Leisure Care Homes Limited

Westcotes Residential Care Home

Inspection report

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Lincolnshire
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Tel: 01754610616

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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
Westcotes Residential Care Home is residential care home providing personal and nursing care to 14 people aged 65 and over at the time of the inspection. The service can support up to 17 people.

People's experience of using this service and what we found
There was a lack of effective management at the home and there had not been a registered manager in post for over a year. While the provider had arranged some management cover it was not effective. Systems to monitor the quality of care provided were not maintained. Incidents in the service were not monitored and action was not taken to keep people safe from future incidents.

Risks to people receiving care and from the environment had not been fully identified. Where action had been identified to keep people safe guidance was generic and contained conflicting information. This did not support staff to provide safe care. Medicines and infection control were not well managed and increased the risks to people.

Staffing levels did not support people's needs and had impacted on the care they received. Staff had received training in how to provide safe care for people. However, we saw that they did not always work in line with their training, including in how to keep people safe from harm. The provider had not always ensured prompt effective action was taken when concerns were raised.

People were not 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.

Care plans showed staff had a limited understanding of how people living with dementia were able to identify and assess risks to themselves. In addition, people living at the home were not shown how to understand people living with dementia.

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 29 May 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the key question

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

Enforcement

We have identified breaches in relation to the poor management of risks to people, people's not having assessments and care plans which were regularly reviewed and reflected their needs, the provider's inability to safeguarding people from harm, people's ability to make decisions, insufficient staffing levels, the poor quality of the premises and the ineffective management of the home at this inspection.

Due to the concerns identified we imposed conditions of the provider's registration to increase the level of monitoring of the home.

Follow up
We will continue to monitor information we receive about the service until we 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 of 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**

Westcotes Residential 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 two inspectors and an assistant inspector.

Service and service type
Westcotes Residential Care Home 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
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 this information to plan our inspection.

During the inspection
We spoke with three people who lived at the home about their experience of the care provided. We spoke

with two members of staff and the provider. 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 four people's care records and multiple medication records. We looked at two 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 from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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; assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

• At our last two inspection the provider had failed to robustly assess the risks relating to the use of medicines and the health, safety and welfare of people. 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.

• The provider had not ensured people's medicines were available to them when needed. For example, one person who needed pain relief four times a day was unable to have any for two and a half days as the staff had failed to reorder in a timely fashion.

• Records did not always support the safe administration of records. For example, we saw one medicine for pain relief was recorded in the medicines book twice. One did not have a strength recorded against it. Therefore, it was unclear if this person had received the correct dose of pain relief.

• Two people were self-administering their medicines. There had been no assessment to see if they were capable of managing their medicines safely. In addition, their medicines, some of which required secure storage, were not stored securely in their bedrooms.

• Staff did not follow the provider's policies or their training when recording medicines. We saw one member of staff had administered a medicine and had not recorded it as new charts were unavailable. They had requested another member of staff sign for them. This meant staff had failed to follow procedures for the safe administration of medicines and had increased the risk of a medicines error. Medicines brought into the home by a person on respite care had not been prescribed by a GP and there was no advice available to staff on how to support the person to take this medicine.

• Risks to people had not always been identified and care was not always planned to keep them safe. The registered person had not ensured people living with dementia were kept safe. Records showed two people had been able to leave the home unobserved multiple times. This put the people at risk as they were unable to protect themselves from danger. There was no guidance in their care plans on action staff needed to take to keep them safe.

• The provider did not learn from incidents. Despite the risk of people leaving the home unobserved no measures had been put in place to keep them safe. No investigation of the incidents had occurred. Staff told us they were keeping the front door locked. However, we found other doors in the home were unsecure. The front door was unlocked and at times was open.

