Morleigh Limited

Elmsleigh Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Elmsleigh is a care home that provides nursing care for up to 48 older people, some of whom had a diagnosis of dementia or other mental health conditions. On the day of the inspection there were 44 people living at Elmsleigh. 32 people lived in the main house and 12 people lived in the adjoining annex (called the bungalow).

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. The manager in charge of the day to day running of the service had submitted an application to CQC for the registered manager position. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We carried out this unannounced inspection of Elmsleigh Care Home on 14 June 2016. At this comprehensive inspection we checked to see if the service had made the required improvements identified at the inspection of 8 September 2015. In September 2015 we found the premises and equipment were not properly maintained. Some areas of the building did not have hot water due to problems with the boiler. There was broken equipment stored around the building, including in areas used by people such as lounges and bathrooms. There were two dirty shower rooms where the showers had been removed and the space was being used to store broken equipment. Toilet facilities in both these shower rooms were being used by people.

We also found there were not enough working hoists and wheelchairs to meet people's needs. There were insufficient adaptations to the premises to support people with dementia.

At this inspection we found that signage to help people with dementia to orientate independently around the building was in place. Additional hoists and wheelchairs were available in the service and staff told us there was enough suitable equipment to meet people's needs. The two shower rooms, identified at the inspection in September 2015 as being dirty, had been partially re-decorated although the floors where the showers had been were still dirty and stained.

There was still broken equipment stored around the premises, including in the two shower rooms identified

at the last inspection. There were three bathrooms where water was either at the incorrect temperature or taps that were not working. An unlocked boiler room put people at risk of harm because the room had hot pipes and electrical equipment. During the afternoon we found the heating along one corridor of the premises was not working. After we advised the deputy manager, the thermostat was altered, and by end of the inspection heating had been restored to that area. These concerns potentially put people at risk of harm and created an environment that was not homely or pleasing for people to live in.

We had concerns about the safety of two people living at the service who had been assessed as being at high risk of falls and 'unsafe if left unobserved'. Both people had moved from other services where they had been funded for individual support. The funding for additional staff had not transferred with them and managers had not put any additional staff on duty each day. The numbers of staff on duty were not enough to provide individual care for each of these people. Records showed that both persons A and B had fallen on a number of occasions. At the time of our inspection one person was in hospital and the other person had recently returned from hospital. Both had been admitted to hospital with injuries from falls at the service. Insufficient action had been taken to mitigate the risk of harm to these two people.

Advice was sought from external healthcare professionals but not always acted upon. For example, records for one person showed that in February 2016 a discussion took place between the service and an external healthcare professional. This discussion suggested the service should provide protective headwear because the person was at high risk of hitting their head when falling. This had not been actioned and suitable protective headwear had not been obtained despite this person continuing to have frequent falls and being at risk of hitting their head.

Care plans were personalised to the individual and gave clear details about each person's specific needs and how they liked to be supported. These were reviewed monthly or as people's needs changed.

Where people were assessed as being at risk of skin damage due to pressure, appropriate equipment such as hospital beds and pressure relieving mattresses were in place. Care plans detailed where people needed to be regularly re-positioned and how often staff should carry out this task. Staff monitored the food and fluid intake for people who were assessed as being at risk being undernourished and dehydrated.

Safe arrangements were in place for the storing and administration of medicines. People received their medicines at the prescribed time.

Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge. Staff knew how to recognise and report the signs of abuse.

Management and staff had a good understanding of the Mental Capacity Act 2005 (MCA). Where people did not have the capacity to make certain decisions the management and staff acted in accordance with legal requirements under the MCA. Staff applied the principles of the MCA in the way they cared for people and told us they always assumed people had mental capacity.

There was a management structure in the service, where the responsibilities of each role were defined by the organisation. Staff had a positive attitude and they told us they felt supported by the management. Comments from staff included, "Can approach them easily [management]", "I am happy, we have been through a rough patch, it is better now" and "There is good communication with managers, we have lots of support and good handovers each shift."

People and their families were given information about how to complain. People told us they knew how to

raise a concern and they would be comfortable doing so. Where complaints had been made appropriate action had been taken to resolve the concerns raised to the person's satisfaction. There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

We identified breaches of the regulations. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Insufficient action had been taken to mitigate the risk of harm to people who were at high risk of serious injury from falling.

Premises and equipment were not properly maintained.

