ONH (Herts) Limited

The Orchard Nursing Home

Inspection report

129-135 Camp Road
St Albans
Hertfordshire
AL1 5HL

Tel: 01727832611

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22 December 2015

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 21 and 22 December 2015 and was unannounced.

The Orchard Nursing Home provides accommodation and personal care for up to 63 people older people, some of whom live with dementia. There were 50 people living at the service on the day of our inspection.

The service had recently been purchased by a new provider and the registered manager had resigned their position. This was the first inspection since the provider bought the home. The home had been managed during the transition period by a peripatetic manager employed by the provider but they had recently left the service. A peripatetic manager is a manager who moves between services owned by the same provider when they are without a registered manager. There was a newly appointed manager in post and the service had notified us of their intention to apply for their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection under the previous provider on 10 March 2015, the service was found to be meeting the required standards and was rated as Good. We carried out this inspection due to concerns raised with us about the welfare of people living at the service and found that the provider was not meeting the standards. We found there to be issues in regards to ensuring people received safe and appropriate care, staffing, management of medicines, complaints, communication, records and the management and leadership of in the home.

We found the service to be in breach of the Health and Social Care Act (Regulated Activities) 2014 Regulations. You can see what action we took at the back of our report.

The service was suffering severe staff vacancies and as a result was using a high level of agency staff. There were no systems in place or records available to ensure that in this period of difficulty staff could and were providing safe care to people. We saw many examples of people not receiving safe care.

There was limited leadership on the floors of the home and the permanent nurses who were responsible were expected to provide leadership with limited support and resources. The limited continuity of staff impacted on care delivery, maintenance of records, the management of medicines and people's access to health care professionals.

People did not enjoy the food they were provided with and did not always receive the appropriate support with eating and drinking.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was working in accordance with MCA and had submitted DoLS applications which were pending an outcome. However, least restrictive options were not practised while these were pending and documentation did not support the needs of people and did not provide guidance to staff.

People and their relatives praised the permanent staff for their dedication in a difficult time and told us they were kind. Staff told us that agency staff were doing their best without guidance on how to work in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive safe care.

There was a large amount of agency staff being used without the appropriate systems in place to ensure safe care was provided.

Medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

People were supported by staff who had not received appropriate training and supervision.

People's ability to make decisions was not always assessed and documentation did not support DoLS restrictions.

There was not always sufficient support with eating and drinking.

There was access to health care professionals but staff were not always proactive in arranging this.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always promoted.

People were not involved in planning or reviewing their care.

People's preferences were not always promoted.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care needs were not always met.

People's care plans were not complete or accurate.

Feedback and complaints were not always responded to appropriately.

People had access to activities.

Is the service well-led?

Requires Improvement

The service was not well led.

People and their relatives had no faith in the management team.

There was a lack of leadership in the home.

Systems in place to monitor the quality of the service had not identified or addressed the issues we found on inspection.
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The Orchard Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 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 Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 21 and 22 December 2015 and was carried out by three inspectors. The visit was unannounced. Before our inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with six people who lived at the service, eight relatives, nine members of staff, two agency staff members, the manager, peripatetic manager and the regional manager. A peripatetic manager is a manager employed by the provider to provide management cover where needed. We received feedback from social care professionals and viewed six people's support plans.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Inadequate

Is the service safe?

Our findings

People were not always safe from harm as information was not available to ensure they received safe care and treatment in all cases. We found that accidents were not monitored and safe care was not always provided.

People who were living on the 2nd floor of the home were unable to give us their views of care received due to the complex conditions they lived with. However, our observations showed that people did not always receive safe care. For example, in relation to moving and handling and pressure care management. We saw that staff used differing and unsafe moving and handling techniques when they helped people to transfer from wheelchairs to chairs. People at risk of developing pressure ulcers had not been supported to use pressure relieving cushions appropriate to their needs and had not been repositioned in a way that reduced the risks. We also found that pressure mattress settings were incorrect in a number of cases which meant that people's needs had not been met in a safe and effective way.

