Making Space

Swallow Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Swallow Lodge is a short-term respite service providing personal and nursing care to five people at the time of the inspection. The service is registered to provide accommodation for a maximum of eight people with a learning disability. People stay at the service to receive respite care, and over a period of a year, up to 60 people use the service.

People's experience of using this service and what we found

Right Support
The service did not support people to have maximum choice, control, be independent and have control over their own lives. Where people lacked capacity to make decisions, the provider failed to put in place documents to support decision making.

Ineffective care planning led to people experiencing increased periods of distress and restrictive practices.

A complete failure to record and monitor incidents meant there were no learning to avoid and reduce reoccurrence.

The service failed to provide a safe, well maintained environment; areas often had to be closed off from use due to risk behaviour presented by people.

Planned activities were minimal and people lacked stimulation and interaction from staff due to significant staffing issues at the service.

Medicines were not managed safely. The provider failed to put in place 'as and when required' (PRN) protocols for antipsychotics, meaning we could not be assured this was given appropriately.

Right Care
Peoples equality and diversity needs were not always met. Cultural needs were not understood or met.

People did not always have the opportunity to have privacy, the provider had failed to design the environment to promote this.

The service failed to protect people from poor care and abuse. Staff had failed to identify, record and report incidents, the provider had failed to monitor the quality of the service resulting in poor care and incidents of a safeguarding nature occurring.

The service did not have enough staff to meet the needs of people. Staff deployment meant people did not have suitably qualified and skilled staff to support them.

Risk management was poor. A lack of support plans and assessments in place meant people's needs were not identified assessed or managed effectively.

Opportunities for people to engage in activities were minimal. The provider failed to personalise and plan meaningful activities for people.

Right culture□
There were indicators of a closed culture and a punitive approach used by staff. Staff had a lack of support or guidance on how to support people to lead inclusive and empowered lives.

People received poor quality care, due to staff not having the required skills and abilities to meet people's needs.

Staff did not always know the person due to a lack of training and support plans in place. This meant care was not personalised or tailored to their needs.

Staff turnover was high, meaning people received inconsistent care from staff that did not know them.

The culture of the home was negative, and staff told us they had to just get through the day. Meaning there was no drive for improvement or quality within the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 29 December 2018)

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, personalised care, dignity and respect, deprivations or liberty and leadership at this inspection.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Swallow Lodge

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors and an Expert by Experience carried out the inspection An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced

What we did before 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and five relatives about their experience of the care provided. We spoke with six members of staff including the operations manager, senior carers, carers.

We reviewed a range of records. This included five people's care records and five medication records. We looked at three 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.

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

Systems and processes to safeguard people from the risk of abuse

- People were not kept safe from avoidable harm. Staff supporting emergency admissions were exclusively agency staff, who did not have any information of how to support the person, as a consequence a series of incidents had occurred resulting in injury to staff and damaged to the environment. People were regularly left unsupervised during their stay due to staff supporting with incidents involving other people within the service.
- Staff had training on safeguarding, however, staff did not know how to recognise and report abuse. We found incidents of a safeguarding nature on the providers electronic incident log had occurred and were not reported to the relevant professional bodies, meaning these could not be investigated fully, we were also informed by staff of further incidents that had occurred but due to lack of staff had not been reported.
- There are indicators of a closed culture at the service where punitive measures were used to manage people's distressed behaviour. We reviewed daily notes and found that staff were potentially using restrictive interventions without appropriate care plans and authorisations, for example, it was documented "[Person] 'calmed' down and was allowed to go to the lounge." This indicates a culture of control where staff have power over service users.

Assessing risk, safety monitoring and management

- People's risk were not managed. We found historical information in care plans and risk assessment not relevant to people's current and ongoing needs, we also found no care plans or risk assessments in place for people who presented significant risk to themselves or others. This meant people's risk were not assessed, monitored or managed effectively, leading to poor care and unwarranted restrictions for people.
- People did not always get the support they needed due to staff being unable to access their care records or not informed of the correct processes to input information. We found information about risks people presented with were not always communicated. Agency staff were exclusively supporting emergency placements and had not being given the information or access to required documents. As a consequence, staff had failed to keep accurate and up to date records for people.
- We found restrictive practices were used for people limiting their freedoms. For example, daily notes had recorded, "[Person] was restrained by another member of staff." We found there were no risk assessments or support plans in place related to the use of restraint or restrictive practices. Furthermore, we found no evidence of incidents recorded when restraint or restrictive practices were used.
- We found risks to people were significantly increased due to a failure to assess environmental risks, for example, due to a failure to identify and assess these risks, it had led to furniture being damaged and people put at risk from injury.

