Roseberry Care Centres (England) Ltd

The Beaufort Care Home

Inspection report

56 Kenilworth Road
Coventry
West Midlands
CV4 7AH

Tel: 02476419593

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Beaufort Care Home is registered to provide personal and nursing care for up to 29 people aged 65 and over. Nursing care is provided. At the time of the inspection 21 people lived at the home.

People's experience of using this service and what we found
The quality and safety of the service had deteriorated since our last inspection and some previously demonstrated standards had not been maintained. The provider's systems and processes designed to identify shortfalls, and drive improvement remained ineffective. The lack of provider and management level oversight of the service meant action had not been taken to address the breaches of the regulations we had identified in January 2022. Opportunities to learn lessons had been missed. Relatives felt some improvements had been made since the manager had worked at the home but further improvement was needed to ensure people always received good quality, compassionate, individualised and safe care as a minimum standard.

People did not consistently receive good quality safe care. The limited availability of staff negatively impacted on people's safety and experiences. Risks associated with people's care were not always assessed and well managed. Medicines and staff recruitment were not consistently managed safely in line with the providers procedures and best practice guidance. Improvements required in relation to the prevention and control of infection had not been made.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People felt safe. Permanent staff knew the people they supported, and people spoke highly of them. However, people did not always receive personalised care that met their needs. Some care records lacked the information staff needed to provide care safely. In addition, other care records had not been completed, contained gaps or inaccurate information. People continued to have limited opportunities to follow their interests and do things they enjoyed. Complaints were managed in line with the provider's policy and procedure. Staff had been trained to support people at the end stage of their lives.
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 11 March 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected

We received concerns in relation to staffing levels at the home and people's care and support needs not being met. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to the way people's care was provided, safety, staffing and governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive section below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Beaufort Care 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.

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 and a specialist advisor. Our specialist advisor was a registered nurse who had expertise in supporting older people and people living with dementia.

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

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

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since our last inspection and sought feedback from the local authority who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with 6 people who lived at The Beaufort and 4 people's relatives to find out what it was like to live at the home and to gather their experience of the care provided. We spoke with 10 members of staff including the regional operations manager, the manager, the clinical lead, nurses, care staff, and a member of housekeeping staff. We carried out general observations of the care and support provided in communal areas.

We looked at 3 staff recruitment files, staff training records and records associated with the provider's quality monitoring systems.

We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and a variety of records relating to the management of the service.

After the inspection
We shared our inspection findings with the local authority and the Integrated Care Board. ICS's replaced Clinical commissioning groups in the NHS in England from July 2022.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection we found people were at risk because the provider had not consistently followed national guidance in relation to infection control. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Previously, we were not assured the provider was using PPE effectively and safely. During this visit those concerns remained. Throughout our visit on numerous occasions we observed staff wore their face masks below their noses. This demonstrated lessons had not been learnt. Also, used masks and gloves were not disposed of safely to mitigate the risk of cross infection. This was unsafe practice.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst the home was observed to be clean during the inspection, some paintwork in communal areas such as on handrails had worn away. That made those areas difficult to clean. Laundry processes did not always follow national guidance. For example, linen was observed in 3 open weave baskets on the floor in the laundry. This practice created an infection prevention and control risk.
- We were somewhat assured that the provider's infection prevention and control policy was up to date. The providers policy reflected current guidance to support staff to follow safe infection control practice. However, the provider had not ensured staff always worked in line with their expectations.
- We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Whilst staff had completed IPC training, they did not consistently put their training into practice to keep people safe.

We found no evidence that people had been harmed however they were at risk because the provider did not consistently follow national guidance in relation to infection control. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes
● The provider facilitated visits in line with guidance. Relatives confirmed they were able to visit their family members when they chose.

