspection a new registered manager and regional manager had worked hard to improve the quality of the service provided. We found however that people were not yet living a full and varied life which promoted their wellbeing and was the least restrictive.
- The provider's checks and audits had not identified that activities for people were lacking. This meant people were experiencing poor outcomes to their quality of life.
- We were not assured that people were fully protected from risks associated with day-to-day activities as records were not regularly updated, staff were not trained in certain aspects of peoples care and support and relationships with other health care professionals were fragmented. A high number of incidents would not help people to feel safe.
- We were not assured the provider and registered manager fully recognised their legal responsibilities and accountability as a registered provider. Notifications were not being submitted in a timely way.
- The provider had not always ensured their staff received the training they required to fulfil their role appropriately. The local authority told us they provided free positive behavioural support training which could be made available to support staff but there had been no uptake of this training by the provider. This meant people were being cared for by staff who might not have been appropriately skilled and trained.
- The provider had internal resources it could draw upon to support staff in managing potentially difficult situations and reduce the number of incidents. The regional manager said they had sought advice, but the behavioural management plans had not been updated accordingly to show there had been professional input in meeting people's needs.
- information governance was poor, so we were not assured of the quality and accuracy of the data we reviewed. This was also the view of other health care professionals we spoke with and a family member who expressed concern that unexplained bruising had not been logged appropriately. This was confirmed by the local authority.

Our findings meant the provider had failed to provide a well-planned, safe service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good

outcomes for people.
●Improvements across the service were noted in some areas but further work was necessary to ensure a positive culture was firmly embedded. During our 2 days we noted staff were polite and felt happy with the current management support. We did however note some negative practices. For example, people were not all given the opportunity to partake in daily living skills like shopping and meal preparation, across both services. Sometimes staff spoke with people using inappropriate language and staff discussed people not fully ensuring people's privacy.
●People's social opportunities were limited in the evening as staff numbers reduced and it was not clear from people's records how they would like to spend their time. Choices offered were limited. We noted from multiple records that people spent a lot of time watching television and could not see if this was in line with people's preferences. This could contribute to people's sense of frustration and boredom.
●Routines were inflexible, and people's records did not provide clear justification as to why restrictions were in place or in people's best interest. For example, denying access to the kitchen based on risk when 1-1 staffing support was available to support individuals. Measures in place to keep one person safe meant that others also experienced unnecessary restrictions.

Our findings meant the provider had failed to provide and promote a positive person-centred culture. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Continuous learning and improving care
●We were not assured that robust information systems were in place or working effectively. We were mindful that records were being converted to electronic systems, but we were not provided with robust information which was up to date and current in respect of people's needs.
●Information was in accessible formats but not used consistently by staff to help people make informed choices about their care. Choice was not fully promoted in a way which was accessible to everyone using the service.
●The service had identified improvements and were working hard to improve the service, but this was a service that has been unable to sustain a good rating over 7 years, being rated good only once in this time. This impacts on the outcome of care people receive.

Working in partnership with others
● Staff told us they worked collaboratively with health and social care professionals. However, we spoke with health care professionals and identified examples of where referrals were delayed due to referrals being posted and not received. or the service had not updated professionals regarding changes in people's needs.

●Staff supported people to stay in contact with family and arranged visits and supported with transport to and from parents' homes.
●The service manager and regional manager spoke positively about the culture of the service and had started to make improvements. They stated the organisation supported and listened to its staff and wider stakeholders. Surveys had been used to identify improvements and people had the opportunity to give feedback where they were able to and to work towards clearly set objectives.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The service were unable to demonstrate how they always acted in people's best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was unable to demonstrate how they fully protected people from the risk of abuse due to the high number of incidents and lack of staff training in understanding why these incidents were occurring and how to reduce them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was unable to adequately demonstrate how staff have the skills and necessary competencies to meet peoples needs safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not assess, review and mitigate risks effectively which exposed people to potential avoidable harm. Concerns were identified about medicines and infection control.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not yet effectively management and information systems and governance required improvement.

The enforcement action we took:

warning notice