Cleveden Care Limited

Teesdale Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 26 June 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. A second day of inspection took place on 7 July 2017, and was announced.

The service was last inspected in June 2015 and was rated Good.

Teesdale Lodge Nursing Home is a 40 bedded purpose built, single storey care home. Personal care and nursing care primarily to older people is provided. All bedrooms are single rooms with en suite facilities. The home is situated close to a bus service and within a 10 minute walk to Stockton town centre. At the time of our inspection 32 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people using the service were not always effectively assessed or acted on. People's medicines were not always managed safely. Fire drills were not regularly carried out. This meant effective plans and procedures were not always in place to support people in emergency situations. The manager did not effectively monitor staffing levels to ensure they were sufficient staff to keep people safe. Staff usually received the training they needed to support people but effective procedures were not in place to plan and record training. We saw examples of people's privacy and dignity being compromised. We were not notified about a safeguarding incident as required by the service until inspectors asked the manager to submit the notification. Procedures were not in place to assess, monitor and improve standards at the service.

The provider's recruitment processes reduced the risk of unsuitable staff being employed.

Staff were supported through regular supervisions and appraisals. People were not always effectively supported to access food and nutrition. People's rights under the Mental Capacity Act 2005 (MCA) were protected. This meant the service did not always work effectively with external professionals to monitor and promote people's health, for example in managing nutrition and pressure care.

People and relatives spoke positively about staff at the service, describing them as kind and caring. However, we also saw that staffing levels at the service meant that staff were always very busy and there was very little time for them to have meaningful engagement with people. People were supported to access advocacy services and receive end of life care where needed.

People told us they were supported to access activities they enjoyed. However, during the two days of our visit we did not see any activities taking place. People's activity preferences were recorded in their care plans but we were not shown any evidence of how these were used to plan and deliver activities people enjoyed.

Care plan reviews and daily notes had not always identified changes to people's nutritional support needs or pressure care. As a result people had not always received responsive care. Policies and procedures were in place to respond to complaints.

People, relatives and staff spoke positively about the management of the service. Feedback was sought from people using the service and staff through an annual questionnaire and at meetings.

We found four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to medicine management, risk assessment and response, fire safety, staffing levels, dignity and respect and good governance.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not always effectively assessed and acted on.

Medicines were not managed safely.

Staffing levels were not effectively monitored to ensure they were safe.

Emergency plans were not subject to regular review.

Is the service effective?

Requires Improvement

The service was not effective.

Training was not effectively planned or recorded.

People did not always receive effective support with food and hydration.

The service did not always work effectively with external professionals.

People's rights under the Mental Capacity Act 2005 were protected.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and respect was not always protected.

Support was often focused on the task rather than the person due to time pressure on staff.

People were supported to access advocacy services and end of life care where needed.

Is the service responsive?

Requires Improvement

The service was not responsive.

Activity provision was limited and not responsive to people's specific needs.

Care plans did not always reflect people's current support needs.

Procedures were in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not well-led.

The manager had not always submitted required notifications to CQC.

Quality assurances processes were ineffective at monitoring and improving standards.

Feedback was sought from people and staff.

Teesdale Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of one adult social care inspector, a specialist advisor and an expert by experience. The specialist advisor was a nurse. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

Prior to the inspection, we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team, Healthwatch and other professionals who worked with the service to gain their views of the care provided by Teesdale Lodge Nursing Home. The feedback we received is detailed within the main body of this report.

During the inspection we spoke with four people who used the service. We also spoke with four relatives of people using the service.

We looked at eight care plans, medicine administration records (MARs) and handover sheets. We spoke with eight members of staff, including the manager and care staff. We looked at four staff files, which included recruitment records.

Inadequate

Is the service safe?

Our findings

Risks to people using the service were not always effectively assessed or acted on. Before people started using the service they were assessed in a number of areas, including mobility, falls, nutrition and skin integrity. Where issues were identified, they were supposed to be monitored through 'monthly dependency assessments' which were designed to monitor whether risks to people had improved or worsened.

