Abbey Court Nursing and Residential Homes Limited

Abbey Court Nursing and Residential Home

Inspection report

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Date of inspection visit:
27 January 2020
30 January 2020

Date of publication:
20 April 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Abbey Court Nursing and Residential Home is a nursing home providing personal and nursing care for up to 40 people. There were 36 people living at the home at the time of our inspection. The service provides support to older people with a range of support needs including complex health conditions and dementia.

The service is a large adapted property. Accommodation is split across three floors and there are several communal living areas.

People's experience of using this service and what we found
Risks associated with people's care and support and the environment were not managed safely. This placed people at risk of harm. Opportunities to learn from incidents had been missed. Medicines were not always stored or managed safely. There were not always enough staff to meet people's needs and ensure their safety.

Overall, safe recruitment practices were followed, and the home was clean and hygienic, some equipment and furnishings required cleaning to ensure effective infection prevention.

People were not supported to have maximum choice and control of their lives and staff did not always 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. People were at risk of dehydration and malnutrition due to poor monitoring and failure to follow nationally recognised guidance.

Overall, people were supported with their health needs and had access to healthcare services, although care plans did not always contained personalised health information. Overall, the home was adapted to meet people's needs. People were supported by staff who had the training and support required to provide effective care.

People were not always provided with dignified support and staff did not always respect their right to privacy. Whilst people told us staff were often kind and caring, we saw this was not always so. We received variable feedback about people's involvement in their care.

People were not always provided with individualised care that met their needs and reflected their preferences. Staff did not consistently have a good understanding of people's needs. There was limited evidence that people and their families had been given the opportunity to discuss their end of life wishes. People were provided with opportunities for activity and were supported to stay in touch with people who were important to them. People and their families felt comfortable raising any complaints or concerns.

Abbey Court was not well led. The registered manager did not have adequate time to oversee the running of the home. The provider did not operate effective governance systems to ensure the quality, safety or

improvement of people's care when needed. There had been a failure to identify and address issues with the health, safety and quality of care provided. Audits were not always effective, and the provider did not have sufficient oversight of the running of the home. There were limited opportunities for people and staff to get involved driving improvements. The management team worked in partnership with health and social care professionals and had links with the community.

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 requires improvement (report published 27 September 2019).

Why we inspected
The inspection was prompted, in part, due to concerns received about unsafe moving and handling practice and neglect of people's care needs. A decision was made for us to bring the scheduled inspection forward and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this report.

Enforcement
We have identified breaches in relation to risk management, the environment, safeguarding, staffing, consent, how people are treated and leadership and governance at this inspection. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published, to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authorities, to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Abbey Court Nursing and Residential Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Abbey Court 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 information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and three relatives about their experience of the care provided. We spoke with three members of care staff, a nurse, a member of the catering team, the administration manager, the registered manager and one of the company directors.

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

We reviewed a range of records. This included eight people's care records and multiple medicine records. We looked at four staff files in relation to their recruitment and 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 from the provider to validate evidence found. The reviewed information the provider sent us about staff recruitment, training and fire risk management.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not consistently protected risks associated with their care and support.
- Risks were not always managed safely. For example, there were not sufficient control measures in place to alert staff to the risk of people falling, which meant staff were not able to intervene to reduce risk. Some equipment intended to reduce injury resulting from falls may have increased the likelihood of people falling and there was no evidence that people's wellbeing was monitored when they had sustained an injury because of a fall.
- People were not adequately protected from environmental risks. Some areas of the home posed a risk to people. Dangerous building equipment and an area of the home which was being extended were accessible to people. This posed a risk of people sustaining injury.
- People were not fully protected from the risk of fire. Evacuation plans were not sufficient and there were not adequate checks to ensure fire control measures were in place and effective. These issues increased the risk that people and staff may be harmed in the event of a fire. We informed the local fire service.
- People were not adequately protected from the risk of Legionella. The Legionella risk assessment was out of date and there were not sufficient control measures in place to reduce the risk of legionella growth in the water supply. These issues increased the risk of legionella developing which could have a negative impact on people's health.

