Chase Lodge Care Home Limited

Chase Lodge Care Home

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Chase Lodge Care Home is a residential care home. The care service accommodates up to 21 people in one building. At the time of our inspection 20 people were living at Chase Lodge Care Home. However, one person was in hospital. The service specialises in providing care to people living with complex mental health needs.

People's experience of using this service and what we found
People did not receive their medicines safely and were not protected fully from the risk of infection. We had identified this at the last inspection, however improvements had not been made. Risks from uncovered radiators had not been identified and assessed. People told us they felt safe at the service. Staff understood how to keep people safe and what to do if they suspected abuse.

The environment was poorly maintained. Bedrooms, some beds, ensuite bathrooms, and some carpets in communal areas were in need of redecoration or replacement. The shortfalls had been identified but action was not taken for several months and the majority of actions were still outstanding. People's care needs were not always assessed effectively although staff were aware of their needs. Staff had not all received the necessary training and had not received regular supervision. The service worked within the Mental Capacity Act but recording of capacity assessments was of poor quality. We have made a recommendation about this. People were positive about meals at the service.

People were very complimentary about the staff and the care they received, however the poor quality of the environment had an impact on people's dignity. Staff respected people's privacy, always knocking on doors and seeking permission to enter. Staff understood how people's mental health could impact on their daily lives. People were able to express preferences for care and support and this was respected.

The provider had implemented a new electronic care records, however these records contained insufficient information about people's care needs, history and preferences. Care plans were not person-centred and failed to reflect individual care needs. At the last inspection we found people had limited access to activities and this has not improved. There was one notable piece of person-centred work which had a significant impact on improving one person's quality of life.

At the last inspection we found five breaches of regulation and these breaches had not been met. Whilst there was a more organised governance structure and audits had been introduced, these did not always result in quality improvement, which included management of medicines, the environment and the quality of records in the new electronic care records system. Staff told us the registered manager was open and approachable. The service met their responsibilities under the Duty of Candour regulations.

People were supported to have choice and control of their lives, people were able to come and go freely and choose how and where they spent their time.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 18 October 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to individualised care, staff training and supervision, cleanliness and quality of the environment and the management of the service at this inspection.

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

Chase Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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
The inspection team consisted of three inspectors spread over the two days of inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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. We reviewed statutory notifications the service had submitted. Notifications are information about specific events that the service is legally required to send us.

During the inspection
During the inspection we spoke with eight people living at the home, and seven staff members, this included senior staff, the registered manager and the provider. We also spoke with one health professional. We reviewed six people's care and support records, three staff files. Medicine administration records and nine staff supervision records. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and

complaints.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Staff did not always sign Medicines Administration Records (MARs) to evidence medicines had been given. There was a process in place for checking to ensure all medicines had been signed for; however, this system was not effective. Gaps had not been identified and followed up. This meant it was unclear if people had received their medicines.
- Stocks of medicines were not checked regularly. Some people had not received their medicines. Two people's medicines were out of stock, one medicine for four days whilst another person's medicine had run out the previous day. Staff told us they would try to get an emergency prescription when this happened.
- One person only received a medicine prescribed four times a day three times with no reason for the missed dose recorded on MARs. One day MARs were not completed for this medicine.
- Some people had been prescribed additional medicines on a PRN (as required) basis. At the last inspection we found there were no protocols in place to inform staff when these medicines were required and information about the safe administration of these medicines. These protocols were now in place.
- Some people had been prescribed creams. Staff had not completed application records consistently. There was no system in place to check people had these creams applied regularly as the prescriber intended.

We found no evidence that people had been harmed, however, systems were either not in place or effective enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to consistently ensure that national standards in respect of infection control were maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15

● Some areas of the service to be unhygienic. For example, bathroom floors were stained and not always sealed, and some bathroom walls had broken tiles. This meant bacteria could potentially lodge in these gaps.

● Some carpets in communal areas of the home were worn and dirty.

● Two people had stained bedding and bed bases.

● Although the provider had identified the need for colour coded mops, to reduce the risk of cross contamination, these mops and buckets had been purchased the week before the inspection.

● We noted mops left in dirty water or stored wet in buckets. This was not in line with best practice.

● The laundry did not have a system in place to ensure clean and dirty laundry were kept separate.