Staff knew how to recognise and report the signs of abuse. The service had safe recruitment arrangements in place.

Is the service effective?

Requires Improvement

The service was not entirely effective. Equipment was stored around the premises in areas regularly used by people, creating an environment that was not homely or pleasing for people to live in.

Advice was sought from external healthcare professionals but not always acted upon, resulting in some people's needs not being met.

Staff were knowledgeable about how to meet people's individual needs. People were supported to have their healthcare needs met by external professionals as necessary.

Where people did not have the capacity to make decisions for themselves management acted in accordance with the legal requirements.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

Care plans detailed people's choices and preferences about their care and support. Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

Staff supported people to take part in social activities of their choice.

People and their families told us they could raise concerns and when they did action was taken to resolve these concerns.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. The manager had been in post for four months and they, together with a newly appointed deputy manager, had provided stable management and leadership for the service. However, the service did not have a registered manager in post.

Staff said they were supported by the management and they worked together as a team.

There were systems in place to assess and monitor the quality of the service provided to people. However, audits had not identified some areas where improvement was required.

Elmsleigh Care 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.

This unannounced inspection took place on 14 June 2016. The inspection team consisted of two inspectors.

We reviewed information we held about the home before the inspection including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with two people who were able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices.

We also spoke with eight care staff, the clinical lead (who was also the nurse in charge that day), the deputy manager and the provider. We also spoke with five visiting relatives. We looked at six records relating to the care of individuals, four staff recruitment files, staff training records and records relating to the running of the home.

Requires Improvement

Our findings

At our inspection of 8 September 2015 we found that the premises and equipment were not properly maintained. Some areas of the building did not have hot water due to problems with the boiler. There were two dirty shower rooms where the showers had been removed and the space was being used to store broken equipment. Broken equipment, stored around the building, had not been repaired or removed as was appropriate.

At this inspection while we found some improvements had been made to the premises and equipment there were still areas of concern. The two shower rooms, identified at the inspection in September 2015 as being dirty, had been partially re-decorated although the floors where the showers had been were stained and dirty. We also found there was broken equipment stored around the premises, including in the two shower rooms identified at the last inspection.

There were three bathrooms that were not in full working order and posed a potential risk of harm to people using them. One bathroom had a missing toilet seat and the water in the sink had a hot water temperature recorded at 50 degrees centigrade, which was too hot to be safely used by people living at the service. Hot water at this temperature is a scalding risk. A second bathroom had no hot water in the sink and a third bathroom had no cold water and the hot tap was loose and moved from its fitting when used.

An unlocked boiler room, accessed through a bathroom, put people at risk of harm because the room had hot pipes and electrical equipment.

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

We had concerns about the safety of two people living at the service who had been assessed as being at high risk of falls. Both people were mobile and often very active, frequently moving from one area of the premises to another. However, they had no awareness of their physical capabilities or the risk to their safety. Records showed that both persons A and B had fallen on a number of occasions. At the time of our inspection one was person was in hospital and the other person had recently returned from hospital. Both had been admitted to hospital with injuries from falls at the service. One person was admitted to hospital with a fractured hip and the other person with a suspected head injury.

Risks assessments had been completed for both people and the level of risk of harm from falls had clearly

been identified. An entry in the care plan for one of them, dated 21 March 2016, stated, "[Person's name] has had a high amount of falls recently. This has now caused a safety concern for them. They are unsafe if left unobserved." However, there were no instructions for staff as to whether or not the person was to be kept in 'line of sight'. Staff said they tried to keep the person in 'line of sight', however, they added that this was not always possible to achieve. Conversations with staff showed they were worried that people were at risk of harm and that they may not be able to prevent this from happening. We observed during our inspection that staff were unable to give constant individual support for the person.

Both people had moved from other services where they had been funded for individual support. The funding for additional staff had not transferred with them and managers had not put any additional staff on duty each day. The numbers of staff on duty were not enough to provide individual care for each of these people.

While we could see staff were working hard to try and prevent these two people from falling, they were both at significant risk of sustaining serious injuries from repeated falls. We therefore found that the provider had not taken sufficient action to mitigate the risk of harm to these two people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had their own individual slings while other people, who used the same size and type, shared slings. We had previously raised with the provider, when inspecting other services within the Morleigh group, that this is not considered to be good practice. This is because there is a risk of cross infection and lack of respect for people's dignity. The deputy manager and provider told us that an audit of slings had taken place and as a result some slings had been removed and were due to be replaced. The provider assured us that new slings to replace the ones removed from the service would be put in place as soon as was practicable. Once these additional slings were in place each person would have their own sling.