Learning lessons when things go wrong

- Opportunities to learn from adverse incidents had been missed.
- There was no evidence that action was taken following incidents to reduce future risk or address issues with staff practice. One person had sustained an injury whilst being supported by staff. The incident had not been reviewed, consequently there was no evidence any remedial management actions to prevent any reoccurrence.
- Patterns and trends of accidents and incidents had not been identified and consequently risk reduction measures had not been implemented. For example, one person had spilt a hot drink on themselves twice, the second time sustaining a scald. Their care plan did not clearly outline risk reduction measures. This meant the person remained at risk of harm.

Using medicines safely

- Medicines were not always managed safely.
- The provider had not ensured that all staff responsible had the competency to administer people's medicines. A nurse had not had any training in medicines management since they started work at Abbey

Court and their competency to administer medicines had not been assessed. This posed a risk of unsafe medicines practices.
● Protocols for the administration of 'as required' medicines were not adequately detailed. There was not always sufficient information about indicators of people's pain to consistently guide staff to administer their 'as required' pain relief. This posed a risk that the medicine may not be administered effectively.
● Medicines were not always stored safely. Medicines were left unsupervised in communal areas. This posed a risk that people may access medicines not prescribed to them.

The failure to provide consistently safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not fully protected from the risk of abuse.
● Background checks had not been completed on family members of staff who lived in flats above the service. These people were able to access the service. The risk of these people having unrestricted access to people living at the home had not been mitigated. This risk placed people at risk of abuse.

The failure to protect people from abuse and improper treatment was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not always enough staff deployed to ensure people's safety and wellbeing.
● The majority of the people and staff we spoke with told us they did not think there were enough staff. This was also confirmed by our observations of people's care.
● Staffing levels were not based upon an assessment of people's needs. This meant there was no formal way of ensuring staffing levels were sufficient to meet individual need. This had an impact at key times of day, in particular mornings. Insufficient staffing levels meant people were left waiting for assistance to go to the toilet, this was undignified and posed a risk to their skin integrity. We have reported further on this in the 'Caring' section of this report.

The failure to deploy enough staff, was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices were followed; however, further work was required to ensure the physical and mental health of staff was considered when recruiting. The administration manager commenced action to address this during our inspection.

Preventing and controlling infection
● Overall the environment was clean and hygienic. Personal protective equipment was available to staff and we observed staff followed infection control procedures.
● However, we found, some furniture and items of equipment were not clean, or were damaged, which did not promote effective cleaning.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 had the appropriate legal authority and were being met.

● People's rights under the MCA were not respected as there was no evidence that decisions made on behalf of people were in their best interests.
● There were no mental capacity assessments in place for people whose capacity to consent was in question. For example, several people's care files were marked as 'Not for hospital admission.' There were no capacity assessments in place for people who were unable to consent to this, to show how the decisions had been made and who was involved. This meant there was no evidence of compliance with the principles of the MCA.

The failure to apply the principles of the MCA was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS had been applied for as required. Where conditions were in place the home was working towards complying with them.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not effectively protected from the risk of dehydration and malnutrition.
● Weight records showed that several people had recently lost weight. For example, one person had lost eight percent of their body weight in three months. Despite this, there was no increased monitoring in place to identify any further deterioration.
● Monitoring of food and fluid intake was poor. Food and fluid records did not evidence whether a person

was provided with a specialist diet recommended by a dietician. Furthermore, the person's fluid intake was very low, staff had not identified the low intake and there was no evidence of any action take to address this.

The failure to consistently provide safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The majority of feedback about the quality of food was positive. Most people told us they had a choice of home cooked food.
● One person told us their choice of food was limited due to a limited supply of food that met their dietary requirements. This was confirmed by our observations and feedback from some staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before moving into the home. This information was used to develop their care plans.
● Although nationally recognised tools were used to assess risk these were not always used effectively. For example, a nutrition risk assessment had been scored incorrectly and this had resulted in a failure to monitor risk.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People told us they were supported with their health needs and people's relatives said they were kept informed about any changes to people's needs.
● There were positive links with the local doctor's surgery. A GP visited the service on a fortnightly basis, this meant people and families had regular access to a GP to discuss non – urgent concerns.
● A health professional spoke positively about the approach of the nursing team. They said, '(The nurses) frequently identify and report medical problems arising. They are pragmatic and engage with medical and therapy plans.'
● There was evidence that advice had been sought from external health professionals, such as physiotherapists and specialist nurses when needed.
● There was a risk people may receive inconsistent support in relation to their health conditions as care plans did not always contain personalised information about health conditions and the impact upon the person.

