Care Expertise Limited

Spring Lake

Inspection report

17 Forty Lane
Wembley
Middlesex
HA9 9EA

Date of inspection visit:
13 January 2017
16 January 2017

Date of publication:
07 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 took place on 12 and 16 January 2017 and was unannounced.

Spring Lake provides accommodation for up to 11 people with varying support needs including people living with learning disabilities, autism, behaviours that challenge services and other complex needs. At this inspection there were 10 people living at the service.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run. A registered manager was in place.

During our inspection we identified a number of concerns about the care, safety and welfare of people who used the service. The quality assurance processes in place at the service were not robust enough to assess, monitor and mitigate the risks relating to the health and welfare of people using the service and to drive service improvement.

Although relatives and professionals told us staff were kind and caring, some staff expressed concerns that people's choices and preferences were not always respected. We saw that not all people received personalised care and support that met their needs and took account of their preferences. Improvements were required to ensure care was provided in line with people's individual needs, and to make sure people's choices and dignity were respected.

There were processes in place to seek the views of people who used the service and those acting on their behalf but it was unclear how this feedback was used effectively to improve the quality of the service. Improvements were required to ensure people's concerns and complaints were acted upon.

Risks to people's safety and wellbeing were not always managed effectively to make sure people were protected from harm. We saw that some risks to people's well-being had not been identified or adequately mitigated. This had put people's welfare at risk.

Facilities at the home were not well maintained in order to meet people's needs safely and effectively. Some areas of the premises were in a poor state of repair and required attention in order to reduce risks to people. We observed that the emergency lighting system required repairing and the hot water supply and showering facilities at the home were faulty.

People were not protected against the risk of the spread of infection. Staff did not follow correct procedure to ensure laundry was processed correctly in order to reduce the risk of cross infection.

Staff did not always gain consent from some people before providing care and treatment. In one example,

we saw where people did not have mental capacity to make specific decisions about their care and treatment, The Mental Capacity Act (2005) was not fully adhered to. The provider had failed to appropriately assess this person's mental capacity in relation to restrictions of their freedom and liberty.

There were procedures in place to ensure people's medicines were managed safely. Staff regularly reviewed and audited medicines to ensure they met people's current needs.

Staff were aware of the provider's safeguarding policies and procedures and their role and responsibilities in keeping people safe. The provider was working with the local authority in investigating some current safeguarding concerns.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People were supported to maintain balanced diet based on their preferences. Staff had a good understanding of people's preferences and supported them to make choices in relation to their nutrition.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what action to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risks to people receiving care were not always sufficiently assessed to ensure steps were taken to keep people safe from harm.

There were areas where infection prevention and control practices could be improved to demonstrate that staff were aware of hygiene and cross infection risks.

Staff demonstrated a good understanding of safeguarding procedures.

Medicines were administered safely by staff and there arrangements for ordering, storage, administration and recording of medicines.

Staff had been employed following effective recruitment and selection processes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not follow the Mental Capacity Act 2005 guidance when a person's liberties were being restricted to keep them safe.

People were provided with a choice of healthy food and drink to ensure their nutritional needs were met.

The service responded positively to changes in people's health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Although staff were kind and caring, some management

decisions ensured that people's choices and preferences were not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans did not provide sufficient detail and some required updating.

It was unclear how feedback was used effectively to improve the quality of the service. Improvements were required to ensure people's concerns and complaints were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems were in place to capture the views of people, their relatives and staff, but these were not yet being used to direct improvement of the service.

There were systems to monitor the quality of the service but these were not yet being used effectively.

Spring Lake

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 16 January 2017 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some information about the service. What the service does well and the improvements they plan to make. We reviewed the PIR and other information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

Before we carried out the inspection we reviewed the information we hold about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

All people who lived at Spring Lake had learning disabilities and other complex needs. They were unable to communicate with us in a way which we always understood. We spent considerable time observing care to help us understand the experience of people who could not talk with us. We also spoke with three relatives, seven health professional and completed various observations throughout our inspection. We spoke with the registered manager, the deputy manager, quality assurance manager and eight members of staff. We also contacted the local safeguarding team.

We reviewed the care records of six people and the medicines records of four people. We also looked at records relating to the management of the service. These included health and safety check records, audits, accidents and incidents reports and seven staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Relatives of people who used the service told us people received safe care and support. One relative told us, "I can't fault them." Another relative said, "This is a very good home." On the whole, we saw risk assessments had been undertaken to minimise any potential risks to people using the service. However, we could not be certain that staff always had the correct information needed to make sure care was delivered in a safe way. This is because, in some files no risk assessments had been completed or updated to identify areas of risk and outline what, if any, action staff should take to minimise them.

