Amicura Limited

Eagle View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Eagle View Care Home is a residential care home providing personal care to up to 42 people. The service provides support to older people and people living with dementia. The service can also support younger adults and adults with a physical disability. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
People were not protected from the risk of abuse and improper treatment. Risks to people were not always appropriately assessed, managed, and mitigated. There were medicine stock discrepancies which could not be accounted for. Some areas of the service required cleaning and maintenance. There were some gaps in required recruitment checks.

People's needs were not always fully assessed. Where people's needs had been assessed, these needs were not always met. There were sufficient numbers of staff, but they were not always appropriately trained or deployed. Mealtimes were not always person-centred.

People were not always treated with dignity and respect. People were not always fully supported to be independent. We received mixed feedback from family members as to whether they were involved in their relatives' care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in place did not support this practice.

People were not supported to take part in a range of meaningful activities. On the first day of our inspection there was limited interaction between staff and people using the service. Care was not person-centred, and people's needs and preferences were not always met. People's communication needs were not always robustly considered or met.

The culture of the service was not person-centred. Systems and processes had not identified or resolved in a timely manner concerns around person-centred care, safeguarding and dignity and respect. The provider's systems and processes were not established or operated effectively to assess and monitor the service, and to ensure continuous learning and the improvement of the quality of care. The quality of the service had deteriorated since our previous inspection.

The manager had arranged safeguarding training and had raised awareness of safeguarding and whistleblowing procedures. People we spoke with were happy with the care provided. Medicines were stored safely and securely. A home improvement plan was in place.

Staff confirmed they had regular supervisions, and these were useful. People's weight was monitored, and referrals made to the dietician where appropriate. People had access to a regular GP who carried out a weekly visit. During the second day of our inspection, we observed kind, caring and attentive interactions between staff and people. A new activities co-ordinator had been recruited.

Information about making a complaint was accessible for people and their relatives. People's end of life wishes were recorded in their care plans. Staff generally told us they felt supported by management and staff told us they felt more able to raise a concern now, than previously. The manager had introduced 'resident of the day' to involve people more and gather feedback about their experience of the service. Most relatives told us they were kept up to date and were involved in discussions.

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

Rating at last inspection
The last rating for this service was good (published 28 September 2022).

Why we inspected
We received concerns in relation to staff practice and the culture of the service. As a result, a decision was made to undertake a focused inspection to review the key questions of safe, effective, and well-led. Due to concerns identified during the inspection, the scope of the inspection was widened to include all five key questions.

We have found that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last inspection, by selecting the 'All inspection reports and timeline' link for Eagle View Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding, staffing, recruitment, and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Eagle View Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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
This inspection was carried out by 3 inspectors and an Expert by Experience. 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
Eagle View Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Eagle View Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager was in post who had commenced an application to register.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 17 January 2024 and ended on 30 January 2024. We visited the location's service on 17 and 24 January 2024.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 6 relatives about their experience of the care provided. We carried out observations to help us understand the experiences of people. We spoke with, and received feedback from, 21 members of staff including the manager, the regional manager, the project manager, senior care workers, care workers, administration, maintenance, domestic, kitchen and activities staff. We also spoke with the nominated individual who is the person nominated to speak with CQC on behalf of the provider.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including training data and quality assurance records were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed 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 protected from the risk of abuse. We identified 2 safeguarding concerns during the inspection, which we reported to the local authority safeguarding team. These concerns involved inappropriate staff practices and had not been identified by staff or the management team.

People were not protected from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had arranged face to face safeguarding training to take place.
● The manager had raised awareness of safeguarding and whistleblowing procedures, with information sheets placed around the home and conversations taking place with staff in meetings and handovers.
● People we spoke with were happy with the care provided, and family members told us their relatives were generally well cared for. One relative told us, "Yes I do think [person] is safe and this has turned out the best for [person]." One person told us, "I am very happy here."