● The environment was in poor condition and did not encourage a comfortable, homely feel.

●People's bedrooms were in need of decoration, wallpaper and coving was hanging off in one person's bedroom.

● People had mismatched furniture which was worn, and in some cases needed repair.

● Bedroom carpets did not all fit well and some were dirty or in need of replacing.

● Four ensuites had stained flooring, two had broken light fittings.

● Carpets in communal areas were in need of replacement.

●The provider had undertaken a thorough audit of the environment in February 2019 but at the time of inspection the majority of identified needs had not been addressed.

We found no evidence that people had been harmed, however, there was a lack of maintenance and action taken to address cleanliness and infection control risks. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The provider had not always identified risks to people from the environment, and where risks were identified had not always acted. People were not protected from the risk of burns from uncovered radiators. All radiators within the service were uncovered but the risk to people from these had not been assessed to determine if any action was needed. This meant there was a potential for people to burn themselves when in contact with hot surfaces.

●There had been a fire in the lounge at the service in May 2019. A new fire risk assessment had been booked prior to the fire and was carried out on 04 June 2019.

● Staff had not conducted a fire drill since the fire but had marked the area of the risk assessment in respect of fire drills as complete. There was no list of the location of fire extinguishers. Not all staff had completed fire training.

● Staff at the service were able to tell us about risks to people and steps they took to keep people safe. For example, staff monitored one person's mental health and intervened early to help them avoid being exploited in the community. However, staff had not accurately recorded risks to people within the electronic records system.

We found no evidence that people had been harmed, however, systems either not in place or effective enough to demonstrate environmental risks were effectively managed. This placed people at risk of harm. This was a continued 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

● The provider had policies and procedures in place for safeguarding vulnerable adults.
● Staff knew the correct action to take if they had any concerns, however, not all staff had received training in safeguarding adults.
● The service had informed both the local safeguarding team and CQC when concerns had been identified and had put measures in place to ensure peoples' safety.
● People told us they felt safe. Comments included, "Absolutely I feel safe," and, "I feel more safe here than anywhere else."

Staffing and recruitment
● There were enough staff to keep people safe and to meet their needs on a daily basis. People were attended to quickly but in a calm and unhurried fashion. Staff told us there was enough of them.
● The provider followed a recruitment procedure to reduce the risk of employing unsuitable staff. Staff files showed the provider had carried out checks before employing new members of staff. All contained a Disclosure and Barring number (DBS) this is a check that is made to ensure potential staff have not been convicted of any offence which would make them unsuitable to work with vulnerable people.
● Staff files also contained proof of identity, an application form, a record of their interview and two references.

Learning lessons when things go wrong
● The provider reviewed incidents and accidents. However, these did not always inform improvements and practices. For example, despite a fire at the service in May 2019, not all staff were trained in fire awareness and no fire drills had been held since this event.

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 now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider had not ensured staff had received training and supervision to enable them to carry out their roles effectively. Not all staff had completed training identified as required by the provider. For example, no staff had received training in infection control, 44% of staff had received training in safeguarding vulnerable adults and only 39% of staff had completed training in health and safety.
- Supervision records showed that staff had not received regular supervision. Supervision is where staff meet with a senior staff member to review and discuss work or any other issues affecting the people who use the service. Records provided by the registered manager demonstrated this.

We found no evidence that people had been harmed, however, staff were not receiving appropriate training and support. 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.

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.

- People's care records did not contain accurate information about their mental capacity. A number of people's capacity fluctuated when their mental health condition deteriorated. This was not reflected in their care records which meant there was a risk that appropriate care may not be provided when people did not have capacity.
- One person's records stated they did not have capacity as they were unable to understand, retain and weigh up information. The registered manager told us this was not accurate, and the person made all their own decisions.
- Staff told us they had training in the MCA, however, the provider's training matrix showed nobody had

undertaken training. Two staff said they would make a referral to the GP if they were concerned about a person's ability to make a decision.
● One member of staff said, "they have capacity until told otherwise" and another said, "you have to prove they don't have capacity."

