ADR Care Homes Limited

St Nicholas Care Home

Inspection report

1-3 St Nicholas Place
Sheringham
Norfolk
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14 May 2019

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31 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: St Nicholas is a residential care home that was providing accommodation and personal care to 15 people aged 65 and over at the time of the inspection.

People's experience of using this service:
After our inspection in November 2018, the provider sent us an action plan detailing what improvements they intended to make to achieve compliance with the regulations. They stated that all actions would be completed by 31 January 2019.

We found a continuation of widespread failings across the service. The provider had not taken sufficient action to address the six breaches of the regulations found at our last inspection. At this inspection we found a further breach of the regulations. Therefore, the provider is now in breach of seven of the regulations.

The unstable leadership and lack of oversight from the provider meant there were not effective systems in place to monitor and assess the quality of service being delivered. Audits carried out were ineffective in identifying and mitigating risks in relation to the health and safety of people using the service.

People were not invited to provide feedback about the service but their relatives and staff were asked to complete a satisfaction survey. The provider had not reviewed the responses. This meant any shortfalls identified in the responses had not been addressed. There was also a lack of action taken when audits identified shortfalls in the quality of service being delivered.

Individual risks to people's health, wellbeing and safety were not adequately planned for or mitigated. People were not supported to maintain a healthy intake of food and fluid.

A number of risks found within the environment were found which the provider had failed to identify through their checks of the service. There were poor infection control procedures.

The provider failed to adequately review accidents and incidents and learn lessons from poor practice. They also failed to notify the Commission of all notifiable incidents.

Staff did not work in line with the principles of the Mental Capacity Act 2005. Assessments of people's capacity were generic and there was a lack of consideration given to maximising people's ability to make decisions.

People were not cared for in a way that upheld their dignity and privacy.

People's care records were not person-centred and did not detail their most current needs.

Medicines were managed and administered in a safe way.

Staff felt supported in their role and attended regular staff meetings.
Rating at last inspection: The service was rated inadequate at the last inspection and remained in special measures. The report was published on 22 January 2019.

Following the last inspection, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We asked them to complete an urgent action plan telling us what they would do and by when to improve the key questions of safe, effective, caring, responsive and well-led to at least 'Good.' We took immediate enforcement action to stop further admissions to the service.

Why we inspected: We inspected on 14 May 2019 because the home was in special measures which means we must return within six months to check the service again.

Enforcement: 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: The overall rating for this service is inadequate and the service therefore remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

For more details, please see the full report which is on the CQC 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? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

St Nicholas 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors, a medicines inspector and an assistant inspector.

Service and service type:
St Nicholas is 'care home'. People in care homes receive accommodation and 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. St Nicholas can accommodate up to 39 people, 15 people were living in the service at the time of our inspection.

There was a manager who had been in post since February 2019, but they were not registered with the Care Quality Commission.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection we reviewed the information that we held about the service and registered provider. This included any notifications and safeguarding information that the service had told us about. Statutory notifications are information that the service is legally required to tell us about and include significant events such as accidents, injuries and safeguarding notifications. We also contacted the local authority and safeguarding team for feedback about the service.

During the inspection we looked at nine people's care files, three staff recruitment files and a range of

documents relating to the day to day running of the service. We also spoke with five people who lived in the service, one relative, the manager, two members of care staff and a member of kitchen staff. We also made observations of the care and treatment people received throughout the inspection.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection on 20 November 2018 we rated this key question as inadequate and found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. The provider did not have robust systems in place to mitigate the risk of the spread of infection. At this inspection we found sufficient actions had not been taken and the provider remained in breach of this regulation.