• Risks to people while mobilising around the home were not properly assessed. Care plans contained conflicting information on people's ability to mobilise around the home and which equipment was needed to keep them safe. For example, one person's care plan noted they should use two differing pieces of

equipment.
• Care plans did not contain enough information on how to use equipment safely. For example, when a person was being hoisted by staff onto the stair lift they became distressed and the hoist tipped over. There was no record in their care plan that this person became distressed when being hoisted and when they were assisted by a certain member of staff who made them anxious.
• Care plans did not record how staff could keep people safe from falls. Records showed one person was having multiple falls but the care plan did not contain any information on how staff could help prevent falls.
• The provider and staff did not ensure equipment was safe to use. The footplate on the stairlift was broken but staff continued to use the lift while it was broken. There were no risk assessments in place on action staff should take to keep people safe while the stairlift was not functioning properly. One person told us how they had been on the stair lift and had bumped their knees on the railings as they were not properly supported in the chair.
• People were not protected from the risks of dangerous chemicals. For example, we saw the cupboard where the provider stored cleaning fluids was unlocked and the room they were in was also unlocked. Some people at the home living with dementia would be unable to identify the risk of ingesting this fluid.
• At the last inspection we identified concerns about the cleanliness of the home. At this inspection we found not enough improvements had been made.
• People were not protected for infection control risks. In the first-floor bathroom a waterproof dressing cover had been put away wet and so bacteria would be able to breed in the warm damp environment.
• A clinical waste bag had been removed from the waste bin and left on the floor of the unlocked first-floor bathroom. In one person's bedroom we found an open sharps box which contained needles from the person's daily injections. This room was also unlocked. Some people living at the home had dementia and would at times walk around the homes and go into rooms. They were at risk of handling these potentially dangerous items.
• Pull cords in bathroom were not wipeable so could not be effectively cleaned. Some of the taps had lime scale on them which harbours infection. The fire escape had not been regularly cleaned. The handrail was covered in bird faeces and rust. This would spread the risk of infection.

This was a continuing breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.
You can see what action we told the provider to take at the back of the full version of the report.

Systems and processes to safeguard people from the risk of abuse
• The provider had not ensured that appropriate action was taken to keep people safe from abuse. The local safeguarding authority had shared with the provider concerns regarding two members of staff. The provider had not taken immediate action to keep people safe. Both members of staff had continued to work with people until the safeguarding authority requested the provider take action to investigate the concerns. This in action put people at further risk of abuse.
• In addition, the registered provider had not taken action when people were at risk of abuse from others living at the home. Records showed one person had been physically abusive towards another person living at the home.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13 Safeguarding service users from abuse and improper treatment

Staffing and recruitment
• Staff explained that the current staffing levels were set at three care workers from 7am until 2pm, two care workers from 2pm until 9pm, with an extra care worker from 4pm until 8pm and then two care workers from 9pm until 7am. In addition, there should be a manager in post to support and direct care workers to safely

meet people's needs.
• Rotas showed in the three weeks prior to our inspection 15 shifts had not been staffed with care workers to meet the needs of people living at the home. This had impacted on the care people received. For example, some people had not received baths. Where people had baths while the home was short staffed it had put others at risk as staff were not available to monitor that other people were safe in the home.
• In addition, while there was no manager in post, there had been no extra staff employed to cover management duties that required completing. For example, in the handover book on 27 June 2019, it was recorded staff needed to try and arrange cover for the 4pm to 8pm shifts as the staff on duty had not had time to contact staff. This did not safely meet people's needs.
• The rotas also showed there were five consecutive days when there was no housekeeper due to annual leave. This was planned leave, but no action had been taken by the provider to provide cover.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing levels.

• Records showed the provider had completed all the necessary checks on people before they were allowed to work at the home.

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.

Adapting service, design, decoration to meet people's needs
• At the last inspection we found the provider had not maintained the home to an acceptable standard. At this inspection we found the provider had not made the required improvements. The home still had not been maintained to an appropriate standard to effectively support people's well-being.
• There were recurrent issues with the stair lift. This has been raised as an issue with us at previous inspections. The provider submitted a notification on 9 November 2018 to inform us the stair lift was not working and they were awaiting essential parts needed for repair with an expected date of 14 November for completion. During this time people who were unable to walk down stairs were restricted to their bedrooms. A safeguarding referral made on 8 July 2019 identified the stair lift was again not working and had been broken for two weeks. One person living at the home told us they had gone downstairs on their hands and knees when the lift was not working.
• When we inspected the stair lift was working to the first floor. However, the footplate was not working properly as it would not go down when the seat was lowered as it was meant to do. Staff told us it could be lowered manually, but people chose not to use it as the footrest would return very quickly to the upright position and may catch people's legs.
• The window restrictors in bedrooms were not fit for purpose. Thin chains were used which could be broken if a person tried to force the window. Health and safety regulations require window restrictors to be suitably robust to withstand foreseeable force.
• A ramp was in place to enable wheelchairs to the change in level on the first floor. This ramp was stored in the hallway. However, this limited the space people had to manoeuvre along the hallway. With the ramp having sharp corners this was a safety hazard.
• Vanity units in some bedrooms were old and worn and would not be able to be cleaned properly. The furniture in some people's bedrooms was old and worn and did not support people's well-being.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15(1) Premises and equipment