On the day of the inspection there were nine care staff and one nurse on duty from 8.00am until 2.00pm and eight care staff and one nurse from 2.00pm until 8.00pm to meet the needs of 44 people. Staff were allocated to work either in the main house or the bungalow. Six care staff were allocated to the main house and three to the bungalow. During the day staff moved between the two units in order to meet people's needs. Sometimes staff would move, for short periods, between the two units to cover for staff breaks and when staff were supporting people in their rooms. For example, staff answered a call bell in the corridor close to the bungalow because they were free to do so and they could quickly respond to help the person. In addition to these staff were the deputy manager, kitchen and domestic staff.

New staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks. Recent changes to the provider's centralised recruitment systems had resulted in improved communication between head office and each service. The deputy manager told us that two new staff had worked some shadow shifts in the service recently. However, these staff would not be included in the rotas until head office told them all their recruitment checks had been completed.

Medicines were managed safely at Elmsleigh. All medicines were stored appropriately and Medicines Administration Record (MAR) charts were fully completed. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records demonstrated the room and refrigerator temperatures were consistently monitored. This showed medicines that required cold

storage were safely managed. Staff had received appropriate training in administrating and managing medicines and regular audits were completed.

Some people needed to have their medicines given to them covertly (disguised in their food). This was because they refused to take their medicines and did not have the capacity to understand the consequences of not taking them. Records showed that advice had been sought from GPs and pharmacists about how the medicines should be given safely. Best interest meetings had taken place involving people's families and their GP. Agreements for medicines to be given covertly were reviewed annually with the appropriate healthcare professionals.

Where people were assessed as being at risk of skin damage due to pressure, appropriate equipment such as hospital beds and pressure relieving mattresses were in place. This equipment was checked daily by the nurse in charge of each shift to help ensure people were protected from the risk of developing pressures sores.

Records showed that manual handling equipment, such as hoists and bath seats, had been serviced. There was a system of health and safety risk assessment. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills.

Requires Improvement

Our findings

At our inspection of 8 September 2015 we found there was broken equipment stored around the building, including in areas used by people such as lounges and bathrooms. There were insufficient adaptations to the premises to support people with dementia. There were not enough working hoists and wheelchairs to meet people's needs. Some parts of the building had unpleasant odours present.

At this inspection broken equipment was still being stored around the premises in areas regularly used by people. For example, in bathrooms used by people, in corridors and in one of the lounges. On the day of our inspection a visitor reported a broken chair in one of the lounges, which was removed by staff.

During the afternoon of the inspection we found the heating in one corridor of the premises was not working. People, who were in rooms in that corridor, told us they felt cold. We advised the deputy manager who told us the thermostat had been turned down to 15 degrees centigrade. The heating in that area of the building came on once the temperature on the thermostat was turned up. All of the above created an environment that was not homely or pleasing for people to live in.

This contributed to a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Advice was sought from external healthcare professionals but not always acted upon. For example, records for one person showed that in February 2016 a discussion took place between the service and an external healthcare professional. This discussion suggested the service should provide protective headwear because the person was at high risk of hitting their head when falling. This had not been actioned and suitable protective headwear had not been obtained. The person had recently hit their head during a fall which had resulted in being admitted to hospital with a suspected head injury. Although, after scans it was confirmed that they had not sustained a head injury, they remained at a high risk of injury due to hitting their head when falling.

This contributed to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection in September 2015 some improvements had been made to the environment. Signage to help people with dementia to orientate independently around the building was in place. Additional hoists and wheelchairs were available in the service and staff told us there was enough suitable equipment

available to use. The premises were clean and odour free.

Staff were knowledgeable about the people living at the service and had the skills to meet people's needs. Staff told us they had received relevant training for their role and training was regularly updated. There were opportunities for obtaining additional qualifications. All care staff had either completed or were working towards a Diploma in Health and Social Care.