However, risks to people using the service were not always effectively assessed or addressed. In April 2017, the Commission was made aware of an incident concerning a person who required a soft food diet. Records showed that risks to the person had not always been addressed or information shared effectively between staff to help keep the person safe. We saw that another person had moved into the service with a grade one pressure sore which deteriorated to a grade three pressure sore across a two month period. We looked at the person's care records and saw they did not always detail how staff should monitor the person's skin. We also saw that a medicine recommendation made by district nurses to help manage the person's skin damage had not always been followed and staff had used a different medicine on the person. For the same person we saw that no medicines were recorded as being administered for six days. This meant it was not possible to determine whether the person had received the treatment needed to reduce their risk of pressure damage.

During the inspection we saw that another person had been admitted to hospital for treatment for extreme dehydration. We reviewed their care records and saw that they had been consuming low levels of fluids in the week leading up to their admission. Staff had contacted the person's GP in relation to possible weight loss but there was no record of them mentioning the person's low fluid intake. Two days before the person was admitted to hospital, the person's relatives had raised their concerns about fluid intake with staff, and they were told they should speak with the manager about this and staff were informed. There was no record of any other action taken. We also saw that not everyone who needed one had an emergency healthcare plan in place. This meant risks to people were not always effectively monitored or action taken to keep them safe.

People's medicines were not always managed safely. Staff managed the medicines of everyone who used the service. People had an individual medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

We saw some duplicate entries on MARs prepared by the pharmacy used by the service, so it was not always clear what medicines people were taking or had in stock. Where handwritten MARs were used, administration was not always double-signed for in line with the provider's medicine policy. Some people had 'discontinued' recorded against some medicines but there was no clear record of who had authorised this. We were sent the relevant authorisation one month after our inspection. This meant there was no clear record in place of who was administering and managing people's medicines at the time of our inspection. Topical MARs (TMARs) were used to manage topical medicines such as creams.

On TMARS, inconsistent records were kept to show where, how frequently and when the topical medicines

were applied. For one person we saw that incorrect medicines were shown on the pre-printed TMAR chart. For another person we saw that incorrect medicines were documented on the TMAR chart. Some people used 'as and when required' (PRN) medicines. Some people's PRN information was not up-to-date and information was missing for some medicines. Not everyone had a PRN care plan in place where needed, which meant there was no guidance for staff on to ensure people were given their medicines in a safe, consistent and appropriate way.

Some people at the services used prescribed controlled drugs. Controlled drugs are medicines that have strict legal controls because they are liable to misuse. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. Staff knew the required procedures for managing controlled drugs. We saw from the controlled drugs records that staff had made on the MAR matched the records in the controlled drugs record book and that the stock balance records were correct.

However, other medicines were not always safely stored. Fridge storage temperatures were not consistently recorded to ensure medicines were stored within recommended ranges. For 2017, no records were available for fridge temperature recordings save for between 1 July and 7 July 2017. The manager told us temperatures were taken daily but records were sometimes mislaid by agency staff. On the records that were in place we saw two examples where the maximum temperature recorded was over eight degrees centigrade. This is higher than recommended for cool storage and action had not been taken by staff to ensure medicines were safe to use. This meant procedures were not in place to safely manage people's medicines.

Checks were made of equipment and the premises to ensure they were safe for people to use, and required test certificates were in place. A business contingency plan was in place to help ensure people received a continuity of care in emergency situations. However, we saw that only two planned fire drills had taken place since January 2016 despite the provider's policy stating a minimum of two day and two night drills should take place every year. This meant that despite plans and procedures being in place they were not always operated effectively to support people in emergency situations.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager did not effectively monitor staffing levels to ensure they were sufficient to keep people safe. At the time of our inspection, day staffing levels (during the week and at weekends) were two nurses, one senior care assistant and four care assistants. Night staffing levels (during the week and at weekends) were one nurse and three care assistants. The provider and manager had set the staffing levels on the basis of the number of people living at the service. However, this did not factor in people's level of dependency on staff or the layout of the building.

At the time of our inspection eight people were assessed as being fully immobile and a further 20 people required 2:1 support. We asked the manager how people would be safely evacuated in a night emergency. The manager said, "It does need looking at. We have had discussions between the staff." The manager also said, "I don't know if the building is factored in to staff numbers. I haven't really thought about it, but there are some areas that aren't supervised. We can only fit people in there who don't need supervising. So we can only put people in the main lounge. I do find staff are very busy and (people) need to be in bed for their safety."