We recommend the provider review the recording of capacity in people's records and consider best practice guidelines for staff training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff were aware of people's needs, however there was a lack of evidence that thorough assessment of people's needs had taken place. Staff used an electronic assessment tool which generated care plans. This tool offered a series of boxes to tick and consisted of very general categories of need rather than individualised assessment. The care plans produced by the assessment tool were generic and consisted of a list of all possible actions that might be needed rather than the care needed by the individual.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink sufficient amounts. The provider employed kitchen staff to cook meals. People said the food was good, "Meals are good, they do their best," and, "Food is very good." People with diabetes were offered suitable diabetic choices.
● One person told us staff made sure the particular snacks they liked were available.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with healthcare professionals to support people to access appropriate health care. A healthcare professional told us that staff identified when people's health was deteriorating and liaised with services.
● People's care records did not always contain accurate information to guide staff to identify and support people's deteriorating health. For example, one person was at high risk of developing chest infections, but their care records did not contain information for staff on how to identify when the person became unwell.
● Everybody living at the service had complex mental health needs. Care plans did not identify how individuals might present if their mental health deteriorated. There was no information to guide staff on how to support individuals and at what point to contact mental health professionals.

Adapting service, design, decoration to meet people's needs
● The lounge had been refurbished following the fire and new blinds and curtains fitted in the second lounge/dining room. People had been involved in choosing decorations for this lounge.
● Four bedrooms rooms were due to have new windows fitted on the 8th and 9th October.
● One person collected clocks had completely covered the walls of their room with these.
● Some people's bedrooms were in a state of disrepair needing new carpets and beds. The registered manager told us it was the individuals' choice to live in this way. One person asked about their bedroom told us, "It's a lovely room to be in".
● A second person told us they had chosen the colour of their walls.

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 good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- The environment did not respect people's dignity. The provider was in the process of refurbishing the two communal lounge diners following a fire at the service in May. However, other communal areas were of a poor standard as detailed in other areas of the report.
- On arrival on the first day of inspection the front garden was full of discarded furniture which had been there for some time. When we returned two days later all this rubbish had been removed.
- Staff always knocked before entering people's rooms. If people didn't want them to enter they respected this.
- People were supported to be as independent as possible. For example, one person who had a stoma was supported to care for this independently.

Ensuring people are well treated and supported; respecting equality and diversity

- One person told us, ""Its brilliant, I appreciate staff they are excellent" and a second said, "staff are marvellous." We observed staff speaking politely to people with a friendly manner.
- The registered manager and staff team knew people well and spoke in a positive and respectful way about people.
- People were able to specify their preferences for the gender of carers delivering their support.
- Staff understood how people's mental health could impact on their communication and behaviour. They registered manager understood if someone was behaving in ways that challenged it may be due to their mental health. For example, one person was challenging with night staff; the GP had been called as we were told this is often an indication the person was becoming unwell. Both staff and people living at the service were positive about their relationships.

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

- People were supported to make decisions about their care as far as possible. One person told us, "I have everything I want." Records we viewed contained minimal information about people's personal history, preferences, likes or dislikes.

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 requires improvement. 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.

At our last inspection the provider had failed to consistently ensure that people were supported to follow their own interests or encouraged to develop new interests. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9

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

- People's care records did not contain personalised information about their care needs. The provider had implemented an electronic care records system. The system had not been personalised to individuals and all care records contained lists of generic statements.
- Three people who had a diagnosis of paranoid schizophrenia had the same care plan. These plans contained the statement, "I may well have a tendency to argue and have potential for violence due to this form of schizophrenia." None of the three people were assessed as at risk of being violent.
- The care plans for these three people in respect of their mental diagnosis, did not respect their human rights. There was no information about how these individuals lived with schizophrenia, what helped or exacerbated their condition. The care plan presented people as a list of symptoms.
- One person's mental health care plan directed staff to, "Remind me of who is visiting me and why." Staff are offered suggestions such as giving visitors a break and providing resources such as books or other materials may help." There was no information about their mental health condition and how it affected this person. The person had no cognitive or memory impairment.

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 a lack of organised activities in the service to support people to maintain their interests.
- One person told us they weren't allowed out alone and "got bored quickly". They told us they loved cooking and loved food but "couldn't do it here." A second person mentioned they hadn't been to church for a long time because they had lost confidence going out by themselves. Their mother lived in a local care home, but they hadn't seen her for a while due to lack of confidence going out alone.
- A third person whose care records directed staff to, "Encourage meaningful activity" had only two activities recorded in the first two weeks of September which was helping to fold napkins. There was one recorded instance where staff talked with them about their mental health and feeling low. The staff member recorded they discussed a trip out with the person but at the time of our inspection it had not taken place.