Accidents and incidents were not sufficiently monitored to ensure all remedial and risk reducing actions were completed. For example, where a person had suffered four falls in close succession there was no review of recently prescribed medicines that may have increased the risk of falls. In another case a person had ill-fitting slippers which may have contributed to their falls. However, the ill-fitting slippers were left in their wardrobe where they may have continued to be used due to the lack of communication in the home and the inconsistency of staff. We also observed another person walk around, assisted by two staff members and the manager, one of their slippers had slipped half off and not worn properly or safely. Neither the manager or staff members addressed the fact that the slipper was half off and which increased the person's risk of falling.

In addition, we saw where someone had complained of bruising as a result of being 'pulled up by their hands', the accident form had been filed away and no action taken. We also saw there were other accident forms with unexplained bruises and skin tears listed and no investigation had been carried out. The manager and regional manager did not know if an investigation had been carried out and there were no records in place to suggest it had been, Which meant that appropriate steps had not been taken to identify, monitor and reduce the risks posed to people's health and well-being in all cases. There was no analysis of the accidents and incidents that had occurred to help identify themes and trends.

Medicines were not always managed safely. We found that the recording of medicines was not always accurate. For example, the amount of medicines carried forward from one cycle to another were not recorded on the medicine charts. There were no opening dates on the medicines which were received in boxes from the pharmacy and controlled medicines were not recorded in line with national guidance to ensure that the records were accurate and medicines could be accounted for.

Records maintained about the administration of people's medicines were inconsistent. Medicine charts did not clearly or accurately identify the amount of medicines people required. For example, some instructions read, 'administer one or two' and we saw that staff had not recorded the amount given. Because people's

medicines had not been managed in a safe and effective way it was not always impossible to be sure they had received their medicines in accordance with the prescriber's instructions.

We also found that some doses of medicine had been missed and in one instance, even though the person concerned told us they hadn't received it, the medicine in question had been signed as having been administered. We also found discrepancies in the quantities of three medicines we counted as the amount of tablets in stock did not tally with the amount expected to be in stock. In addition, medicines prescribed for pain relief on an as needed basis, were not recorded on the medicine charts and as a result people may not have been offered pain relief when needed.

Due to the unsafe management of medicines and people being at risk of, and receiving, unsafe care, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People were not always protected from the risk of abuse. In addition to the unexplained bruises and skin tears, people told us that staff were at times, "rough." One person told us they had bruises as a result of staff 'roughly' moving them in bed. Another person told us, "I had to ask a couple of staff to be careful when handling me. Some of them are very heavy handed and I really have sensitive skin and it hurts if they are not gentle." These issues had not been reported to the local authority or investigated and as a result people were at risk of further incidents of rough handling and injury. The manager and regional manager did not know if an investigation had been completed following these incidents. Staff were not clear on how to report concerns outside of the organisation and had not reported, except in one instance, complaints from people stating they had been roughly handled. We observed people having their hands and arms grabbed roughly by staff who supported them with personal care and reported our concerns to the local authority's safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

There were not always sufficient numbers of staff available People told us that sometimes they had to wait for personal care and support. One person said, "I press my bell at times and I have to wait long times. This caused me to have accidents [incontinence]." Another person said, "If I press my bell, staff will come, sometimes quicker, sometimes I have to wait because they have so much to do and so many people to look after."

The service had staffing shortages and as a result used a high volume of agency staff. There was no information or guidance available to permanent or agency staff on how to provide safe care as care plans were either incomplete or out of date. Some staff were able to describe risks to people's health and welfare however, due to a lack of staff continuity, particularly on the 2nd floor, the service could not ensure people received safe care. One staff member told us, "Most of the agency workers are ok and we can work well together. Some come here and they are new. That`s when it is hard." We noted that on the 2nd floor there were four agency staff members and only one permanent staff member, whereas on the ground floor there were four permanent staff and only one agency staff member. We asked the manager why agency staff had not been evenly distributed around the home to ensure continuity of care. The manager told us, "I don't know, the rota was done by [peripatetic manager]." They had not reviewed it to ensure staff were satisfactorily deployed and all shifts were covered.

The rota did not accurately reflect the staff who worked at the service during our inspection. The manager could not be sure who was present and who had called in sick. One agency nurse on the 2nd floor had worked a night shift but because sufficient staff had not arrived to relieve them they commenced the morning medicines round. Around two hours later, the regional manager arrived and worked on the 2nd

floor to provide nursing support but were not present for the whole shift, only to administer medicines.