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.
• A member of staff told us four people living at the home had dementia and may be unable to make decisions for themselves. However, their rights under the Mental Capacity Act (2005) were not protected. Care plans contained conflicting information about service user's abilities to make decisions for themselves and there was no attempt to assess people's ability in line with the Mental Capacity Act (2005) or to ensure decisions made were in service user's best interests. Only one DoLS application had been submitted.
• Staff told us one person was currently remaining upstairs following the incident with the hoist falling over. This meant the person was restricted to their bedroom, as there were no communal areas upstairs. There was no mental capacity assessment in place to show if the person had the capacity to agree to this restriction or if a decision was needed in their best interest. Restricting the person to their bedroom impacted on their rights as it placed them in social isolation.
• When care plans had been reviewed people were required to sign them to show they agreed with them. However, for people living with dementia there was no mental capacity assessment to show if they were able to make an informed decision about agreeing to the information in their care plan. In addition, where care plans had been signed on the person's behalf there was no best interest decision to show alternatives had been considered.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11(1) need for consent

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• At the last inspection we found people did not always receive an assessment before moving into the home. At this inspection we found there had been no improvement in the assessment of people.
• Two people had recently moved into the home. There had been no assessment of their needs and no care plans had been developed to support staff to provide care to meet their needs.
• The provider had purchased a quality system to support staff to provide care, in line with current best practice guidelines. However, while the policies in the system did reflect latest best practice. They had not been implemented as staff were not working in line with the policies. For example, if staff had followed the new medicines policy this would have ensured people received their prescribed medicines safely.

Staff support: induction, training, skills and experience
• The provider had a training plan in place which showed all staff had received the mandatory training needed to provide safe and effective care. For example, staff had received training in supporting people to move safely and in how to protect people from the risk of infection.
• However, we saw training was not being put into practice. For example, infection control concerns were identified during the inspection which staff should have been aware were poor practice. In addition, they had not raised concerns over unsafe practices when they supported people to move.

Supporting people to eat and drink enough to maintain a balanced diet
• People's weights were monitored and records showed there was no one at the home who was at risk of becoming malnourished. There was also no one currently who was at risk of choking.

• Care plans showed staff had raised concerns about one person who would often refuse food. They had contacted the person's GP and arranged for them to be given a calorie rich supplement to ensure they maintained a healthy weight.
• The dining room was set out nicely for lunch and we saw people enjoyed the food offered to them.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare advice and support as needed to maintain their health. For example, we saw healthcare professionals such as GP's and community nurses had been contacted when staff were concerned a person may have an infection.
• However, records showed that one person, who staff should have supported, had missed their hospital appointment. Records showed this had been rebooked for a later date. This meant the person's care was delayed. This could have worsened their ongoing health issues.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence 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.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us some of the staff were kind to them, but raised concerns that others were not so kind to some people. They told us two members of staff were curt when talking with people and would shout at them. They identified these staff as the two who had been named in the safeguarding referral.
• Some care plans contained conflicting information on people's capacity. Care plans showed a lack of understanding dementia may impact on people's ability to understand the restrictions put in place for their safety. For example, one included comments the person refused to listen to instructions and they knew not to use the stairs independently. This showed a lack of respect and understanding for a person living with dementia.

Supporting people to express their views and be involved in making decisions about their care
• People's ability to make decisions about their care was at times restricted by the lack of action to ensure suitable equipment was available to assist them. For example, one person had been restricted to their bedroom as it was felt they were unsafe on the stair lift. No action had been identified in their care plan to show how this could be resolved to allow them to spend time with others in communal areas.
• Another person told us they wanted to go out but had not been able to do this due to issues with their wheelchair. No action had been taken by the provider to arrange for a review of their wheelchair.