We received mixed feedback on staffing levels. Some staff and people said staffing was sufficient. One person said, "Always seems plenty of staff." A visiting relative told us, "I find there is enough [staff]." However,

the person they were visiting said, "Definitely need more staff. I can't always get in the chair because I require the hoist." They went on to say staff were sometimes too busy to assist with this in a timely way. A member of staff we spoke with said, "There are sometimes enough staff, but we can struggle at weekends and with just four care assistants." Our judgment was that the provider and manager were not effectively monitoring staffing levels to ensure they were sufficient to keep people safe.

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

The provider's recruitment processes reduced the risk of unsuitable staff being employed. Applicants were required to set out their employment history, provide proof of identity and submit written references. Disclosure and Barring Service (DBS) checks were also carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people from working with children and adults. Checks were made with the Nursing and Midwifery Council (NMC) on the registration status of nursing staff. The NMC is the professional regulatory body for nurses and maintains a register of nurses and midwives allowed to practise in the UK, including any restrictions that have been placed on the individual's practice.

Requires Improvement

Is the service effective?

Our findings

The provider required staff to complete training in a number of areas, including food hygiene, health and safety, manual handling and dementia care. The manager monitored and planned training on a training chart. When we reviewed this we saw refresher training was not recorded. Refresher training ensures that staff knowledge and skills are current and reflect best practice. We asked the manager about refresher training. They told us, "I would hope staff would have had refresher training, but it's not on there (the training chart). I need to work out how to keep track of refresher training."

We also saw that one person at the service used percutaneous endoscopic gastrostomy (PEG) for their food and nutrition. PEG is a system used where people having difficulty swallowing foods and fluids. The person started using the service in 2016 but at the time of our inspection staff had not received PEG training. Nursing staff at the service were trained to use PEG and were responsible for managing it for the person. However, using a PEG can impact on other aspects of a person's support and staff had not received training on these. We spoke with the provider after the inspection, who told us PEG training had been arranged for all staff as a result of our visit.

This meant procedures were not in place to ensure staff received the training needed to support people effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff told us they found meetings useful and were encouraged to raise any support needs they had. A member of staff we spoke with said, "If I ever do mention something management will do their best to help." Another member of staff said, "I find them useful. They can lead to change."

People were not always effectively supported to access food and nutrition. When people started using the service their dietary needs and preferences were assessed and care plans developed. The service used recognised tools such as the Malnutrition Universal Screening Tool (MUST) to monitor people's nutritional health. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

However, for one person we saw there was no record of their 'nutrition and hydration' care plan being reviewed between May 2016 and March 2017. This meant changes to the person's support needs had not been recorded which led to an incident involving their soft diet. The same person's care plan said their GP should be contacted for a dietician referral if the person lost more than 2kg of weight. The person's records showed that they had lost that much weight over a period of months but staff had not made a referral to the dietician until three months after the weight loss first occured. For another person, their nutrition and hydration care plan stated they needed encouragement with fluids but did not say how this should be done or set a target for amount of fluids the person should be encouraged to drink. Records showed that the

person was consuming low levels of fluids and staff had not sought the help of external professionals in managing this. This meant people's nutritional health was not always effectively promoted.

Despite the evidence we found, people told us they thought staff had the skills needed to support them. One person we spoke with said, "Staff are very, very competent." Another person said staff were, "Very, very good." Staff also told us they received the training they needed to provide effective support. One member of staff said, "We get training. I've just been told about some training later this month and I had infection control training a few weeks ago."

The service was provided in purpose-built, single story premises. People's rooms were located in corridors that radiated out from a central hallway. There was a main lounge and dining room near this hallway, and two lounges at the end of corridors. We found that the environment was not always suitable for people living with a dementia. Corridors looked identical which meant it was difficult to orientate yourself when you walked down them. Signage and directions around the building was limited and not always dementia friendly. There was limited personalisation of communal areas, which meant the service had a clinical atmosphere. A professional who gave us feedback before our inspection told us, "The general layout of the building has an impersonal feel and is dated."

