Rose Petals Health Care Ltd

Clare Mount

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clare Mount is a residential care home providing personal and nursing care for up to 29 in one adapted building. At the time of the inspection there were 26 people using the service.

People's experience of using this service and what we found
Medicines were not managed safely which placed people at risk of harm. Risks to people's health, safety and wellbeing were not managed safely and there was a lack of guidance in place to support and manage people's behaviours. People's health needs had not always been escalated and there was a delay in people receiving timely healthcare.

There was a high turnover of staff at the home and communication was poor. The majority of staff did not have English as their first language and some did not always actively try to engage with people living at the home. Staff records showed that staff had received training, but could not always demonstrate this learning. There was a lack of training for staff around support for people's behaviours that challenged and most staff had no previous experience of working in care.

Care records were not detailed enough and there was conflicting information in people's care plans. There was a lack of personalised care at the service, shared laundry and a lack of stimulation. There were limited social activities on offer for people and some people told us that their television and radio were broken. People's spiritual and religious needs were not being met.

We received mixed feedback from people and their families about the service. Relatives told us there was a lack of communication at the service and a lack of privacy and dignity for people. Some relatives told us people's rooms were not always clean. There was a lack of oral healthcare for people and people's health needs were not always met. The culture was poor at the service and people's humans rights were not being upheld.

People generally told us that the food was good and one relative remarked how their family member's weight had increased since being at the service. Professionals that had recently visited the service gave positive feedback about the staff, who they said were caring and helpful. Staff we spoke with told us that the registered manager was supportive and team meetings were taking place.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always follow infection control procedures and the home was not clean in some areas.

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

Rating at last inspection
The last rating for this service was good (published 13 January 2021).

Why we inspected
We received concerns in relation to staffing and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

The provider had taken action to mitigate the risks following inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clare Mount nursing home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, staffing, person centred care and good governance at this inspection. We have also made a recommendation around mental capacity and DoLS.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Clare Mount

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection took place over five days and was undertaken by two inspectors, a medicines inspector and a specialist nurse.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information that we had received about the service since the last inspection. We sought feedback from the local authority who had shared some concerns about the service.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and nine relatives about their experience of the care. We also spoke with two visiting professionals and one social worker. We spoke with eleven members of staff including the registered manager.

We reviewed a range of records, which included four people's care records and records about medicines for 16 people. We spoke with one nurse who had responsibility for administering medicines on the day of the inspection. We looked at ten staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification and requested further information from the provider to minimise the risks that we found on inspection. The provider sent us an action plan with timescales addressing our immediate concerns. We also arranged a meeting with the provider to enable them to give further reassurances.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

Systems and processes to safeguard people from the risk of abuse

- Staff's understanding of safeguarding was limited. For example, we became aware of an individual who had approached us in pain, from a serious skin breakdown on their back. We raised this as an issue with a staff member who did not recognise this as a problem and told us that it was not being treated.
- Written records did not reflect the extent of an open wound and we raised a safeguarding alert regarding this with the local authority and ensured the person had access to medical treatment.

Systems were not robust enough to safeguard people from the risk of abuse. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Some people told us they felt safe at the service and family members felt that their relatives were safe. One relative told us, "[Relative] is my world, I would not have her here if it was not good care."
- According to staff training records staff had received safeguarding training and we saw evidence of group supervisions around safeguarding policies.

Assessing risk, safety monitoring and management

- Risks were not being managed effectively. We found choking risk assessments did not contain sufficient detail to keep people safe and there were no strategies in place for managing people's behaviour safely. This was raised with the registered manager urgently and updated choking risk assessments were sent to us.
- We found gloves on display in the corridors which were a risk, as these could be picked up and ingested by people. This was raised as an issue and the registered manager removed these.
- Bath hoists were not fitted with safety belts in line with current safety guidelines. The registered manager sent evidence following inspection that this had been addressed.
- The cleaning cupboard door was found unlocked on two separate occasions which was a risk that people may access chemicals. The staff member apologised and ensured that these were kept locked.
- The fire system was bleeping continually and this had not been picked up by anyone. This posed a risk that staff were not taking fire safety seriously and could potentially put people at harm. We raised this as an issue with the registered manager who ensured that this was addressed.
- Fire drill records showed that not all staff were taking part, which also raised concerns about the competency of staff to manage risks around fire safety.