Respecting and promoting people's privacy, dignity and independence
• Some people at the home were living with dementia. People told us this was poorly managed, which resulted in tension between some people and other people's behaviours. For example, we saw one person living with dementia was continually approaching a person and irritating them. This person commented loudly about their behaviour, calling them childish. There was no staff interaction to monitor or diffuse the situation which meant people's dignity was affected.
• People's care plans were kept securely in the office and so could not be accessed by unauthorised people.

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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• At the last inspection we found care plans were not person centred and only contained generic information. At this inspection we found the provider had failed to make improvements to care plans to support individual care for people.
• Four people living at the home did not have care plans in place to enable staff to provide person centred care which met their individual needs.
• Where people did have care plans in place they did not reflect people's needs. The information was not specific to their individual needs and did not reflect the care they needed. There was conflicting information recorded and care plans did not support staff to provide care responsive to their needs.
• Care was not delivered in line with people's care plans. One person's care plan noted they should be encouraged to walk as much as possible. The person told us staff had not supported them to do this which meant their strength had deteriorated to the extent they now lacked the ability to walk and they needed hoisting at all times.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 Person centred care

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 plans noted people's individual communication needs, for example if they needed glasses or used a hearing aid. However, plans did not include information on whether different communication formats, such as large print or verbal information, could improve people's understanding of information.

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 told us they activities did not support their needs. For example, they were unable to go out into the local community.
• In addition, due to staff shortages, regular in-house activities had not been provided for people.

Improving care quality in response to complaints or concerns

• People were unclear on who to complain to. Some people would speak to a member of the care staff, some to the registered manager of the provider's other homes and some to the provider.
• No formal complaints had been recorded since our last inspection.

End of life care and support

●At the time of the inspection no one was receiving end of life care. We discussed with staff how they would support people at the end of their life and they were able to describe how they would liaise with other healthcare professionals to ensure people had a pain free death.

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 Inadequate. At this inspection this key question remained the same.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;Working in partnership with others

• At the last two inspections we found the provider had breached regulations in relation to ensuring the management of the home was effective. At this inspection we found the provider had not made the improvements necessary to meet the regulations.
• There was no registered manager for the home. The previous manager had deregistered 15 May 2018. The had been a manager had been in post between May 2018 and June 2019. However, they had failed to complete their registration process with us. At the time of the inspection there was no manager in the home.
• A senior care worker was in charge of the day to day running of the home. They had been promoted from a care worker position two weeks prior to the inspection. They had not been given any essential additional training, so they lacked the skills and knowledge to run the home. Furthermore, they continued to work as a care worker, and were given no extra hours to manage the home. This meant there was no effective oversight of the management of the home.
• The provider had arranged for the registered manager of their other registered home to visit once a week and for a consultant to visit once a week. However, given the concerns we found when we inspected, it was clear these arrangements had not ensured that people had received safe, high quality care.
• The consultant was implementing new policies. However, they were not ensuring that staff were working in line with these new policies. For example, the medicines policy would have prevented the issues we found had staff been aware of and working in line with the new policy.
• There was a lack of oversight of the home and a lack of awareness of the seriousness of the concerns we found. The provider told us they were aware of some concerns but were confident they would soon be resolved.
• There was a lack of ongoing auditing of the care provided. The senior care worker was unable to identify any audits completed on the quality of care provided in the home. This meant issues were not being consistently identified or rectified.
● At the last inspection we found the provider had completed a survey regarding the quality of care people

received. It had identified action was needed in relation to the environment and the quality of activities available to people. At this inspection we found the provider had failed to take action to resolve these concerns. People told us activities were lacking and improvements were still needed to the environment, as detailed in the effective domain of this report.

- The provider had started to work with the local authority to help them make improvements. However, findings from this inspection show sufficient improvements had not been made, despite this support.

This was a continuing breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

You can see what action we told the provider to take at the back of the full version of the report.

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 The provider had not ensured that the care provided safely met people's needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that they worked in line with the Mental Capacity Act (2005).

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 The provider had not ensured that people were protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises were properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient staff to meet people's needs.

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 The provider had not ensured that care and treatment was provided in a safe why for people. This included the risks of receiving care, the safe management of medicines and the management of infection control.

The enforcement action we took:

We imposed a condition relating tot he management of risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were effective systems in place to assess, monitor and mitigate the risks to people receiving care.

The enforcement action we took:

We imposed a condition relating to the management of the home.