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw from people's care records that mental capacity assessments had been completed for people where appropriate and best interest decisions made for their care and treatment. Care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date, the correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Staff we spoke with had a good working knowledge of the principles of the MCA and could describe how they put these into practice when supporting people. One member of staff told us, "We always try to give people choice, even if they can't make all decisions for themselves."

People and their relatives told us they were supported to access external professionals when they needed them. One person we spoke with told us how they were being supported to visit the hospital for some planned surgery. A relative we spoke with said a person was experiencing pain and was taken to hospital "straight away" to be examined.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. These included GPs, community matrons, community nurses, speech and language therapists and social workers. However, we also saw examples of

staff not making referrals to dieticians where appropriate and of not following district nurse medicine advice in the management of pressure sores. This meant the service did not always work effectively with external professionals to monitor and promote people's health.

Requires Improvement

Is the service caring?

Our findings

We found that staffing levels at the service meant staff were always very busy and there was very little time for them to have meaningful engagement with people. We observed that there was very limited social interaction between people and staff. For example, we saw some people left alone to watch TV in a lounge for 40 minutes before a member of staff came in to speak with them. Most people spent all day in their bedrooms, with staff entering them only to deliver support. A professional who gave us feedback before the inspection said, "I feel that care and the environment could be improved. Patients seem to be always in their rooms in bed." The only social interaction we saw between people and staff was during lunchtime, when staff were supporting people with their meals. This meant care was often focused on the task in hand instead of concentrating on the person receiving support. A member of staff we spoke with said, "There is no time to get to know people. There is always a pressure of time and always a catch-up pressure. I would love to get to know them."

We saw examples of people's privacy and dignity being compromised. We arrived early on the first day of inspection to speak with night staff. On arrival we saw that 26 people had their bedroom doors open, which meant we could see them sleeping or stirring in bed. We saw one person with their sheet off the bottom half of their bed which meant we saw them in their underwear and with a continence pad showing. We asked the manager why so many bedroom doors were open. The manager said people used to have sleep care plans in which most people said they preferred to have their door open, but these were not in place at the time of our inspection. On the first day of inspection we also saw that people's confidential dietary support needs and preferences were pinned up on a dining room wall. This had been removed by the second day of our inspection, but this meant that people's confidential information had been publically displayed.

This meant that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these issues people and relatives spoke positively about staff at the service, describing them as kind and caring. One person we spoke with said, "Staff are nice, kind and brilliant." Another person said, "Staff are very friendly." Staff we spoke with were committed to providing high quality, caring support.

At the time of our inspection one person was using an advocate. Advocates help to ensure that people's views and preferences are heard. The manager was able to explain how the advocate was involved in the person's care.

No one was receiving end of life care at the time of our inspection, but policies and procedures were in place to arrange this where needed based upon the Gold Standard Framework. The Gold Standard Framework is a systematic, evidence-based approach to optimising care for people approaching the end of life. A relative we spoke with said they had been involved in discussions about one person's end of life care. We saw that end of life care plans (Emergency Health Care Plan) were in place for people, which meant information was available to inform staff of the person's preferences at this important time and to ensure their final wishes were respected. However, we did see that one person was missing these care plans. The manager and

provider said these would be put in place.

Requires Improvement

Is the service responsive?

Our findings

At the time of our inspection there was no activities co-ordinator but the provider and manager told us one had been recruited and would be starting at the service soon. Until then care and kitchen staff were required to carry out activities. During the two days of our visit we did not see any activities taking place and most people spent all day in their room. People's activity preferences were recorded in their care plans but we were not shown any evidence of how these were used to plan and deliver activities people enjoyed.

Staff we spoke with did not think enough activities were provided to people at the service. One member of staff told us, "I don't think there are enough activities. We occasionally have an entertainer in, but other places do that weekly. Most people just spend their days in their room." Another member of staff said, "Things are offered to people but it's debatable whether it's enough. I don't think most people would take things up" and "We brought in a 'Wish a Day' scheme but we don't have time to do it. We used to do things like take people to the river, but it is so difficult to find the time. We can't find time due to staffing."

Despite this, people told us they were supported to access activities they enjoyed. One person we spoke with said, "At Easter we had a singer and have had drinks on the balcony one afternoon". Another person said, "I never feel isolated, I have my door open during the day and can see what's going on. I also enjoy going to [named club] where I meet friends and talk with them".