Adapting service, design, decoration to meet people's needs
● Overall, the home was adapted to meet people's needs.
● Aids and equipment had been installed throughout the home. This enabled people with mobility needs to move safely around the building and there was a call bell system to ensure people could request staff support.
● Some signage throughout the home did not promote a homely environment, for example, slippery when wet signs were permanently displayed on some bedroom doors.
● Some areas of the home were unsafe, we have reported upon this in the 'Safe' section of this report.

Staff support: induction, training, skills and experience
● People were supported by staff that had the skills and knowledge to provide effective quality care and support.
● Records showed staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service.

● Nurses had specialist clinical training to ensure their competency.
● New staff received a care induction when they started work at the service, this included training and shadowing experienced staff to learn from them.
● Staff told us they felt supported and records showed they had opportunities to discuss and review their work.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not consistently treated with dignity and respect.
- We observed that people did not always receive timely support with continence care. People had to request continence care multiple times in communal areas, this meant that others knew about their intimate care needs. This was not dignified.
- One person told us, "It is always like this, I have never seen anything like it, there is no wonder people end up weeing themselves."
- Staff did not always respond to people's requests for support. We observed a person shout "Nurse," two staff were standing directly behind them, but neither responded. They told us they were waiting to go to the toilet.
- A member of staff told us, "It is like this every day." They then turned to a person who was asking to go to the toilet and said, "Don't worry you are on the list." We asked if there was a list, the member of staff and said, "There isn't a list, but it makes them feel better if I say that."
- People's right to privacy was not upheld at all times. We saw records of personal care were left on window sills in the corridors. These were accessible to other people and visitors to the home.

The failure to consistently treat people with dignity and respect their right to privacy was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the above, most people and their relatives told us staff were kind and caring in their approach. We observed that, when staff had time, they took opportunities to sit and chat with people. At these times staff were friendly and professional in their manner.
- People told us they were free from discrimination and staff had training to enable them to recognise and accommodate people's diverse needs.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were involved in day to day decisions about their care.
- Feedback about involvement in care planning was varied. One relative told us, "I have input into care planning, everything is discussed." In contrast the relative of another person said, "I have had no involvement in care planning."
- The above inconsistency was also reflected in care plans, some contained person centred information

about what mattered to people, whereas other care plans were based solely on people's support needs.
● People had access to an advocate if they required one to help them express their views and there was information about independent advocacy displayed in the service. No one was using an advocate at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People were not always provided with individualised care that met their needs and reflected their preferences
- Care plans did not always reflect people's needs. Some people told us staff did not have a good understanding of their needs and said this meant staff did not provide the support they needed. One person said that staff did not provide them with appropriate skin care. Their care plan did not provide adequate guidance for staff on how to provide them with support to maintain their skin integrity.
- Staff did not always have a good understanding of people's needs. Three staff told us that they did not support anyone whose behaviour could pose a risk to others. However, this was not the case. Records showed one person sometimes behaved in a way that placed them and staff at risk. Staff lack of knowledge in this area posed a risk that the person may not get the support they required.
- There was limited evidence that people and their families had been given the opportunity to discuss their end of life care wishes. This meant some people did not have any information documented about their end of life wishes. This lack of information posed a risk that their final wishes may not be met.

The failure to ensure people were provided with person centred care was a 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 provider was meeting the requirements of the AIS. People's care plans contained information about each person's individual communication needs and staff demonstrated an understanding of this. Information could be made available to people in a range of formats to help the understand.

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

- People were provided with opportunities for activity and were supported to stay in touch with people who were important to them.
- There was a programme of activities that ran four days a week, the activities coordinator met with people and their families regularly to ensure opportunities were based upon people's interests. Activities included games, exercise sessions, art and craft, hand and nail care and music. The activity coordinator ran regular

coffee mornings and organised events such as talent evenings and cultural celebrations. They also spent time chatting with people on a one to one basis.
● People were supported to go out and about. Staff accompanied people into the local community, on the day of inspection a group of people went for a meal at a local pub together.
● People's families and friends were welcomed into the home. Visitors to the home were positive about the atmosphere and told us staff were friendly and welcoming.