One person had diabetes and was at risk due to unstable blood sugar levels. However, there was no risk assessment for staff to support them to identify when this person had unstable blood sugars, the triggers and signs of this. This meant staff did not have relevant health information or specific information regarding risks and method of mitigating the risks. We discussed this with the registered manager who contacted a healthcare professional soon after the inspection and supported staff to write a diabetes risk assessment plan.

In another care plan, it was noted that someone was at risk of having epileptic seizures. We saw that there was a risk assessment in relation to this but this was not detailed, and did not provide guidance or any further information instructing staff on what action they needed to take, to reduce the risk. When we brought this to the attention of the registered manager she told us relevant information was in a separate document, which we saw. However, the risk assessment did not refer staff to this guidance. This was not an effective method for informing staff on how to reduce the risk. The registered manager and the deputy manager agreed this was not clear and would update the risk assessment to make it clear to all staff working with the person.

Another person using the service did not have a care plan or risk assessment to advise staff of how to provide appropriate care and treatment. Staff told us the person repetitively asked for water. Drinking water excessively could cause hyponatraemia. This is hazardous and could lead to hospital admissions, seizures and in extreme cases death. However, when we looked at the care records of this person there was no record of the diagnosis nor was there a care plan or risk assessment. The management and staff were not aware of the specific diagnosis. Following the inspection, the registered manager told us that she had contacted this person's GP, and that the GP had confirmed a diagnosis. The registered manager also sent us the care records of this person that she had acquired from the person's GP. The records confirmed that the person had previous episodes of hyponatraemia. The absence of this medical history, care plan and risk plan, meant this person was not always protected from associated risks because assessments of their needs did not include all relevant potential risks and how to reduce these.

The fire safety arrangements for the home were not safe. During the tour of the home with the home's health and safety lead officer, we observed that there were two unmounted fire extinguishers on the first floor which were kept locked in a side cabinet. The side cabinet had a keypad code for access. The cabinet was full of clutter, including a broken fan. On the ground floor we also saw that there were unmounted fire extinguishers near the fire panel and another unmounted fire extinguisher in the laundry room. This meant

that in the event of a fire, staff would have difficulties to access the extinguishers.

The care records of people did not contain Personal Emergency Evacuation Plans (PEEPS). When we asked the registered manager and the deputy manager about this and they told us that they had not, "heard of PEEPS." This meant individuals who may not be able to reach a final place of safety unaided or within a satisfactory period of time in the event of any emergency did not have an up to date evacuation plan.

The above is evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We completed a tour of the premises as part of our inspection and saw that some areas of the premises were unsafe and required attention in order to reduce risks to people. The driveway at the front of the service was in a poor state of repair. We observed that the driveway was littered with hazards including potholes, loose stones and other debris from damaged tarmac, which posed risks to people. This had also been identified in numerous audits carried out by the provider as an area of priority because it was used as an escape route in a fire emergency. A few parents had raised concerns about the state of the driveway, citing risks of falls to people.

During our tour of the premises we also saw that emergency lighting system required repairing. Three emergency lights were not working, including one at the landing near the front door, a second on the first floor and the third on the second floor. This meant there was no sufficient backup to the normal escape route lighting to assist people to evacuate the premises in case of an emergency. When we brought this to the attention of the registered manager, she told us an engineer had been booked. However, we saw from records this had been a pending issue since September 2016.

The hot water supply and showering facilities at the home were faulty. During the inspection we carried out checks of the ground floor toilet, three people's bedrooms, shower room, the middle toilet on the first floor and the kitchen. We ran each hot water tap for up to three minutes to allow sufficient time for the water to heat up. Of the six hot water taps tested, only the kitchen basin had hot water, all other taps ran lukewarm water and in some instances we noted that water flow was also restricted. This was also true of the shower; which was running with lukewarm water. Following the inspection, the registered manager informed us that this was due to a faulty secondary hot water pump which was not circulating the hot water. We have since received evidence this has been repaired.

We found the provider had failed to ensure the facilities are maintained for the delivery of care in order to meet people's needs safely and effectively. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

People were not protected against the risk of the spread of infection. For example, we saw that staff did not follow the correct procedures for managing soiled laundry. Staff told us and we confirmed with the registered manager and the deputy manager that soiled laundry was washed in the shower room before it was carried to the laundry room. There was an infection control policy but this was not detailed and current. We recommend the service ensures the Department of Heath Guidelines on Infection Control are followed to ensure people are protected from the risks associated with cross infection.