Using medicines safely

● Medicines were not managed safely. We found the use of antipsychotics had not been assessed and managed appropriately. 'As and when' [PRN] protocols were not in place meaning staff did not have any guidance of when to administer medicines.
● We found PRN medicines would not be administered in a timely way in the community due to staff providing support not having the required training. This meant people were at risk of poor medicines management and accessing PRN in a timely way.
● We reviewed medicines administration charts [MAR] and found one person had 19 administrations of antipsychotics in a three week period, we found no reasons why this had been administered and could not be assured staff had appropriately administered medicines in line with NHS England guidelines 'Stopping over-medication of people with a learning disability, autism or both' [STOMP].

Learning lessons when things go wrong
● There was no evidence of learning from incidents. Daily notes showed there were 31 incidents of distressed behaviour involving one person. Incidents included damage to property, absconding and physical aggression towards staff. Only two incidents involving this person were logged on the provider incident log.
● Another person had a total of seven incidents detailed in their daily notes, including physical and verbal aggression to staff, they also displayed verbal aggression and attempting to force entry to a property. None of these incidents were logged on the provider incident log.
● Staff told us they were not always aware of incidents when people were supported by agency staff, furthermore, as detailed above agency staff were not given any information, guidance or access to the provider's electronic recording system, to record and report incidents appropriately.
● Due to the providers failure to ensure staff reported and recorded incidents appropriately, we found no evidence incidents were reviewed or monitored to prevent reoccurrence.

Staffing and recruitment
● The service did not have enough suitably trained and competent staff. Agency staff were heavily relied upon and at times did not turn up meaning people did not always receive their assessed level of staff support.
● We reviewed arrangements for deploying staff and found staff supporting did not always have the required skills to meet the needs of people, despite this the provider allocated these staff to support, placing people at risk of poor care.

The provider failed to assess and manage risks relating to restrictive practices, medicines management, staffing levels and behaviour management. This placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keep premises clean and hygienic.

● The service prevented visitors from catching and spreading infections.
● The service followed shielding and social distancing rules.
● Staff used personal protective equipment (PPE) effectively and safely.
● The service tested for infection in people using the service and staff.
● The service promoted safety through the layout of the premises and staff's hygiene practices.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to

alert other agencies to concerns affecting people's health and wellbeing.
● The service's infection prevention and control policy were up to date.

Inadequate

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 good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were not assessed. We reviewed care files and found an old care plan from 2018 was used to support a person on admission. This care plan did not contain information regarding the person's current and ongoing needs; therefore, staff did not have the information to meet their needs. This placed people at risk of poor care.
- Staff told us they had highlighted to the manager they could not meet the needs of people before moving into the service, however, people had still been admitted to the home when their needs could not be met. This posed a risk and directly impacted on them, other people and staff.
- We found no de-escalation strategies for people who presented with distressed behaviours. This meant staff were not informed of distraction techniques or triggers to prevent escalation for the person.
- Care plans for regular respite admissions, did not always contain information to meet their physical medical conditions, for example, a person who required medical nutritional support did not have the guidance in place for staff to ensure the function of the medical equipment.

Staff support: induction, training, skills and experience

- Staff did not always have the appropriate training to meet the needs of people. We reviewed training in place for staff and found no specific training in place for people's identified needs. The provider failed to adopt safe staffing practices, meaning staff had reduced opportunity to gain adequate skills and knowledge to meet the needs of people.
- A review of the rotas found, during April 2022 'there was only eight days which were covered by a member of staff who was trained in both behaviour and medicines management'. This placed people at risk of avoidable harm if incidents took place or PRN medicine was required.
- We found staff who delivered care did not have the understanding or knowledge of restrictive practices, and we found restrictive practices were used by staff. Meaning people who had a learning disability did not have their human rights supported or respected. Issues identified during inspection demonstrated staff lacked knowledge in regards of understanding risk management, behaviour management and communication leading to people being at risk.