Improving care quality in response to complaints or concerns
● People felt comfortable raising any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns.
● There was a complaints procedure in place and complaints had been investigated and responded to in an appropriate and timely manner. The registered manage had written to people and offered an apology for any upset caused and improvements had been made to care when needed.

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 requires improvement. 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; Continuous learning and improving care;

- There was insufficient leadership at the service. The registered manager was only allocated eight hours a week to oversee the running of the home. The lack of dedicated time for the registered manger to run the home had resulted in a failure to ensure robust and effective governance processes. Consequently, issues with the safety and quality of care cited in this report had not been identified or addressed.
- Governance and oversight of the service and was poorly coordinated and fragmented. There was no central person who had an oversight of all areas of quality and safety. This had led to disorganisation and meant the provider was unable to evidence compliance with the legal regulations in some areas. For example, no one was able to locate the fire risk assessments and checks on either day of inspection.
- Systems to check the safety and quality of the service were not effective. Consequently, issues we found at this inspection had not been identified or addressed. Care plan audits had been completed. However, these focused upon the paperwork and did not assess whether care plans reflected people's needs. There had not been any health and safety audits, this meant issues with unsafe areas of the home had not been identified or addressed.
- Opportunities to learn from incidents, address poor performance and improve practice had been missed. We found analysis of falls and other health incidents had not been conducted since September 2019. This meant themes and trends of incidents had not been identified to consider the prevention of risk.
- The provider did not conduct any formal audits at the service. The director told us they trusted the registered manager to run the service and consequently did not formally check any aspect of their work. This had resulted in a failure to identify that audits and checks were not completed regularly or effectively. This meant the quality and safety of people's care was not effectively ensured.

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

- The culture of the home did not consistently promote good care outcomes for people. We shared feedback about our observations of people waiting for care and having to ask multiple times to go to the toilet. We were told that this just how care was and it appeared to be accepted practice. This did not promote a culture of person-centred care.
- Service provision was not based upon national legislation and good practice. For example, falls management at the service did not reflect nationally recognised good practice guidance in relation to falls prevention. The registered manager did not have an adequate knowledge of the MCA. Consequently, the principles of the Act had not been applied to ensure people's rights were respected. Failure to implement

legislation and best practice placed people at risk of harm and did not always ensure their rights and best interests.

The failure to ensure effective governance and leadership was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been a failure to notify CQC of an important event when it happened within the service, which the provider is required to by law. We had not been notified of a recent allegation of abuse. A failure to notify us as required can have a negative impact on our ability monitor the safety of people's care at the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Opportunities for people and staff to get involved in the running of the home were limited.
● Regular meetings where held for staff, the purpose of these was to share information and address issues with performance. There was little evidence that staff were consulted about the running of the home.
● We were informed that a visitor held meetings with people who used the service. However, there were no records of the meetings and consequently we were not provided with any information about how the outcome of these meetings were used to drive improvement.

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 understood their duty to be open and honest with people. Records showed the registered manager had been in touch with people and their families following incidents or complaints, to offer an apology.

Working in partnership with others
● The management team told us they worked in partnership with external health and social care professionals.
● Members of the local community were invited to some activities such as annual fundraising events.

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 18 Registration Regulations 2009 Notifications of other incidents The Commission was not notified of an allegation of abuse as required. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not consistently provided with person centred care that met their needs. Regulation 9(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not provided with dignified support and their right to privacy was not always respected. Regulation 10(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act (2005) were not respected as the principles of the Act were not applied. Regulation 11(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care and support

	and the environment were not managed safely. This placed people at risk of harm. Regulation 12(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Regulation 13(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and management systems were ineffective. This had resulted in a failure to identify and address issues with the health, safety and quality of care provided. Regulation 17(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to ensure people's safety and meet their needs. Regulation 18(1)

The enforcement action we took:

We imposed conditions on the registration of the provider.