We found no evidence that people had been harmed, however systems were not robust enough to demonstrate safety people and the environment was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014

● Environmental checks were being undertaken and we saw evidence of this, for example, regular call bell checks, water temperature checks and emergency lighting.
● The home was secure and keypads were fitted to all external doors. Accidents and incidents were recorded and monitored.

Using medicines safely.
● Medicines were not managed safely. Some people missed doses of their medicines and creams because there was no stock available in the home. For example, one person did not receive prescribed eye drops for 18 days.
● Time sensitive medicines and medicines prescribed to be given when required were not managed safely.
●Records showed that medicines and creams were not always given or applied as prescribed. There was conflicting information recorded about some people's allergies. We also found that not all medicines were stored safely.
● No records were made to show that medicated patches and infusions to treat Parkinson's disease or insulin injections sites were rotated in line with the manufacturers' directions. We also saw was a lack of information about how people with diabetes should be supported for example there was no safe range for their blood sugars recorded or actions to take if they were outside the safe range. These issues were raised with the registered manager who acted on this information.

Systems were not robust enough to demonstrate that medicines were being managed safely. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff responsible for administering medication received appropriate training and competency checks of staff were being completed.

Staffing and recruitment
● There was a high staff turnover at the service. This meant that people at the service did not receive consistency of staffing.
● The registered manager did not ensure that recruitment was safe and appropriate checks were not always taking place. There were concerns around the quality of the references received and the validity of some references.
● There was conflicting information about which staff should be working on shift and their roles and responsibilities. We raised this as a concern with the registered manager and have requested detailed information about staffing.
● One staff member had conditions of employment imposed by another regulator and these were not adhered to. Rota's showed the supervision arrangements of this individual were insufficient.
● Some people and relatives told us that at times they struggled to understand staff. We observed some people struggling with staff's dialect and whilst speaking with staff noted that they did not always understand.
● People being supported on 1-1 support was not always managed in a person-centred way.

We found no evidence that people had been harmed, however systems for ensuring staff received support, training and professional development was not effective. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● Staffing levels were safe and at the time of inspection there were appropriate numbers of staff.
● People we spoke with told us the staff were caring and that they were generally happy with them. We observed some good interactions with certain members of staff.

Preventing and controlling infection
● Infection control procedures were not being followed. There was plenty of personal protective equipment (PPE) in stock but it was not being used effectively to safeguard people and staff. Staff did not always wear masks and some staff were wearing them under their chin. This included the registered manager who was not leading by example.
● A domestic was working throughout the day, however, parts of the home were not clean and the cleaning routine in place was basic. We saw some soiled bedding and dirty handprints to some walls and doorways. We raised these issues as immediate concerns with the registered manager who took actions to address them.

We found no evidence that people had been harmed, however infection control procedures were not being followed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a process in place to ensure staff and visitors were tested on arrival to the home. Specific risk assessments were in place in addition to an IPC audit.

Learning lessons when things go wrong
● there was little evidence seen of learning lessons when things go wrong. Following on from inspection we could see evidence that the RM had held a lessons learned meeting to discuss the safeguarding where an individual did not receive their eye drops for a lengthy period of time. We saw measures were put in place to prevent a reoccurrence of this happening.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not always accurately assessed and linked to detailed care plans.
- There was also conflicting information in care plans. For example, care plans acknowledged the need that individuals required full support for personal hygiene but there was no guidance for staff on how to support people with this effectively, including their personal preferences.
- Information was basic and there was little consideration of people's emotional and behavioural needs in assessments. There was a lack of guidance and strategies in place for dealing with people's behaviours to ensure people were kept safe. For example, there were no clear strategies for staff to follow to ensure that they were consistent in how they managed the care of people who may display behaviours which could challenge others.