We reviewed staff records and saw all employees underwent pre-employment checks including enhanced

Disclosure and Barring Service (DBS) checks. This meant the service had in place a robust approach to vetting prospective members of staff. This helped to reduce the risk of unsuitable staff being employed.

People's medicines were administered safely. We looked at the medicine records, which indicated people received their medicines as prescribed. Records showed that all staff who administered medicines had been trained to do so. We looked at the medicine storage facilities and found that medicines were stored properly.

The MAR charts were signed and up to date. Staff kept an on-going record of how much medicine was administered and how much was left, to make sure medicines were always available when people needed them. Audit records showed management regularly checked medicines were stored, administered and disposed of safely.

We saw people were protected from the risk of abuse and avoidable harm. The risk of abuse was minimised because there were clear policies and procedures in place to provide staff with information on how to protect people in the event of an allegation or suspicion of abuse.

Staff had received training in how to safeguard people. They were able to explain the types of abuse that people were at risk of, who they would report this to and where the relevant guidance was kept. We saw staff had previously raised concerns with the registered manager and she had reported and dealt with the matters appropriately.

Requires Improvement

Is the service effective?

Our findings

On the day of our visit we found the home was not always following the guidance of the Mental Capacity Act 2005 (MCA). The 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.

We looked at people's records and found that best interests decisions had not always been made for all people receiving care. The service had not followed the principles of the MCA in relation to the care of one person. There was no assessment carried out in respect of a restriction that was in place for this person. Staff told us and we confirmed from records that this person was restricted from drinking fluids. We looked at this person's fluid intake chart and saw that they were restricted to drinking 250mls of fluids at specific times of the day; 8am, 10am, 12pm, 4pm, 5pm and 6pm. We observed during supper at 7pm, that this person was asked to leave the table before staff could serve drinks to others. We asked staff why this person was being asked to leave the table before they had a drink and we were told this person was not allowed to have drinks after 7pm. The care records of this person did not have evidence of best interests meetings having taken place. This meant that the service could not demonstrate that they were always complying with the principles of MCA.

The above concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; need for consent.

People can only be deprived of their liberty so that they can 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 within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met in respect of other people living at the home. We found in all other examples that DoLS were in place or had been requested for people who required some form of restrictive care to keep them safe. Best interests decisions had included external healthcare representatives and family members to help ensure the person's views were represented.

We looked at how people were supported to maintain good nutrition and hydration. We saw people had specific care plans in place with regards to nutritional intake. This provided an overview about peoples likes and dislikes. For example, the care plans recorded if people required assistance to eat their meals and if they had been referred to other agencies such as SALT (Speech and Language Therapy) or the dietician. We saw two people had input from a dietitian for weight loss and risk of choking.

Our observations showed that people at the service had access to drinks and snacks throughout the inspection visit. They were provided with a choice of hot or cold drinks. Relatives and an advocate of one

person told us that the food was fine and that people were offered a choice at meal times.

Staff were knowledgeable about people's food preferences and nutritional needs. People's dietary needs had been assessed and planned for, including consideration to people's needs associated with their cultural or religious needs.

Overall, people received input into their care from external healthcare professionals such as opticians, chiropodists and GP's. In addition, where people needed more specialist input into their care, from, for example speech and language therapists and challenging behaviour teams, this input was sought by the service. However, we saw that this input had not been sufficiently facilitated for one person.

Relatives and healthcare professionals told us they believed staff were well trained and provided effective care. One relative told us, "Staff do a great job." Professionals, including a district nurse, epilepsy nurse, physiotherapist, and an occupational therapist were equally complimentary about the competence of staff. The feedback included, "Staff look after people well", "Staff follow instructions" and "Staff are open and honest."

The registered manager told us newly recruited staff were working towards completing the care certificate. The induction provided staff with the core training they needed to be able to undertake their role effectively and provided them with an introduction to working in a caring environment. The induction was described by staff in positive terms. The registered manager told us new members of staff spent time working with more experienced staff, until they got to know people and were confident and competent to work unsupervised.

We looked at the training matrix. This showed staff had completed a range of training including medication, moving and handling, health and safety, fire, food hygiene, safeguarding and infection control. We noted some staff required updates in MCA, DOLs and epilepsy training, which we saw was scheduled to be completed.

Requires Improvement

Is the service caring?