Our judgment was that people were at risk of social isolation due to a lack of meaningful activity available at the service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people started using the service their support needs were assessed in a number of areas, including mobility, continence, personal care and skin integrity. Following this initial assessment care plans were developed detailing the person's care needs and how they should be supported with them. People signed these initial assessments to confirm they covered their support needs. Where people lacked capacity to sign we saw they had been approved by their relatives or representatives. Care records contained also contained a basic social profile. This meant that there were some details about the person's preferences, interests, people who were significant to them, spirituality and lifestyle before they moved into the service.

The provider's policy was that care plans should be reviewed monthly or more regularly should people's support needs change. Daily notes were kept for each person with information recorded regarding basic care, hygiene, continence, mobility and nutrition. This was designed to ensure staff had the latest information on people's support needs. However, we saw that care plan reviews and daily notes had not always identified changes to people's nutritional support needs or pressure care. As a result people had not always received responsive care.

Policies and procedures were in place to respond to complaints. The provider had a complaints policy, which set out how complaints would be investigated and the timescale for responding. It also contained information on external bodies people could contact if they were dissatisfied with the outcome. People and

relatives we spoke with said they knew how to complain but did not have anything they wished to complain about. Records confirmed that where issues had been raised they were investigated and responded to following the provider's policy and remedial action taken.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since August 2016. The manager and provider carried out a number of quality assurance checks at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

However, these checks had not identified the issues we found at the inspection in relation to medicine management, risk assessments and responses, fire safety, staffing levels, dignity and respect and training.

The manager and other senior staff carried out audits of care plans, housekeeping records and medicines. It was not always clear from records whether audits had taken place and, if so, whether the remedial action identified had been completed. For example, one person's care plan had been recorded as audited on 20 June 2017 with no remedial action needed. However, an audit of the same person's care plan on 30 June 2017 stated that the plan needed reviewing as this should have been done on 20 June. It was therefore unclear why it had been recorded as reviewed on 20 June 2017. In another example, we saw medicine audits had identified that some staff had not been signing MARs after they administered medicine. However, there was no record of any action taken as a result of this. The provider carried out monthly quality review visits to the service. We reviewed records of these and saw they had not identified the issues we found during the inspection.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had not informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

During our inspection we saw that one person using the service had been hospitalised in June 2017 as a result of extreme hydration. We had not been notified about this as required, and had to ask the manager to send the relevant notification on the second day of our visit.

This meant procedures were not in place to assess, monitor and improve standards at the service. It also meant the manager had not always notified us of events and incidents as required. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff spoke positively about the management of the service. One person told us, "[Manager] is really nice. She came to see me when I was in hospital to do an assessment." Another person said, "The manager is nice to me." A member of staff said, "I feel supported."

Feedback was sought from people using the service and staff through an annual questionnaire. This had last been carried out in 2016, and we saw from the results that positive feedback had been received. For example, 12 people responded to the 2016 survey. All of the respondents said they were happy with their room and would be confident to speak with staff if they had any problems. Eight members of staff

responded to the 2016 questionnaire. All eight responded that the manager was supportive.

Staff told us they were supported through regular staff meetings. Meetings were also held for people living at the service, and relatives were invited to these. One relative told us, "Dates of meetings are displayed on the notice board if we wanted to attend."

After our inspection we spoke with the provider about our findings. The provider said they were working hard to address the issues we identified and sent us an action plan with some details of how this was being done.

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 10 HSCA RA Regulations 2014 Dignity and respect We saw examples of people's privacy and dignity being compromised. People were at risk of social isolation due to the lack of meaningful activity at the service. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The manager did not effectively monitor staffing levels to ensure they were sufficient to keep people safe. Procedures were not in place to ensure staff received the training needed to support people effectively. 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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people using the service were not always effectively assessed or acted on. People's medicines were not always managed safely. Fire drills were not regularly carried out. Regulation 12(1).

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant with this regulation by 15 August 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Procedures were not in place to assess, monitor and improve standards at the service. Regulation 17(2)(a).

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant with this regulation by 15 August 2017.