We found that steps had not been taken to ensure there were enough staff to meet people's on going and continued needs in a safe way. One agency staff member told us, "Even with us agency staff they seem to be short staffed all the time. We come in and they send us from one floor to the other to cover gaps, yesterday they had no nurses." The regional manager told us that shifts were covered with sufficient numbers of staff at all times. However, when we reviewed the rota we saw that there were still two shifts that required additional staff to ensure the shifts were covered so that people's need could be met.

Due to the lack of continuity and ineffective deployment of staff with the appropriate knowledge and skills to meet people's needs, this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People were supported by staff who had been through a robust recruitment procedure. All pre-employment checks were completed prior staff started work at the home. These included written references, proof of identity and a criminal records check. When agency staff worked at the home, the manager received information about their suitability to work with people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who did not have the appropriate support and supervision to carry out their roles effectively. People and their relatives told us there was no guidance for staff on the floors and this impacted on the standards in the home and the care provided. People also told us they needed to show staff how to complete some tasks and how to use some equipment when supporting them.

People told us they didn't think all staff had up to date training. One person told us they needed to instruct staff on how to move them. They said, "I need to tell them what they have to do for me and sometimes how to do it as well." The regional manager provided us with the training statistics for the home and we saw that there were several gaps in training for staff which included moving and handling, safeguarding people from abuse, MCA and DoLS and first aid. This meant that staff who provided care did not have the appropriate training to carry out tasks safely and effectively in all cases.

Staff told us they had not received supervision from seniors or the manager and felt unsupported. One staff member said, "Management hits permanent staff with all the extra outstanding work. They send us letters to outline where we fail, but what they don't realise is that the agency nurses are not doing care plans, they don't do regular paperwork, they are just running the shift and we need to deal with the backlog." However, with the additional pressures put on to permanent staff we found that additional support, guidance and training had not been provided. We asked the manager and the regional manager about staff supervision and staff meetings and were told these had not been held.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People told us that staff asked for consent prior to supporting them. We saw that staff went to great lengths to communicate with one person prior to assisting them to move out of their wheelchair. For example, by writing down the support they were offering prior to carrying out the task. However, information in relation to consent and mental capacity was limited in care plans and there were no records of best interest decisions being made. We were told by the manager that DoLS applications had been made in relation to the use of lap belts and preventing people from leaving the home alone in order to keep them safe. However, there was no reference to these in the care plans and staff were not aware of the least restrictive options in place until a decision was made. The lack of documentation and guidance may have resulted in people's rights not being respected or unlawful restraint.

People told us that the quality of food had deteriorated. One person said, "The food is not good lately. The quality is poor and has no taste." Another person said, "I am diabetic. The food was not bad when I moved in a couple months ago. Lately the food is not good; I cannot get fresh fruits or yoghurts at times. I cannot have sweet puddings." We noted that the service had been without a permanent chef. However, people told us that they were given a choice. Relatives were concerned that people missed their meals when they were in their rooms. One relative told us, "I've arrived here today at 11am and [relative] hasn't had breakfast." Another relative told us, "[Name] told me they had missed their meal and I spoke up, what about the people who can't ask?" We saw that the kitchen used a checklist to help ensure everyone received their meals,

however, we could not be confident that this was used effectively due to other concerns with monitoring, our observations and people's feedback. We noted that mealtime on the 2nd floor was less enjoyable than on the other floors. For example, table cloths, crockery and cutlery was provided on the other floors laid up ready for meals. We saw that at times people waited for a long time for support to eat. At 8.55am on the 2nd floor people sat to the tables with cereal and or toast and did not have drinks available for them.

Relatives told us that at times they supported people to eat rather than watch them sit and wait. We passed this onto the management team who told us they were aware of the situation and possible risks. Some people had been identified as being at risk of not eating or drinking enough to maintain good health. However, we found that the steps put in place to monitor and reduce the risks were not as effective as they could have been in all cases. This was because not everyone had their nutritional risk assessed or their weight monitored. In some instances for those who had been assessed, and where it stated they required weekly weight monitoring, this had not happened. We also found where one person had required a referral to the speech and language team (SALT) for possible swallowing difficultly following a choking incident, this had not been identified or actioned.

This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People had access to health and social care professionals. However, this was not always consistent as concerns about people's health were not always communicated and the relevant health professional was not contacted. For example, in regards to a blood test that was due, referral to a speech and language team and a GP when it was suspected a person had an infection. This did not ensure that people's health needs were promoted.