Our findings

Relatives and professionals told us that staff were caring. One relative told us, "My relative is respected." A representative of one person told us "Staff care about people."

We observed that staff were kind, caring and friendly in their approaches to people's care. We saw staff demonstrated kindness to people, such as holding the hand of an anxious person until they were settled in a seat they liked during lunch time. In another example, staff were able to successfully comfort a person who had become agitated and they understood each person's personality which made it easier for them to support people with their individual needs.

However, although staff showed a caring attitude, some management decisions had ensured deterioration in the overall quality of care provided. Some staff expressed concerns that people's choices and preferences were not always respected. For instance, some staff were not comfortable with the practice of waking up people two hourly during the night as part of managing incontinence. Staff told us some people were not having adequate sleep as a result. The service had not sought professional input, to explore individual ways of managing incontinence. We viewed the sleeping pattern of one person for the whole of December 2016 and 1 January to 15 January 2017. We saw that over this period, the person had slept an average of three hours per night. Whilst there may have been other factors why this person could not have adequate sleep, waking people up every two hours may not have promoted enough sleep.

In another example, we saw that during supper people were served biscuits and given drinks at the end. Whilst, everyone was being given drinks after eating biscuits, one person was asked to leave the table. We observed that the person wanted a drink but was led out of the room. We asked why this person was not offered a drink and staff told us they were not allowed by management because the person was incontinent of urine during the night. Some staff told us they found the practice uncaring.

The provider must therefore ensure that improvements are made to support people's choice and dignity.

Staff supported people to maintain relationships with those important to them, such as relatives and friends. We observed people could have their friends and family visit when they wished and we saw staff facilitated contact when necessary. A relative told us, "The keyworker of my [relative] is excellent. [The keyworker] sends videos to show and to update us on the progress of our [relative]. We have received a video to show that our [relative] is eating well." Relatives told us that they were always made welcome when they visited their relatives. They were also included in activities which took place and were invited to special events held at the house like birthdays, Christmas and summer BBQ's.

None of the people living at the home were able to express their views clearly because of their complex needs. We saw the service made effort to ensure their views were heard and acted on. People who had difficulty communicating were enabled to give their views through a range of means. We saw many examples of communication tools and systems, each tailored to the specific needs of the person, including those associated with facial expressions, gestures, Makaton, symbols, objects of reference and PECS (Picture

Exchange Communication System). Additionally, the service consulted with people's relative.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. We received mixed messages from relatives and staff. Some staff told us the service was responsive whilst others disagreed. We checked records and observed care and found the service required some improvement in this area.

Care plans did not always contain the correct information to enable staff to be responsive to people's needs. We were told by staff that three people were woken up routinely, every night to use the toilet every two hours as practice to manage urine incontinence. This was also confirmed by the deputy manager and the registered manager. We looked at the care records of two people who were affected by this practice. We saw that details of this practice were not recorded. The registered manager and the deputy manager confirmed this practice was not recorded. This was discussed with the registered manager and we asked them to review and acknowledge people's preferences in relation to their sleeping routine.

There was a record of the sleeping pattern of the third person. We viewed the sleeping pattern of this person for the whole of December 2016 and 1 January to 15 January 2017. We saw that the person slept an average of three hours per night. We were concerned because the practice was not person-centred and not based on each person's individual choice and preference. The service had not sought professional input, to explore individual ways of managing incontinence, whilst at the same time promoting adequate sleep.

At this inspection we found that whilst care plans contained some good person centred detail, they were minimal in detail in other areas. People had person centred plans; health action plans (HAP) and communication passports. However, one person, who had moved into the home a few years ago, did not have person centred care plans in place in relation to their specific medical condition. So, even though there was medical need to restrict fluid intake for this person, this was not carried out in a person centred manner. Staff told us the person repetitively asked for water throughout the day. However, the liquid intake monitoring form showed the person was only offered 250mls of fluid (water, tea or juice) at specific times of the day. The person was offered drinks at 8am, 10am, 12pm, 4pm, 5pm, and 6pm. There was no documented care plan regarding this practice. Therefore, there were no reviews to check if this suited the needs of this person. Following our inspection, we saw medical notes from the person's GP, which suggested that the service adjust the fluid quantities slightly to smaller drinks during the day so that the person could have more drink in the evening.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; person-centred care.