We found no evidence that people had been harmed. However, the systems for ensuring assessments and care plans were accurate and reflected people's needs were not effective. This placed people at risk of harm. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008/ (Regulated Activities) Regulations 2014

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- There were concerns around healthcare support. Oral hygiene needs were not being met at the service. Records showed that people had received oral care when they had not.We found that tubes of denture adhesive had been provided for people instead of toothpaste. The registered manager apologised for this oversight and replaced these with appropriate toothpaste.
- During the inspection we observed unmet health care needs for one individual and spoke to a relative who had concerns that the service had not contacted the GP when they had told the family that they had. The individual subsequently was admitted to hospital, but the family felt that the service should have acted sooner.
- We were also told about concerns around chiropody and how relatives had to prompt the service to ensure these needs were met. We also received feedback that some people had missed vital health appointments due to communication issues. We raised this an urgent issue with the registered manager and reiterated the need for escalating health care needs appropriately in a timely manner.

Systems for ensuring people had their healthcare needs met were not effective. This placed people at risk of harm. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008/

(Regulated Activities) Regulations 2014.

● We also saw evidence of professional visits and referrals to external agencies. Feedback from visiting professionals during inspection was positive and they told us that staff acted on their advice.

Staff support: induction, training, skills and experience
● The registered manager had not ensured that staff had the skills and knowledge to meet people's needs effectively.
● Although the training matrix showed staff had undertaken training in various subjects, when staff were asked they struggled to say what training they had received other than recent dementia and moving and handling training. Staff were not knowledgeable and said they did not find it easy to retain knowledge from the online training sessions. Some staff members had not been included on the training matrix, which indicated that they had not received any training.
● There was an over reliance on the nurse on shift and some staff seemed to lack initiative. For example, when questioned about people's specific needs, staff tended to say that they would check with the nurse on duty.
● Most staff were new to working in care and new staff were shadowing staff that had only been at the service a few months themselves. This meant that there was a lack of experienced staff at the service.

We found no evidence that people had been harmed. However the systems for ensuring staff had the training, the support and experience to competently undertake their role. This placed people at risk of harm. This was further evidence of a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

● Records showed staff had completed inductions and there was evidence of basic supervisions taking place.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty and the appropriate legal authority and were being met.

●The registered manager had submitted DoLS applications where people were being deprived of their liberty.
● According to the training matrix, staff had received training in MCA and DoLS. However, not all staff had received this and staff did not have a good understanding of how to support people human rights in line with the legislation. For example, we observed one staff member disrespectfully telling a resident to sit down, as she "always wandering" and documentation around people's consent was inappropriately being signed by staff members, not service users or their legally nominated deputy.

We recommend the service ensure that all staff are clear about their understanding of the principles of MCA and DoLS.

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

● The physical layout of the building did not lend itself to support people with dementia effectively, for example, for those who enjoyed walking around.

● Most people were sat in the lounge and conservatory at the far end of the building, which was very noisy and connected by a series of long corridors to the front of the building. The quiet lounge at the front of the building was currently being used for visiting so was out of access for people.

● There was dementia friendly signage throughout the home. However, there was no identification of people's rooms. The registered manager contacted us following inspection to show us changes that had been implemented.

● Some bedrooms were in need of redecoration and were not person centred.

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

● People were supported to maintain a balanced diet. Menus reflected what was being offered and people told us they had a choice of food.

● Dining room tables were set with tablecloths and cutlery and we observed people enjoying their meals. Most people told us that they enjoyed the food and we saw evidence of the people being asked for feedback on the menus.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care was not person centred at the service. One person who spent all their time in their room, told us they did not have a working TV and there were no batteries for their radio.
- The registered manager had failed to ensure that one person's religious and cultural needs were being met, as they were unable to light candles and practice their faith.
- Care records did not reflect how people's needs were being met in a personalised way. Records stated full support required, with no indication of people's personal preferences. Women at the service were being supported with personal care by male carers, many of whom lacked capacity to make this choice and could not communicate.
- There were issues around laundry at the service, with clothing being shared between residents and there was a distinct lack of underwear found in people's rooms. These care practices , which was demonstrate a lack of respect for peoples individuality and dignity.
- The main lounge was very noisy and institutional in nature, people were sat around the edges of the room, with staff on 1-1 standing over them. We observed one staff member telling an individual to sit down and the person became annoyed. We asked the reason why they had to sit down and were told that "it's because they like to roam everywhere." People we could speak with told us it was "chaos" in the lounge and "extremely noisy."
- Several people were walking around without slippers on their feet and some people's hair looked very greasy. Deodorants in people's rooms were intended for men but women were also expected to use these.