Staffing and recruitment
● Information we received prior to our inspection indicated low staffing levels were impacting negatively on people's safety and experiences. Our inspection findings confirmed that was correct.
● One person told us, "To be honest the main problem is not enough staff. They can't come when you need them. It's not their fault, they are dealing with someone else."
● Relatives agreed. One relative told us, "Full time (permanent) staff are good but there is not enough of them…it's worse at the weekends. Yesterday, I only saw two staff on duty…" A review of the staff rota confirmed staffing levels the day before our visit were lower than the provider had assessed were needed. This was unsafe. Another relative commented, "[Name] is left waiting. The staff are so busy. It takes a long time for them to be free to help."
● Staff provided examples of how low staffing levels and the high use of agency staff negatively impacted on people. Comments included, "Their (people's) basic needs are met but that not a good quality of life," "The agency staff are not very good and need constant supervision…residents are often very wet in the mornings when agency carers are on duty," and "Residents don't get the attention they should get. [Name] gets bored and says, 'come and sit with me'. We don't have time and have to say we are sorry."
● The manager confirmed staffing requirements were determined by the provider's 'dependency tool'. They told us, "I am looking further into this as I think some resident's dependencies are high but come out as medium."
● Aspects of staff recruitment were not safe. For example, checks to ensure some agency staff working at the home were suitable had not taken place and 1 staff member's application form contained gaps in their employment history. Those gaps had not been explored in line with the providers policy.
● Audits of recruitment files were not robust. Two audits had confirmed interviews for two staff had been conducted in line with the providers expectations That was incorrect.

We found no evidence that people had been harmed however, the provider had failed to ensure staff were of suitable character and available in sufficient numbers to meet people's needs This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The regional operations manager told us they had no concerns about current staffing levels. They said, "We don't just consider the dependency tool. We look at audits and new admissions needs. If [Manager] tells me staffing needs to increase we (provider) would consider that. We recently increased morning levels."
● The management team were open and honest about the recruitment challenges the service faced. They told us a successful recruitment campaign had reduced reliance on agency nurses and agency carers were being block booked to provide some consistency for people.

Assessing risk, safety monitoring and management
● Previously demonstrated standards of individual risk management had not been maintained. This placed people at risk of receiving unsafe care. For example, records showed 1 person was prone to urinary tract infections (UTI's). This risk had not been assessed to help staff provide safe care.
● Risks to people's safety were not always well managed because staff had not followed instructions within people's care records. For example, staff had failed to ensure 1 person wore suitable footwear when they walked around the home with their walking frame. This was unsafe and placed the person at significant risk of falling. When we alerted the manager to this, they told us, "[Name] has no shoes that fit we are going to

buy some slipper socks with tread on the bottoms, we haven't got them yet." In addition, this risk was increased because the rubber ferrules on the person's walking frame had worn away and needed replacing. Ferrules are fitted to walking frames to prevent them from slipping. Responsive action was taken to address this.

● Another person was prescribed a cream to be applied to their face to prevent their skin becoming sore. However, 2 staff members told us they applied the cream to the person's bottom. This was unsafe.

● A 3rd person had a wound and needed their wound dressings changed every 3 days by nurses to promote healing. Records did not confirm this had happened. In addition, a nurse explained there were 'early warning signs' of an infection in the wound. However, limited action to determine this had been taken. The person's relative described communication with nurses about this issue as 'not good'.

● Some people received their nutrition and medicine through a tube directly into their stomach (PEG). Records to confirm the required daily actions had been taken to prevent infection contained gaps. This meant the provider could not be sure people's feeding tubes had been managed in line with nationally recognised guidance issued by National Institute for Health and Clinical Excellence (NICE). NICE develop public health guidance to promote healthier lifestyles and help prevent ill health.

Systems and processes were not sufficient to demonstrate risk was identified, assessed and well-managed. This exposed people to the risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers system for recording and analysing accidents and incidents reduced reoccurrence.

● During and following our inspection visit some action was taken and further action was planned to improve safety. This included risk assessments and care plans being written and shared with staff.

● Despite our findings people felt safe living at The Beaufort. One person told us they felt safe because the front door was locked which meant 'strangers' could not get into their home.

● Relatives had no concerns about their family members safety. One relative commented, "I am in no doubt [Person] is safe."

Using medicines safely; Learning lessons when things go wrong

● The management of medicines was unsafe and standards of medicines safety had deteriorated further since our last inspection.

● One person was prescribed insulin to manage their diabetes. The insulin in use did not have the date of opening recorded which is important to ensure insulin remains effective. When we highlighted this immediate action was taken to ensure the person received their insulin safely.

● Another person with diabetes was prescribed a varying dose of insulin to ensure their blood glucose levels remained within a safe range. Nurses caring for them had failed to complete checks of their blood sugar levels to determine the amount of insulin they needed to administer to manage their condition. This placed the person at significant risk of harm.