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

- Known risks in relation to people's health needs were not adequately planned for. One person was at high risk of urine infections and their continence care plan did not provide details about this or how to identify and treat any infection.
- People who were at risk of developing pressure ulcers were not repositioned according to the frequency detailed in their care plans. We saw from one person's care records they should be repositioned every two hours during the day. Their daily care notes showed this did not happen for six hours. We saw that a second person who should have been repositioned every two hours had also not been repositioned for four hours.
- When people had been repositioned, staff did not always record whether they had turned the person on their side or sat them up.
- One person's care plan stated that they should be encouraged to drink plenty of fluid to maintain their skin integrity but there was no monitoring of their intake of drinks. We saw that staff noted reddening of one person's skin in their daily notes. No action had been taken and staff continued to check the person's skin after this but failed to comment on the redness.
- Records showed that two people were unable to use the call bell. There was nothing in people's care records to show if an alternative had been put in place to ensure they could summon staff assistance when needed.
- Environmental risks were not mitigated. We found the sluice room to be unlocked and noted the bolt on the door was broken. There was a bottle of cleaner and used gloves on the floor.
- A window restrictor on the first floor was a thin chain which was not substantial enough to prevent the window from being fully opened. There were no checks in place to ensure window restrictors were fit for purpose.
- We observed the retractable guard in front of the kitchen to be left open on a number of occasions when staff were not present in there. This meant that people could potentially access a hot water still and other hazards to their safety.

● The business continuity plan gave an alternative place of residence in the event of an emergency but did not give the details of who to contact or if the staff at the service could hold a key to gain access.
● The call bell system was being replaced during our inspection. The work being carried out presented trip hazards to people trying to navigate corridors where there were loose wires and little space left for them to pass safely.
● Cleaning schedules were incomplete. One cleaning schedule we looked at showed the lounges and bathrooms had not been cleaned all week and a another schedule showed commodes had not been cleaned everyday as stipulated by the schedule.
● Our observations showed that a bathroom chair in a first-floor bathroom was covered in grime and hairs. What appeared to be faecal matter was on the side of the toilet. A jug and some plastic beakers were sat on the top of the toilet. A second toilet we looked at was unclean and the floor was carpeted which would make it difficult to clean any spillages.
● We observed a member of housekeeping staff mopping an area of the lounge floor near a person. No sign was put up to show the floor had been mopped. This meant there was a risk to people slipping on the floor.
● In the sluice room we saw a mop was not being dried upside down. This increased the chance of bacterial growth on the mop.
● Records showed that people were not checked at regular intervals after having an accident. Where people had an accident, this was not referenced in their daily notes.
● Analysis of accidents and incidents was not robust. It was identified that most falls took place at night with 15 falls recorded on the falls analysis record over the space of three months. There was no further action taken to reduce this risk.

As a result of these findings, the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection visit the manager sent us evidence of repairs to the sluice door and receipts to show new window restrictors had been ordered.
● Each person had a personal emergency evacuation plan which detailed the support they required to evacuate the building in an emergency.
● Utilities such as water, gas and fire safety equipment were tested regularly.
● The kitchen had received a five-star rating from the Food Standards Agency.
● Slings for hoists were inspected weekly and moving and handling equipment was tested regularly.

Staffing and recruitment
● The manager told us staffing levels had been increased from two staff to three at night. This was in response to concerns we raised at the last inspection about staffing levels. Rotas from the previous four weeks showed there were only two staff on duty for 18 nights over the four weeks.
● Seven people required the support of two staff and one person sometimes required three staff to help with their moving and handling needs. Records showed an increase in accidents during night-time hours. We could not be assured staffing levels were sufficient to meet people's needs at night.
● We received varied views about the staffing levels. One person's relative told us they saw one person eating potato from the floor and another person spill their ice cream because there were not enough staff to supervise the lunchtime meal.
● One person told us, "Staff come more or less straight away."
● Staff recruitment files were not always complete. We saw there was no employment history for one recently recruited member of staff and they had not completed the additional information part in support of their application.
● Background checks such as references and clearance from the Disclosure and Barring Service had been

obtained prior to staff commencing their employment.