Staff lacked competency and support in order to meet people's needs and assess and mitigate known risks to people. This was a breach of Regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs

● The environment was poorly decorated and unwelcoming for people. No consideration had been made to people's sensory needs. During a tour of the service two people were in the lounge faced away from the TV, which was the only source of stimuli within the room. They were also left unsupervised, with no means to manoeuvre themselves.
● Areas of the service were in poor state of repair due to damaged furniture and removed cupboards and wardrobe doors. We spoke with a person residing at the service who told us they didn't have a wardrobe door. When we spoke to a senior member of staff, they told us, "we removed the wardrobe door for a previous placement, we haven't put it back on yet."
● We saw in three of the bathrooms there were broken tiles, a broken mirror and poorly maintained bathroom fittings, all posing a risk of injury for people using these facilities. People's safety could not be assured due to environmental risks.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People were being deprived of their liberty without the legal authority. We found people admitted as an emergency and regular respite admissions did not have the appropriate legal authorisation in place despite identified restrictions being placed on them whilst residing at Swallow Lodge.
● We found 28 people who accessed regular respite, had DoLS documents written by staff in October 2020 but had not been submitted to the legal authority for authorisation.
● A review of people's care files found incomplete or a lack of mental capacity assessments and best interest forms. This meant people did not always have their legal rights upheld.

Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority. This placed people at risk of harm. This was a breach of Regulation 13(5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
● People did not always have access to healthcare services they required. Due to the providers lack of monitoring, we could not be assured people had appropriate referrals made to health professionals when there had been a decline in their wellbeing.
● We found one person only had an historical needs assessment in place, which detailed they were registered with a GP in a different town from two years previously. It could not be evidenced timely access to GP services could be sought if required.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff told us they were responsible to cook and provider meals for people. The senior staff member

planned and bought the food. People were not involved in the planning of the menu.

● People were supported to maintain a balanced diet. We saw a menu that offered choice for people and from daily notes we found on occasion people were supported to have a takeaway of their choice.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Due to the deployment of staff and lack of skills, we found people were not always engaged and stimulated. We observed people left unsupervised for long periods of time with no meaningful activities in place.
- People were not always matched with a staff member, meaning interaction was minimal. For example one staff member told us, "They [public] think it all about activities when they [people] are here for respite, we don't do that, we don't have time for that, we are here to look after them."
- We found language and actions used by staff were at times punitive and derogative towards people for example when we reviewed daily notes, we found comments " [Person] demanded to use the toilet, we allowed this." A further comment was "[Person] was made calm, and later behaved."
- People were not always supported to meet their cultural preferences. For example, staff told us a person who required halal meat was given vegetarian meals as staff had not purchased the correct meat.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- We found people did not always have their privacy respected. A person was unable to access their bedroom without staff fully observing. For example, a bedroom had a floor to ceiling glass wall with a full view of the person's bed. No curtains were in place to give the person any privacy.
- Due to poor deployment of staff and poorly planned care, there were little opportunity for people to try new experiences or achieve steps to independence. Staff lacked guidance of how this could be achieved for people.
- Staff told us due to a lack of diary management for respite admissions, people were often moved out of their bedroom to accommodate the next person coming into the service. For example, if a person came in who required a hoist a person would be moved out of an equipped room to a non-equipped room to make space.

People were consistently treated with a lack of respect and dignity while they received care and treatment at the service. This was a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw staff had a good understanding of people who accessed the respite regularly. We observed people arriving with their relative or carer for respite, greeted by staff, who sought information of how the person had been.

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 good. 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

- People did not receive personalised care. When we reviewed care plans, we found historical information or a complete lack of any documents in place. This meant no personalised care could be delivered.
- Records showed care plans did not always contain the information to ensure people's needs and preferences could be met. For example, a person with complex behavioural needs did not have sufficient guidance for staff about how to support them to ensure theirs and others safety.
- Staff told us they were so short staffed and having to constantly deal with distressed behaviours they did not have time to properly support people. One staff member said, "we do our best, we give them [people] what we can, but is that enough, no, no its not."
- Relatives told us, at time respite was cancelled at very short notice due to staff shortages, causing a direct impact on people. For example, one relative said, "It [respite] has been cancelled four times. I took my son and was told to go home, staff said 'I'm on my own with five respite people'. My son can't cope, and I can't deal with it."