● A third person was prescribed medicine to manage their pain via a patch applied directly to their skin. Records did not confirm daily checks of the patch had been completed as required. The checks are important as patches can fall off or accidentally be removed by the person.

● The provider could not demonstrate people had always received their medicines, including those prescribed to manage, high blood pressure and heart failure when they needed them. Three people's Medicine Administration Records (MAR) contained missing signatures and 4 people's MAR's showed their prescribed medicine had not always been available.

● The management of prescribed creams had not improved. Some prescribed creams and lotions continued to be in use without having their date of opening recorded. This is important to ensure creams in use remain effective. In addition, records did not show creams had been applied as prescribed. One person

was prescribed a cream to be applied to their skin each time staff provided assistance with continence care. Records had not been completed to show the cream had been applied on multiple occasions since September 2022. This demonstrated lessons had not been learned and opportunities to improve medicines management safety had been missed.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate people's medicines were managed and administered safely. This placed people at 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.

● Following our visit some action was taken to improve medicines safety. This included replacing the creams which did not have the dates of opening recorded and implementing further checks of medicine records.
● People told us they received their medicines when they needed them. One person told us, "I get my tablets when I need them. Nurses are good with the tablets. They give me a drink and ask me if I have taken them."

Systems and processes to safeguard people from the risk of abuse
● Staff received training in safeguarding adults and understood their responsibilities to report any related concerns. Staff were confident the manager would take appropriate action to protect people from harm and discrimination.
● Systems and processes were in place to protect people from the risk of harm. The manager had reported safeguarding concerns to the local authority and to us (CQC) as required by the regulations.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Requires Improvement

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 remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure the care and treatment people received was personalised to their preferences and needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People continued not to receive personalised care and support. Low staffing levels detailed within the safe domain of this report meant staff were not available or did not have enough time to provide the individualised care and support people needed.
● Feedback from relatives confirmed this. One relative explained their family member had lived at the home since October 2022 and cleanliness and personal appearance was important to them. The relative commented. "[Name] has had one shower, they could do with another."
● Poor practice was accepted. Personal hygiene records showed people's preferences had not been met. Six of the 8 records we reviewed indicated people had not been offered or assisted to have a bath or shower for over 6 weeks. A staff member told us, "It's hard. If we get time, we do baths and showers but only if we have time."
● Some daily records completed by staff contained inaccurate information. One person's records showed they had been assisted with nail care. This conflicted with our observations. Another person's records showed they had been assisted by staff to clean their teeth during the morning of our inspection visit. We saw the person's toothbrush was dry and their toothpaste tube had a dry crust across the opening. The manager assured us they would speak to night staff about this.
● The action taken at our last inspection to ensure people's care records provided staff with the information they needed to provide individualised, safe care had not been maintained. For example, a care plan to inform staff how to support a person to manage their urinary catheter was not in place. Another person's care plan incorrectly documented the person had a urinary tract infection (UTI).
● Some people's care plans contained conflicting and confusing information. For example, 1 section of a person's care plan informed staff the person did not have any teeth and they had refused dentures this conflicted with their oral care plan which informed staff they required assistance to brush their own teeth.
● During our previous inspections in March 2021 and January 2022 people told us they had very limited opportunities to do things they enjoyed and were of interest to them. At this visit whilst some action had been taken, improvement in this area had been too slow. One person told us, "Really, all I get to do is read

my paper." A relative commented, "There is not a lot of stimulation. It must be a very boring life."

The provider had failed to ensure people received person-centred care that met their needs. This was a continued breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, conversations with permanent staff members demonstrated they knew people well.

Improving care quality in response to complaints or concerns
● People and their relatives knew how to make a complaint and felt able to do so. One relative told us, "[Manager] is extremely approachable. I know if I had a complaint it would be dealt with very swiftly."
● Records showed complaints had been managed in line with the provider's procedure.
● The provider's complaints procedure was displayed in the home's reception.

End of life care and support
● Some people living at the home were in the end stage of their lives. End of life care plans contained some information about people's wishes.
● Staff had received training and felt confident to care for people at the end of their lives.

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.
● The manager was familiar with the requirements of the AIS and their responsibilities in relation to this.
● Some information about the service was available in a variety of formats including pictorial and large print.

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 our inspections in March 2021 and January 2022 we rated this key question required improvement. At this inspection the rating has changed 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.