Systems and processes to safeguard people from the risk of abuse
● Staff understood what constituted abuse and knew who they would report concerns to.
● Training records showed staff received training in safeguarding.
● Details of the local safeguarding team were displayed in the foyer.

Using medicines safely
● When staff applied people's medicines prescribed for external application such as creams, records were completed on the electronic system, however, the records lacked detail about which creams were applied. There was a lack of information for staff to refer to such as where on the body people's external medicines should be applied. The acting manager informed us that this would be resolved immediately.
● There was a system in place for ordering and giving people their medicines as prescribed.
● Medicines were stored securely.
● Staff had received training and there were records in place showing that all members of staff handling and giving people their medicines had been assessed for their competency.
● Oral medicines given by staff were recorded on Medicine Administration Records (MAR charts). These showed that people received their medicines as prescribed. Daily checks were in place to check people's medicines and their records and there were systems in place to record medicine discrepancies and errors.
● There was written guidance to help staff give people their medicines prescribed on a when required basis appropriately and consistently. However, we noted that for one person prescribed a medicine to manage their anxiety, the written guidance lacked sufficient detail about the appropriate circumstances for its use.
● When people had known allergies and sensitivities to medicines records were sometimes inconsistent which could have led to error and medicines being administered inappropriately.

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

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our last inspection on 20 November 2018 we rated this key question as requires improvement. This was because we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found where people lacked the mental capacity to make a specific decision, the provider had not
acted in accordance with the requirements of the Mental Capacity Act 2005. We found a further breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure the nutritional and hydration needs of people were consistently met. At this inspection we found improvements had not been made and the provider remained in breach of both regulations.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Assessments of people's capacity were generic and did not detail specific decisions to be made in people's best interests and one member of staff we spoke with did not know how many people were being deprived of their liberty.
- Capacity assessments did not always reflect why some people were being deprived of their liberty.
- One person's capacity assessment stated that personal care should be delivered in their best interest but it then went on to state the person was able to attend to some of their personal care themselves but did not specify what.
- A second person's mental capacity care plan stated they were able to make day to day decisions but did not specify what these were. Their mental capacity assessment stated that the person was unable to make

day to day decisions.
● A third person's care records stated they had fluctuating capacity and were able to make some decisions for themselves. Their mental capacity assessment did not reference their fluctuating capacity and how to maximise their ability to maintain their independence in making decisions.

As a result of these findings, the provider remained in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with had a good understanding of the MCA. And one member of staff we spoke with told us how they offered people daily choices.

Supporting people to eat and drink enough to maintain a balanced diet
● A number of people were at risk of not eating or drinking enough. Nutritional assessments stated their food and fluid intake should be monitored.
● No food and fluid charts were in place for people who were nutritionally at risk and the amounts of food and fluid people had consumed were not documented in people's daily notes.
● One person was at risk of choking on their food. Their care plan stated staff should be in the corridor to monitor them whilst they were eating. We saw this person was not observed over lunch. We saw they had both their main meal and dessert placed in front of them and they had not eaten it.
● Where people were on a modified diet due to swallowing difficulties, there was no guidance in their care plans about having to monitor for coughing, choking and recurrent chest infections.
● The kitchen staff did not have the most up to date guidance about how to prepare peoples meals according to their needs. Guidance about preparing meals and drinks for people who have difficulty swallowing changed in April 2019. Manufacturers of modified meals and drink thickeners will be using the new terminology and if staff are not aware of this then there is a risk people's meals and drinks will not be prepared according to their needs.
● Kitchen staff did not know the dietary requirements of each person.
● One person's relative told us that people did not always get enough food.

As a result of these findings, the provider remained in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● After our last inspection in November 2018, we placed a condition on the provider's registration which meant they were not permitted to admit people to the service.