Requires Improvement

Is the service caring?

Our findings

People told us that most staff were kind. One person said, "The staff who work here permanently are lovely, they go way beyond their job to keep us going, however it is a completely different story with agency staff, they are not as nice." Relatives told us that the permanent staff were lovely. One relative said of the permanent staff, "[Relative] loves the girls and they love her."

People told us that the permanent staff were patient and promoted their dignity. One person said, "The permanent staff are very pleasant and they knock on my door before they come in. They have patience." Staff, in particular the permanent staff members, spoke nicely to people and strived to communicate well. For example, they spent time writing down what they were saying for one person who could not hear. However, we observed one agency staff member physically grabbing a person's hand to get them to hold their drink and this was responded to with anger by the person in question. A permanent staff member then engaged them in a conversation and quickly lifted their mood.

We noted that much of the information about people provided as part of staff handover focused on how certain people may be 'aggressive', 'hit out' or 'pinch' staff. However, there was no information about how to identify triggers to this behaviour or guidance about positive communication or their preferences. We found that few staff knew people well which may have contributed to this behaviour in a way that failed to promote their dignity or personhood. We noted that some staff were attentive, checked if people were cold and offered them additional cushions. However, for the most part people were left to sit in wheelchairs for long periods of time due to a lack of staff rather than choice or comfort.

People and their relatives told us they were not involved in planning or reviewing their care. We found that plans of care had either not been completed or reviewed. We also saw that guidance provided to staff did not accurately reflect whether or not people had been involved in or agreed to the care and support they received. One relative said, "We never seen the care plan or come in for a review. I also have to phone the staff if I want to know how [person] is, they never tell me if they have a bad day or they needed the GP." There were limited permanent staff available to ask how they involved people. However, we spoke with one staff member who was responsible for writing and reviewing people's care plans and they told us, "I always ask people but there's such a shortage of nurses plans are not getting done."

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

Requires Improvement

Is the service responsive?

Our findings

People's basic care needs were met but not always safely and in accordance with assessed needs, or their preferences. One person told us, "Staff come from an agency, it is not their fault they don't know about me. I am straight forward and tell them what they need to do." Another person said, "I do require a stand hoist to transfer and they [staff] come in and they bring a sling in then they go away they come back especially agency staff, seem not to know what they are doing." Relatives told us that care needs were not always met and as a result, one relative told us that their family member was left in their nightclothes until late in the day when they arrived. They told us, "Staff don't read people's care plans before providing care, they don't know people." Another relative said, "I don't know why I'm paying for nursing care." They went on to say that treatment and nursing care was missed due to agency staff being on duty and no continuity or communication. They did say that the permanent nurse for the floor ensured things were done when they were on duty. Staff told us it was hard when agency nurses were on duty because they did not know people well and did not know how the home operated.

People's basic personal care needs were being met. For example, support with getting washed and dressed or going to the toilet. However, relatives told us that this was not always in a timely manner and not in accordance with people's preferences. One relative told us, "I don't feel [relative] gets the care [they] need when they need it." Another relative told us, "They refuse to give [relative] a bath, they insist that [they] has a shower." They went on to tell us that they provide a bath for their relative on their visits. We saw that care was not always given in accordance with people's needs. For example, by reducing the risk of a person developing a pressure ulcer, correct moving and handling or dietary support.

We asked staff how they ensured the correct care was given and records were maintained in a way that helped people receive person centred care. One staff member told us, "When I'm here I make sure things happen but when I'm not, I can't be sure it's done." We noted that some gaps in care were apparent when the staff member had been on leave and was covered by agency staff. Another relative told us they were assured that their relative would be supported to get out of bed but after being in the home for a number of weeks, this had not happened and there was no explanation as to why not. We checked this person's care plan and found that it was not completed in relation to their complex needs and support they required.