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.
● Care records contained generic statements which did not address people's communication needs. Every set of records told staff, "I prefer information to be given to me verbally in easy read font. I do not require any additional support with communication."

We found no evidence that people had been harmed, however, systems were either not in place or effective enough to demonstrate people received person-centred care. This placed people at risk of harm. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We noted particularly good care and support provided to one person whose behaviour could challenge. Their specific behaviour had resulted in a number of placements falling through and they had come close to the service giving notice. However, the registered manager and provider had negotiated a plan with the person to manage their behaviour in a way that prevented any escalation. The person now felt they were being listened to whilst staff felt able to continue to provide support.

Improving care quality in response to complaints or concerns
● The provider responded to complaints appropriately. There was a complaints policy available; one person made regular use of this. Records showed that complaints were recorded and responded to.

End of life care and support
● The majority of people did not have any plans in place regarding their end of life wishes. Care plans contained generic statements generated by the electronic records system. The registered manager told us about one person's last wishes, but this was contradicted by generic statements in their care plan.

Inadequate

Is the service well-led?

Our findings

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.

At our last inspection the provider did not have systems in place to monitor and improve the quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- At the last inspection the service was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices and the provider submitted an action plan. None of these requirements have been met and the service remains in continued breach of these five regulations.
- The provider had failed to identify many of the concerns found at our inspection. On arrival they told us that a lot of progress had been made since the last inspection, particularly in respect of care planning.
- The environment remained of a poor standard, care records did not contain personalised information, staff training numbers were still low, medicines were not managed safely, and staff supervision was not happening on a regular basis .
- Where audits had identified actions needed the provider had not always acted. For example, an environmental audit undertaken in February 2019 identified 11 pages of actions. We asked to see the provider response to this audit, but none was available. Some areas had been improved, for example, new windows ordered, and provision of paper towel holders and loo roll holders. However, there was no schedule of works in place to identify what would be addressed and when.
- An infection control audit, undertaken three-monthly, had identified the need for colour-coded mops and buckets on three occasions before they were purchased for the service.
- Staff told us that the fire, which occurred in May 2019, was responsible for the delay in improvements. However, the requirement notices were issued seven months before the fire.
- A new electronic care records system had been implemented. There was no audit of the quality of care plans, which we found to be of very poor quality and which were not individualised or tailored to individual need.
- Medicines audits had failed to identify shortfalls in medicines records or shortage of stock. There were no systems in place to check stock levels. Audits were only carried out monthly which meant any errors may not be identified for up to four weeks.

We found no evidence that people had been harmed, however, systems either not in place or effective enough to demonstrate environmental risks were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following a fire at the service in May 2019 the provider commissioned a fire safety audit. This identified a number of actions needed, most of which had been completed. The provider had undertaken maintenance of the fire doors and addressed an identified deficit in the laundry.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People told us they were happy and felt safe at the service; they said they had good relationships with the staff team. Staff told us they were happy in the roles and felt supported by the registered manager.

● People were offered the opportunity to give feedback on the running of the service by completing surveys. Their comments and complaints were taken seriously.

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

● Staff said they were confident about raising concerns and they would be listened to. When safeguarding incidents occurred, the registered manager acted in line with guidance. The registered manager informed statutory authorities as required.

Working in partnership with others

●Staff at the service worked with the local community mental health and crisis teams. We received positive feedback about their communication and the quality of their relationships with people. Staff also worked with the local mental health inpatient unit to facilitate discharge home for people.

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 Care plans were not personalised to people's individual needs. People were not supported to undertake activities. This is a repeated breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. People were not protected from the risk of infection. This is a repeated breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were in poor condition with stained and worn furniture. Communal areas and bedrooms were in need of decoration and maintenance. People were not protected from the risk of burns from uncovered radiators.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not always receive training and supervision.

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 There were repeated breached of regulation. There were no effective governance systems in place to monitor to quality and effectiveness of the service

The enforcement action we took:

warning notice