Staff support: induction, training, skills and experience
● New staff completed an induction which included completing training, familiarising themselves with people's care needs and shadow shifts.
● There were some gaps in training records where staff had not completed all of the practical aspects of the provider's training. These included practical training in fire safety and first aid.
● Staff had completed specific training in areas such as continence, bereavement and pressure care.
● Staff had annual appraisals and regular supervisions with the manager. Supervision is a confidential meeting between staff and a senior member of staff to discuss any support they required to carry out their role effectively.

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

● Staff worked with other healthcare professionals to ensure people's health and wellbeing needs could be met, however, guidance from health care professionals was not always reflected in people's care records.
● Healthcare professionals from the local GP practice visited once a week to see if there were any concerns about people's health or wellbeing. They could also review people's medicines. The GP would also visit at other times of the week if required.

Adapting service, design, decoration to meet people's needs
● There was some dementia-friendly signage around the home to show where bathrooms and lounges were.
● Some bathrooms had been refurbished and decorations such as wall stickers and pictures had been added around the home.
● One of the lounges had been decorated in a 1940s theme and people's relatives and staff members donated items to decorate the room.
● People were able to personalise their rooms with their own items.

Requires Improvement

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

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At our last inspection on 20 November 2018 we rated this key question as requires improvement. This was because we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people were treated with respect and have their privacy and dignity upheld. At this inspection we found that sufficient improvements had not been made and the provider was still in breach of this regulation.

Respecting and promoting people's privacy, dignity and independence
● People were not supported to maintain their dignity. We observed two people with very dirty fingernails eating their lunch with their hands.
● People were not supported with their personal care frequently. One person's relative told us their relative had not had a wash for two days.
● Daily records showed people were not supported with changing their incontinence pads frequently. One person had not had their pad changed for over 12 hours.
● Our observations showed a member of staff leaning over one person at lunchtime to cut up their food in front of other people.
● We saw a member of staff taking what appeared to be water to one person's room in a dirty and cracked jug.
● Inspections of the laundry cupboards showed towels people used were threadbare and ripped.
● People's personal information was not kept in a confidential manner. We saw keys were left in the lock to an archive room and one person's medicines records had been left unattended.
● We saw one member of staff stating they would get some cutlery to help one person with their lunch. However, the person's care plan clearly stated they liked to eat with their hands and they would refuse to eat if staff attempted to assist them.

These findings meant the provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw a few new towels had been purchased, however, a number of these had been tied up with ribbon and were being used as decoration in the bathrooms.

Ensuring people are well treated and supported; respecting equality and diversity
● We observed little meaningful conversation between people and the staff. Most of the conversation we

heard was limited to "Are you okay?"
● We did observe some caring interactions between people and the staff. We saw one person who was distressed being comforted by a member of staff who spoke softly to them.
● Staff did not use alternative means of communication for people who were not able to verbalise their needs and wishes. The bi-monthly keyworker session record for one person simply stated, 'Unable to answer.'

Supporting people to express their views and be involved in making decisions about their care
● Only one person we spoke with told us they have been involved in planning their care. A second person said, "You get to know [the staff] and they know what care to provide."
● One person's relative told us they had never been shown any care plans but were asked if they were happy with the care provided to their relative.

Requires Improvement

Is the service responsive?

Our findings

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

RI:□People's needs were not always met. Regulations may or may not have been met.

At our last inspection on 20 November 2018 we rated this key question as requires improvement. This was because we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people the care people received was appropriate, met their needs and reflected their preferences. At this inspection we found sufficient improvements had not been made and the provider remained in breach of this regulation.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People's care was not planned or delivered in a person-centred way.
- Staff did not always know people's individual needs. One person's relative told us a member of staff did not know their relative had false teeth.
- One person's care plan showed they could become easily distressed when receiving personal care. There was nothing in their care plan to show how the person should be reassured. Advice had been sought from healthcare professionals, but this was not included in their care plan.
- People's care records did not reflect people's most current support needs. We were told one person had become withdrawn due to their low mood. There was no mention of this in their care plan.
- People's preferences about their daily routines were not documented. Daily records showed people were supported to get up early in the morning, sometimes before 6 o'clock in this morning.
- Daily notes of people's care did not link to their care planned needs and these notes were brief, therefore, they did not provide an ongoing assessment of people's health and wellbeing.
- Daily notes were task-focussed and only made reference to people's wellbeing as either being 'happy' or 'unhappy'.
- Due to numerous duplicate entries in the daily notes it was difficult to keep track of the care people received.
- People were not supported to maintain their interests or hobbies. One person's care plan detailed what they used to enjoy doing but there was nothing to show how they could be supported to maintain their interests.
- Reviews of people's care records were not robust and did not identify the irregularities we found in people's care records.