People's care plans were either incomplete or inaccurate. We saw that where some people would be at high risk in some areas, such as moving and handling or pressure care management, they had not had assessments completed or care plans developed instructing staff on how and when they needed assistance.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People who lived at the service and their relatives had their feedback sought through meetings and surveys. However, they felt that their views were not listened to as actions stated by the management team as a result were not carried out. There was a complaints log and a record of the regional manager's response to each complaint. There was a record of action taken and feedback to the complainant. However, relatives told us they were unsatisfied with the outcome of complaints and felt that they were not listened to, actions

were not completed and there was no improvement to the service. One relative said, "They don't do what they say they will do." They went in to say that information was promised to relatives following their complaints at a relatives meeting and this wasn't provided. There was no system in place to obtain the views of the handling of complaints and could therefore not be sure that their complaints process met people's satisfaction.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

People were supported to access activities that promoted stimulation and included hobbies and interests. One person said, "I do like the activities especially the art sessions. I like to paint." We observed the activities organiser engaging people in various conversations and activities. We saw that they moved around the room and tried to encourage everyone to participate in reminiscence and sensory stimulation. People and their relatives told us that they received one to one activities when in their rooms and were all positive about the activity team. There was an activity room which included lots of crafts materials and other items for games and puzzles.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that the leadership at the home had declined since the previous manager left and the service had been taken over by a new provider in July 2015. One person said, "The previous manager was lovely, I knew her well. This one is not really communicating with me so I don't know." Another person said, "They [provider] told us in a meeting that nothing will change when they took over the home, but everything changed. Staff are leaving, new policies came in." A relative told us, "New management are not responsive, the new manager does not make [themselves] visible around the home."

Shortly after taking over the service, the registered manager left the service due to relocation, the deputy manager left for another role and six permanent nurses also left due to visa circumstances. To address this there was a peripatetic manager put into the home to oversee the running of the service and the transition period.

There was a new manager in post at the service who had been there three weeks prior to our inspection and a new deputy manager who started on the day of our inspection. There was also a new peripatetic manager appointed to support the manager with running the service during their induction period. A regional manager had also been attending the home to support the new management team. However, we noted that the peripatetic manager who was familiar with the service had been reallocated to a different service. This had clearly not helped ensure the continuity of the service during an unsettled period. .

However, there were concerns raised by people and their relatives about leadership at the home and a lack of responsibility in the absence of the previously employed nurses. They told us this had resulted in poor care and no improvements to the standards in the home. We were told by relatives that the standards in the service had declined significantly and they were concerned for the welfare of people and the morale of staff. One relative said, "What I can't accept is that no-one takes responsibility. They say that it's the nurse on each floor who is in charge but if it's an agency nurse how can they be in charge?" Another relative told us, "There was a power cut the other day and the agency staff, who were in charge, ran around with no idea what to do." Staff also told us that they did not feel there was sufficient leadership and guidance and as result things were not addressed.

There was little or no monitoring or checks being carried out about the services provided or the risks that had been identified or may have arisen. We also found that this had led to incomplete records, safety checks not being completed and other issues we identified during the inspection which had not been addressed by the service. There had been a local authority visit and as a result an action plan had been developed. However, this had not yet improved the standards in the home. In addition we had asked the provider to address a number of issues and concerns we had been told about. They gave us an action plan but we found that this had not been progressed or completed on the day of our inspection. For example, steps had not been taken to ensure there was an accurate record of people's needs available so staff could provide safe care.

There were limited opportunities made available to share lessons learned within the home and there had

only been one staff meeting held with the nurses. For example, information about accidents, incidents and complaints was not shared with staff to ensure lessons were learnt and remedial actions followed through. Also, staff did not always share issues and concerns with the management team. For example, an incident relating to a person choking. This meant that there was no process for ensuring the service worked in accordance with people's needs and maintained the standards.

Permanent staff were committed to providing a good service. However, we were unable to get an accurate understanding of the culture and ethos of the home due to the amount of agency staff and the recently changed management team. The provider was clear that they wanted to provide an open, honest and person first environment but was also aware that significant improvements were required in many areas to make sure people received safe, effective and responsive care at all times.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have their needs assessed or met.

The enforcement action we took:
Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment.

The enforcement action we took:
Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse.

The enforcement action we took:
Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not receive sufficient support to eat and drink.

The enforcement action we took:

Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not responded to in a way that resolved people's concerns.

The enforcement action we took:

Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was ineffective leadership and systems in place to ensure that safety and welfare of people living at the service.

The enforcement action we took:

Imposed restriction of admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staffing available with appropriate knowledge and skills to meet people's needs safely.

The enforcement action we took:

Imposed restriction of admissions