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

At our last inspection the provider's lack of oversight and ineffective quality monitoring systems placed people at risk. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- The provider had failed to ensure action had been taken to address the regulatory breaches and concerns we identified at the last inspection to ensure people received high quality, safe care. This exposed people to unnecessary risk.
- The provider had failed to make and sustain improvements to benefit people. The multiple continued breaches of the regulations we identified demonstrated this.
- The ongoing lack of provider and management level oversight meant some previously evidenced standards and areas of regulatory compliance had not been maintained, including those relating to individual risk and medicines management. This placed people at risk of receiving unsafe care.
- Lessons had not been learned. The providers audits and checks to monitor the quality and safety of the service and to drive forward improvements remained ineffective. This meant the concerns we found including staff recruitment and medicines management had not been identified.
- Whilst we acknowledge the provider's recruitment challenges, systems to ensure there were enough suitable staff on duty were not effective. This impacted negatively on people's experiences.
- The provider had failed to ensure some people received the care they needed to maintain their health and wellbeing. Some records in relation to people's care and treatment needs were not available, were inaccurate or contained conflicting and confusing information. This meant staff did not have the information they needed to provide safe, personalised care.
- The provider had failed to ensure staff consistently followed national guidance to prevent and control the spread of infection. This was unsafe and meant opportunities to improve service safety and drive improvement had been missed.
- The provider had failed to take the timely action needed to ensure people to had the opportunities to do things they enjoyed and were of interest to them.

The provider's continued lack of oversight and failure to operate effective systems and processes to make and sustain improvements to benefit people placed people at risk. Accurate and complete records in respect of each person were not maintained. This was a continued breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from people and relatives indicated some improvements to the leadership and quality of the service were being made. Comments included, "[Name] has been here about 18 months. It's better than it was last year when I would have described the care as awful. I think [Name] gets reasonable care," and "Now they have [Manager], if they could sort the staffing things could be good."
● The manager had been in post since August 2022 and was in the process of consolidating a service improvement plan. However, they recognised the need for additional management resources to implement this. They told us, "I am working on lots of things at the moment. It is challenging when I have to do my own work and deal with things the agency nurses are not able to do." The regional operations manager told us additional support was available to the manager where needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;
● People and relatives were invited to provide feedback through meetings and formal surveys. The manager explained attendance at relative's meetings was low, so they were exploring different ways to share information and gather feedback. This included individual zoom meetings and newsletters issued with a feedback form and pre-paid envelopes to encourage replies.
● The manager and staff team worked closely with health and social care professionals involved in people's care. The manager told us, "Everyone benefits from these relationships. Sharing learning and knowledge benefits the residents. A joint approach is important."
● The manager had developed some links with the local community to benefit people. For example, an area of the homes garden was being used by a local school for their gardening project. The aim was for people with an interesting in gardening to become involved in the project.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager understood their responsibility to be open and honest when things had gone wrong.
● Staff felt supported. Comments included, "[Manager] is approachable you can talk about things or ask for advice at any time," and, "Now it feels like we have some support (from the manager). We have 1 to 1 and staff meetings to discuss things. It's more open."
● The manager told us since taking up post they had spent time encouraging staff to share their ideas and thoughts. They said, "At first staff seemed afraid to come forward. Now they do come forward. The culture is much more open."
● Throughout our inspection the manager was open and honest and welcomed our inspection and feedback. They said, "I really care about this home and we are improving. The environment is better, residents, relatives and staff are happier. I aim to engender good practice through clear leadership which will benefit the residents."

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 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of staff were available to meet people's need and preferences.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 (1) HSCA RA Regulations 2014 Person centred care 9 (1)The provider had not ensured people received personalised care and treatment that met their needs and preferences.

The enforcement action we took:

served warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (c) (g) (h) HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's care and treatment was provided in a safe way. The provider had not ensured risk associated with people's care and treatment was identified, assessed and well managed The provider had not taken all reasonably practical steps to mitigate risk associated with people's care. The provider had not ensured medicines were managed properly and safely in line with their procedure and best practice guidance. The provider had not ensured infection prevention and control was managed in line with current guidance.

The enforcement action we took:

served warning notice

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 Regulation 17 17 (1) (2) (a) (b) (c) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured they had effective systems and processes in place to identify assess and mitigate risks relating to the health and safety and welfare of service users. The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date The provider had not ensured their audit and governance systems were effective.

The enforcement action we took:

served warning notice