These findings meant the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Records showed people's complaints were not treated in a respectful manner. Two people made a similar

complaint; however, one person was living with mental ill health and the way this was referenced in the outcome section of the complaint insinuated this was the reason for the complaint.

End of life care and support

- One person's relative told us they had been consulted about their relative's end of life wishes.
- Details about people's wishes and preferences regarding their end of life care were documented in their care records.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

We continue to remain concerned about the provider's ability to make any improvements. An inspection carried out on 30 January 2017 and 1 February 2017 found the provider had failed to sustain any previous improvements and we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was placed in special measures due to widespread concerns. Further inspections in June 2017, February 2018 and November 2018 found multiple breaches of the regulations and the service remained in special measures. As a result of our inspection in November 2018 we issued a Notice of Decision to restrict any new admissions to the service. At this inspection in May 2019 we found significant shortfalls relating to the leadership and oversight of the service and the provider remains in special measures.

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

- The management of the service has been unstable and there have been three different managers since June 2017.
- Whilst the current manager had a good understanding of person-centred care and was enthusiastic about improving the service, the lack of support available to them did not assure us they would be able to drive any improvement.
- The manager had no experience of managing a service and had not completed any management training. In addition, the provider had not organised a mentor for the manager, for example getting a more experienced manager from one of their other services to mentor them.
- One person's relative told us the manager spent a lot of time in the office leaving senior staff, some of whom were recently employed, to do things on their own.
- The provider did not maintain a good oversight of the service and had only visited the service twice since our last inspection.
- The operations director was responsible for reviewing the audits completed by the manager and developing an action plan. They had failed to do this since February 2019.
- Systems to monitor and assess the quality and safety of the service were undertaken but there was a failure to act on any concerns identified.
- Safety incidents were not thoroughly reviewed, and information and the provider failed to implement practices to mitigate known risks to people's health and safety.
- There was no overview of people's care records and associated ongoing notes of their daily care and treatment. This meant the poor care and treatment people received went unnoticed.

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

● People who lived in the service were not given the opportunity to participate in a satisfaction survey.

● Staff and people's relatives were asked to complete the satisfaction survey in January 2019. At the time of our inspection the responses from these surveys had still not been analysed.

The above findings constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The manager told us they were trying to implement monthly meetings for people who lived in the service. Records showed these were taking place.

● Records showed there were regular meetings for staff to discuss issues such as people's care and any changes within the service.

● Staff we spoke with told us they were able to contribute ideas and found the manager supportive.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● We were not always informed of notifiable incidents. We saw from records that two people had sustained injuries which required medical attention which we were not notified of. The provider is required by law to submit a statutory notification of any significant event. We found we were not always notified of accidents.

Therefore, the provider is in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The lack of effective oversight from the provider and operations director did not allow for the delivery of high-quality care.

Working in partnership with others

● The manager has been working with other agencies such as the local authority and community health professionals to try to improve the service.

● The manager told us they put on coffee mornings at the home and invited people from the community.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18 (1) (2) (e)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1), (3) (a) (c) (d)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with respect and have their dignity and privacy upheld. Regulation 10 (1) (2) (a) (b) (c)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to

make a specific decision the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005.

Regulation 11 (1) (2) (3)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. The provider had failed to mitigate the risk of the spread of infection and ensure effective infection prevention and control. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location