We also saw the results of the latest survey. This had been carried out on staff, professionals, people receiving care and people's relatives. Although, an analysis of the survey had been carried out, the method used to analyse was not suitable to the type of data collected. The service had carried out a survey on four groups and had analysed the feedback together, without distinguishing between the different groups. So, for instance, when the service reported the results of the survey that 87% of respondents were satisfied with the service, it was not clear how many respondents from each group were satisfied. This meant the service

could not tailor responses to specific issues arising from each group.

Improvements are therefore required within this area to ensure that the views and concerns of people and those of their relatives or representatives are adequately responded to.

There was no indication of what had been done in response to the surveys. The registered manager told us they had contacted people individually to discuss their suggestions, however, there was no reference to suggestions or comments or areas identified for improvement. This meant that although there were opportunities to feedback, the provider could not assure us they had responded to people's feedback adequately.

There was a complaints policy in place. Relatives told us they were aware of this and a copy was included in the admission pack and in the bedrooms. Relatives told us they would complain to the registered manager or staff if they were unhappy. We saw the complaints made during the last six months and were satisfied that they had been processed and concluded. However, we found there was no analysis of complaints and no learning had been highlighted in response to the complaints received. This meant that although the provider responded to complaints, there was no evidence to demonstrate that this was used to improve practice or the quality of care for people.

Improvements are therefore required within this area to ensure that the views of people and those of their relatives are used to improve practice.

The home had a varied programme of activity and entertainment on offer. A weekly activities planner was given to people to keep in their room. This was also displayed in the home for information. Activities included board games and music. In addition to organised activities, the home also scheduled unique observances throughout the year, including Diwali Festival, Christmas and Birthdays. We observed participation was voluntary and there were other lounges available for people who did not want to take part in organised activities. We could see the benefits to people's well-being. People looked comfortable and happy.

Requires Improvement

Is the service well-led?

Our findings

Some relatives told us they were pleased with the service. One relative told us, "Staff keep us informed. They tell us what is going on at the home". Another relative said, "The manager and staff are always available if we need them." We also received positive feedback from professionals we spoke with. One healthcare professional told us, "I am pleased with the communication of the managers at the home". We received mixed feedback from staff regarding the leadership of the home.

However, despite some positive feedback about how well-led the service was, we found the service required improvement in this area.

We found the provider's systems for monitoring and reviewing the effectiveness of the care provided was not effective. The provider's own quality audits had failed to sufficiently identify the shortfalls we have highlighted in this report. For example, we saw there had been a failure to identify shortfalls in care records. Some risk assessment records did not provide appropriate guidance for staff about how to minimise risks and some care plans were not accurate and reflective of people's current needs. This meant that staff were not always able to deliver person centred safe care.

We saw the service did not have effective systems to ensure that where risks were identified, measures were introduced to reduce or remove the risks. For example, the registered manager provided us with audits that were carried out between March and November 2016. These audits had identified some shortfalls, including some maintenance work and health safety issues, yet these repairs had still not been carried out by 19 January 2017.

There were no audits that looked at the quality of people's care records. We asked the registered manager to show us what quality assurance systems were in place in relation to people's care plans and risk assessments. The registered manager told us this was an area they wanted to develop. We were shown a new audit form, which the registered manager said was going to be used as from January 2017 to audit people's care records. This meant that at the time of this inspection the service did not check to make sure that people's records were up to date and complete.

We saw that surveys had been completed and the results had been analysed. Where improvements had been identified action plans had not been put in place to improve the service. For example, suggestions had been made to improve front driveway but no action had been taken to make improvements. We spoke with staff and some told us they lacked confidence that things would be made better.

The above is evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

The registered provider was responsive to our feedback, and as a result of our findings informed us of a number of immediate changes they had made. This included reviewing and improving people's care records, repairing the driveway, water system, and fire safety and emergency measures.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Registered persons had failed to ensure that people's care plans met their needs, preferences and had failed to meet people's assessed needs in relation to their sleeping routines and hydration preferences. Regulation 9 (1)(a)(b)(c)(3) (a) (b)(c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always provide care and treatment with the consent of the relevant person. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to adequately assess and mitigate risks to people. Regulation 12(1)(2)(a)(b) (d) (e) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider and registered managed had failed to ensure the premises were suitable to meet people's needs. The premises and

equipment were not properly maintained.
Regulation 15 (1) (c) (e)

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 17 HSCA RA Regulations 2014 Good governance Adequate systems and process were not in place to evaluate and improve the quality of the service people received. Regulation 17 (1)(a)(b)(c)(f)

The enforcement action we took:

We served the provider a warning notice and told them to comply with the Regulation by 10 March 2017.