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.

- When the service supported emergency admissions, we found a complete lack of guidance in place to support people with their communication needs. For example, one person had specific communication needs identified, however no support plan had been developed for this person meaning staff failed to ensure appropriate communication, which saw an increase in distressed behaviours.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to engage in activities. We reviewed one person's care plan which stated they required a full activity schedule and to know what is happening each day. This had not been put into place for the person, as a result the service saw a significant increase in distressed behaviours and placed others at risk.
- We found another person had it written in their need's assessment, attending church was important to them. This had only been achieved once during their stay, predominantly due to a lack of available staff to support the person in the community.

The above concerns demonstrate a failure to ensure care and treatment is personalised specifically for the people using the service. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had failed to identify concerns, staff told us they felt management were unapproachable. Some staff told us they felt they could raise concerns and they would be dealt with. However other staff said, "We raise concerns, but by the time they are dealt with the problem is over, so why bother."

● We reviewed a staff meeting February 2022 and found some staff were not fully aware of how and who to raise concerns to. We found no evidence of action taken to address this and improve staff knowledge.

End of life care and support

● Due to the type of service provided, respite, end of life care was not part of the support delivered.

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 good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We found indicators of a closed culture within the service, due to a lack of manager and provider oversight. The service had seen changes in management resulting in an unstable environment, with no clear guidance and delegation of responsibility.
- The changes in management had meant infrequent management visibility within the service, consequently we found a decline in care standards delivered to people.
- Staff told us they were, "left to it, with no support [from management]",and when they did raise concerns, they often didn't get a response, or it was much later. Staff also told us they felt senior management were not approachable so they didn't bother raising concerns when they knew nothing will be done.
- Management had failed to ensure people's needs could be meet. Admissions had been accepted, when it was clear the service did not have the adequate staffing or skills to support people, this meant people were at risk and had their care impacted, due to inadequate support.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance processes were ineffective. A lack of oversight at the service and provider level meant the quality and safety of the service had declined. We found no effective monitoring in place, which resulted in poor care.
- Organisational governance and quality monitoring systems had failed in assessing, monitoring and mitigating potential risks to people's safety, as evidenced by not identifying accident and incident issues and risk management. We found no systems in place to monitor the safety and effectiveness of service provision. The failure to have these in place significantly restricted the ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.
- Audit documents we reviewed for medicines and health and safety were also ineffective. The provider failed to recognise the risk identified on inspection. Consequently, we found significant concerns in these areas as detailed in the report, which posed risk to 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

- The provider had failed to put in place appropriate management for the service. The service did not have a registered manager and had put in place ad hoc support within their own organisation for several months. A manager was then employed but had been absent from the service at the time of the inspection.

● The provider had also failed to monitor the performance of the management and senior team at Swallow Lodge. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.
● The provider had failed to be open and honest. We found due to a complete lack of oversight the provider had failed to identify incidents that had placed people at risk of harm. Consequently, the provider had failed to notify the relevant professional bodies when appropriate and failed to investigate incidents effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider needed to improve professional relationships with outside agencies to improve people's care. Due to a lack of leadership, closed culture and minimal reporting, we could not be assured people received the referrals to relevant healthcare professionals as and when needed.
● People were not always supported to express their views and make choices. As detailed in caring people's preference were not always met due to ineffective systems in place to identify and support choice.
● Staff had raised numerous concerns, including safeguarding's and staffing, at a staff meeting in February 2022, however, we found no evidence of an action plan following the meeting to address the issues raised.
● We received mixed feedback from relatives. They told us they felt the service was safe but lacked communication, for example one relative told us, "I don't know who the manager is and there is no contact." Another relative said, "Its lovely but disorganised."

Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to demonstrate care and treatment is personalised specifically for the people using the service.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were consistently treated with a lack of respect and dignity while they received care and treatment at the service.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's failure to assess and manage a wide range of risks placing people at risk of avoidable harm.

The enforcement action we took:

Urgent imposing of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm.

The enforcement action we took:

Warning Notice