Systems for ensuring that assessments and care plans were accurate and reflected people's needs were not effective. This placed people at risk of harm. This was a further breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008/ (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager was aware of the AIS and told us that information could be provided in a variety of formats.
- People that had difficulty communicating had access to communication passports with pictures that they could utilise when expressing their needs. There was evidence of user-friendly information and dementia

friendly murals.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● There was limited stimulation for people at the service. On the first day of inspection we saw people watching TV and engaging in some puzzles. Although there was an activity coordinator employed at the service they were providing 1-1 support during our inspection. There was limited evidence of activities for people and records showed that evaluation of activities had not been taking place recently. We observed a singer visiting the service on the final day of inspection and we saw people dancing and enjoying themselves.

● From our observations, people on 1-1 support with staff did not engage in any meaningful activities and there was a lack of sensory stimulation for people. For example, one person on 1-1 support spent all day in their bedroom with staff, just moving from their bed to the chair.

●Staff supported people to maintain relationships with their families. However, some relatives did not always feel that they had been kept updated and felt communication at the service could be improved.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place. The registered manager told us they had only received one complaint. We had seen a lesson's learned meeting that had taken place from a complaint by a family member. Although this detailed what the service had learned from the situation, it did not detail the original complaint or response to the family, so it was difficult to evidence if the service was managing complaints effectively.

End of life care and support

● No one was actively receiving end of life care at the time of the inspection. Staff had not completed training in this area and the registered manager said that this was due to be organised. Staff's understanding of how to support someone on end of life was limited.

● There was evidence of some advanced care plans in place for some individuals, but these were not detailed.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

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

- The registered manager had a lack of effective oversight at the service. Although systems for oversight were in place they were not robust enough to identify the issues that we identified.
- Governance was poor and there was a lack of oversight from the registered provider. There was no evidence of the provider undertaking audits and the issues we found on inspection had not been picked up.
- There was a lack of awareness around managing risks within the service and ensuring that PPE and infection control procedures were being managed in line with government guidance. There was a lack of clarity around recruitment and a lack of transparency around the staff that were working at the service.
- Risks around medicines and access to healthcare were not being addressed effectively by the registered manager.
- Institutional practices and a poor culture where staff did not treat people as individuals meant some people's human rights were diminished.

The provider had failed to ensure systems for governance and management oversight were robust and effective. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

- The registered manager submitted statutory notifications to CQC.

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

- At the last inspection we made a recommendation around considering the gender mix of staffing. Staff providing personal care to females with capacity issues and communication difficulties were predominately male. At this inspection, although more female staff had been recruited, there were still more male staff than women. We raised this as an issue with the registered manager who advised us that four new female staff that had been specifically recruited.
- Staff had completed a feedback survey, but it was service orientated and did not focus on their own personal experience. We saw evidence of supervisions taking place, but these were mainly group supervisions focusing on training aspects and did not allow for staff to discuss any concerns or issues that they may have.
- The registered manager provided incentives for the staff team, such as employee of the month and the

company had their own football team. Team meetings were taking place regularly.

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

● People did not always receive good outcomes. There was a lack of personalised support and the culture of the service was poor. People's individuality was not recognised and upheld and some of their fundamental human rights were not protected.

●The service had a regular newsletter that was displayed on the noticeboard but relatives we spoke with had not received copies and felt that communication at the service was poor. One relative told us, "They don't communicate, we don't know what's going on."

● Some relatives told us that they had not been updated about visiting guidance during covid and felt that they had find out information for themselves. "There was no regular updates during covid and I just felt like I was bothering them when I dropped things off."

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● The registered manager had fostered good links the local authority and other visiting professionals to the service. They had participated in multi-agency meetings with professionals and had provided information to the CQC when requested.

● The registered manager was aware of their responsibilities under the duty of candour.

Continuous learning and improving care

● The registered manager put an urgent action plan in place, to address the issues which we found on inspection. They had engaged the services of a consultant to support them and to make the necessary improvements required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments and care plans were not always accurate and did not reflect people's needs. People at the service did not receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the experience, training and support to competently undertake their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks were not always fully assessed and managed to reduce the risk for people at the service. Infection control procedures were not being managed safely. Medicines were not always being managed safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Good governance

The enforcement action we took:

Warning notice