Staff told us they felt supported by the manager and deputy manager. They told us they had received an annual appraisal to discuss their work and training needs. Nurses received regular one-to-one supervision with the clinical lead. Since starting their role, four months ago, the manager had concentrated on getting to know care staff by working alongside them to support them and observe their practice. Staff confirmed that the manager was very visible in the service and worked with them most days. One care worker said, "[Manager's name] is a good manager, very approachable. They check on us regularly." The manager had started a programme to meet regularly with staff for one-to-one supervision and had carried out the first supervision with each member of care staff.

New staff completed an induction when they commenced employment which included training identified as necessary for the service and familiarisation with the service's policies and procedures. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. One care worker said, "I had training and shadowing for a week before I started to work on my own." The service's induction incorporated the Care Certificate. This is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector.

People had access to healthcare services and received on-going healthcare support. Specialist services such as occupational therapists and dieticians were used when required. People and visitors told us they were sure that a doctor or other health professional would be called if necessary. Visitors told us staff always kept them informed if their relative was unwell or a doctor was called.

People were supported to eat and drink enough and maintain a balanced diet. People were provided with drinks throughout the day and at the lunch tables. People in their bedrooms also had access to drinks. We observed the support people received during the lunchtime period. Staff provided support appropriate to people's individual needs, while enabling people to eat as independently as possible. For example, by serving meals in bowls or with plate guards so people could eat without support from staff.

Some people were assessed as being at risk of not eating or drinking enough to meet their needs. Where people were identified as being at risk staff monitored each person's food and fluid daily intake, to ensure they were appropriately nourished and hydrated. Food and fluid charts were completed by staff so individual people's intake could be monitored.

Staff asked people for their consent before providing care or treatment. People were involved in making choices about how they wanted to live their life and spend their time. The service asked people, or their advocates, to sign consent forms to agree to the care provided. However, consent forms were not consistently signed or an explanation recorded if it was not possible to obtain written consent.

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. Management and staff were clear on the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

Management carried out assessments to see if there were any restrictions in place for people that might mean an application under DoLs would need to be made. Several people had DoLS authorisations and other applications were being processed. Where conditions were applied to the authorisations, records showed that these conditions were being met by the service.

Care records detailed whether people had the capacity to make specific decisions about their care. For example, care records for one person stated, "[person's name] can make day-to-day decisions such as what they would like to eat and drink." Where people did not have the capacity to make certain decisions the service acted in accordance with legal requirements. Where decisions had been made on a person's behalf, the decision had been made in their best interest at a meeting involving key professionals and family where possible.

Good

Our findings

Due to their health needs some people were unable to tell us verbally about their views of the care and support they received. However, we observed people were relaxed and comfortable with staff, and they approached staff for help or support without hesitation. Staff were passionate and enthusiastic about their work and told us they thought people were well cared for. Comments from staff included, "I love my job" and "I enjoy working here, we are a good team." A relative told us, "Staff are very kind and they know my wife's needs."

Staff provided care for people that was appropriate to their needs and helped to support their emotional well-being. Staff were calm, patient and discreet when providing care for people. For example, where some people had difficulty orientating around the premises staff gently showed them where their rooms or bathrooms were located.

People were able to make choices about their daily lives. People's care plans recorded their choices and preferred routines. For example, what time they liked to get up in the morning and go to bed at night. People were able to choose where to spend their time, either in one of the lounges or in their own rooms. During the inspection people moved around the building and went outside into the garden when they chose to. Staff asked people where they wanted to spend their time and what they wanted to eat and drink.

Most people living at Elmsleigh had a diagnosis of dementia or memory difficulties and their ability to make daily decisions could fluctuate. The service had worked with people and their relatives to develop life histories to understand the choices people would have previously made about their daily lives. Staff had a good understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible. Where people had limited verbal communication care plans gave instructions for staff as to how to communicate with people to help ensure their wishes were understood. For example one person's care plan said, "Use visual prompts when asking the person what they want. For example, when asking if they would like a cup of tea, also show them a cup of tea."

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when staff supported with personal care. We observed staff knocked on bedroom doors and waited for a response before entering.

Staff supported people to maintain contact with friends and family. Visitors told us they were always made

welcome and were able to visit at any time. People were able to see their visitors in one of the lounges or in their own room. We observed staff talking with visitors on arrival and making them feel comfortable.

Good

Our findings

People received care and support that was responsive to their needs because staff were aware of the needs of people who lived at Elmsleigh. Staff spoke knowledgeably about how people liked to be supported and what was important to them.

Care plans were personalised to the individual and gave clear details about each person's specific needs and how they liked to be supported. This information provided direction and guidance for staff to follow to meet people's needs and wishes. For example, care plans described in detail how staff should assist people with their personal care including what they were able to do for themselves. Where people needed to be regularly re-positioned care plans detailed how often staff should carry out this task. Daily records showed that people were re-positioned in line with their assessed needs.

Staff told us care plans were informative and gave them the guidance they needed to care for people. Daily records detailed the care and support provided each day and how they had spent their time. Staff were encouraged to give feedback about people's changing needs and this information was used to update care plans and communicate at handovers. The nurse in charge give a handover to staff before they started each shift. This handover gave staff detailed information about each person's needs, if calls to GPs had been made and if any additional monitoring was required for anyone who was unwell.

Care plans were reviewed monthly or as people's needs changed. People, who were able to, were involved in planning and reviewing their care. Where people lacked the capacity to make a decision for themselves, staff involved family members in reviewing care plans.

Before any new people moved into the service a manager carried out an assessment of their needs. This assessment was used to start to develop a care plan for the person. We looked at the care file for a person who had recently moved into the service. Records showed that staff had closely monitored their routines, such as eating and drinking and how they liked to spend their time to build a picture of their needs. As new information was discovered their care plan was updated. Within a few days of the person moving into the service a detailed care plan had been written. This meant staff had clear and accurate information to enable them to meet the person's needs.

The service employed an activities person to carry out activities for two hours in the afternoon five days a week. They facilitated craft work, games and puzzles with people as well as spending time talking with people individually. Some outside entertainers came into the service. On the day of the inspection a local

church visited to sing songs with people and give people the opportunity to receive communion should they wish to.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. A relative told us they had made a complaint a few months ago and that had been quickly resolved.

Requires Improvement

Our findings

The service is required to have a registered manager and there had not been a registered manager in post since March 2015. However, a new manager had been managing the day to day running of the service since February 2016 and they had submitted an application to CQC for the registered manager position.

There were quality assurance systems in place to help ensure that any areas for improvement were identified and addressed. Regular audits were completed for maintenance, dependency levels, care plans, pressure mattresses, bed rails, bath hoists, medicines, pressure sore management, falls, laundry and catering. Monthly visits to the service by the head of operations meant there were checks in place to help ensure any actions from the auditing processes were completed. However, these audits had not identified the areas of concern highlighted in the safe and effective sections of the report. Action had not been taken to carry out the necessary repairs to the premises or to identify the high dependency levels for some people and adjust staffing levels to help ensure their safety.

We looked at the provider's website and found there was no information regarding inspection findings at any Morleigh services. We have asked that the website be updated and will check to see if this has happened.

There was a management structure in the service, where the responsibilities of each role were defined by the organisation. The manager was supported by a newly appointed deputy manager and two senior care staff. The organisation's clinical lead had based themselves at the service since the manager's appointment to provide clinical and management support.

In the time the new management structure had been in place a solid team of nurses and care workers had been developed. Staff had a positive attitude and they told us they felt supported by the management. They were clearly committed to their work with an emphasis on making people's daily lives as pleasurable as possible. The manager worked alongside staff most days and this gave them the opportunity to monitor the quality of the care provided. It also enabled them to identify staff that may have additional training needs or require more support. The deputy manager hours were divided between management time and nurse shifts.

Staff told us they were encouraged to make suggestions about how improvements could be made to the quality of care and support offered to people. They did this through informal conversations with management, at daily handover meetings, staff meetings and one-to-one supervisions. Comments from staff included, "Can approach them easily [management]", "I am happy, we have been through a rough

patch, it is better now" and "There is good communication with managers, we have lots of support and good handovers each shift."

Visitors all told us management were visible in the service they described the management as open and approachable. They told us there had been a several changes of managers over the last few months and they were pleased that the service was experiencing a more stable period.

Management had ensured that the Care Quality Commission (CQC) registration requirements had been complied with. This included submitting notifications, such as deaths or serious accidents and advising CQC of any DoLS or safeguarding referrals.

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 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because premises and equipment were not properly maintained.Regulation 15

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not provided in a safe way. Insufficient action had been taken to mitigate the risk of harm to people using the service. Regulation 12

The enforcement action we took:

warning notice