Assessing risk, safety monitoring and management; learning lessons when things go wrong
● Risks to people were not always appropriately assessed, managed, and mitigated. Risk assessments and care plans were not in place for key areas of risk such as some mental health diagnoses and physical health needs.
● Risks to people, staff and other service users were not appropriately managed around behaviours which may challenge others. Care plans were not always in place, and staff did not always have appropriate information and guidance. Staff told us they did not always know how to manage this risk.
● Where people did display behaviours suggesting distress or a communication need, but which may challenge others, these were not robustly recorded to enable meaningful analysis to be carried out. This meant that trends could not be identified, and learning could not occur over time. Accident and incident forms were not provided when requested, for multiple incidents which had occurred.

Risks to people were not safely assessed, monitored, and managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, additional care plans were implemented, and the manager arranged for staff to receive training in positive behaviour support.

Using medicines safely

● Medicines were not always managed safely. Multiple stock discrepancies were identified on inspection. The manager could not account for these discrepancies. We therefore could not be assured people received their medicines as prescribed.
● Some people were prescribed medicines administered via a patch. The records for these medicines did not inform staff where the patches were to be applied, or how often they were to be rotated.

Medicines were not always managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and securely.

Preventing and controlling infection
● Some areas of the service required cleaning and maintenance. For example, walls and door frames were chipped, and flooring and carpets were dirty in places. Equipment such as wheelchairs, mats, and hoists, was not included on the cleaning schedule, and staff were not able to tell us who had responsibility for cleaning these items.
● On the first day of our inspection, several staff members were not bare below the elbow, which did not support good hand hygiene.

Infection prevention and control was not always managed robustly. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A home improvement plan was in place and the manager had increased domestic assistants' hours.
● There were no restrictions on visiting the service, in line with national guidance at the time.

Staffing and recruitment
● All required checks had not been undertaken prior to people commencing employment. We found 1 staff member had commenced employment prior to a full Disclosure and Barring Service check being in place. A risk assessment had been put in place regarding this, but we observed it not being followed in practice.
● Another staff member's file did not have a full employment history or written explanation of gaps in employment. The provider had a checklist detailing the required pre-employment checks, however, this had not been completed.

All required recruitment checks were not always carried out. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not always fully assessed. Care plans and risk assessments were not always in place around needs such as mental and physical health conditions.
- Where people's needs had been assessed, these were not always met. We observed people's preferences not being met during the inspection. For example, it was important for 1 person to wear their glasses when awake. This person was observed all day without their glasses on.
- Care staff told us they were not supported to read people's care plans and we therefore could not be assured staff were fully aware of people's needs and choices. Comments from care staff included, "I have never seen the care plans. Care staff don't see them, we just ask about people's needs", "I don't know the residents, I haven't read the care plans" and, "I have not actually read a care plan."

People's needs were not always fully assessed and were not always met. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- There were sufficient numbers of staff, but staff did not always have appropriate training, or were not deployed effectively to provide person-centred care. Staff had opportunities to engage with people but on multiple occasions failed to do so. Staff had failed to recognise or resolve the lack of person-centred care.
- Staff had not received training in supporting people with oral healthcare, despite this being highlighted by visiting professionals. Staff had not received training to enable them to safely and appropriately support people who may be communicating anxiety or distress. Staff told us they were not confident in this area and we identified an example of inappropriate practice.

Staff were not trained so as to be fully competent in their roles. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff confirmed they had regular supervisions, and these were useful. Staff comments included, "It's nice to track progress" and, "I find them quite interesting, and it is nice to be able to chat to the manager."

Supporting people to eat and drink enough to maintain a balanced diet
- People had enough to eat and drink throughout the day. However, mealtimes were not always person-centred. For example, people were not always given choice, including those on a modified diet. We observed 'show-plates' being used on some occasions, but not on others.

● One person's care plan confirmed that they preferred to eat their meals at the table with others, as this encouraged them to eat. On both days of our inspection, this person was not supported to eat their meals at the table with others.

Mealtimes were not always person-centred. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's weight was monitored, and staff made appropriate referrals to the dietician.
● On the second day of our inspection, we observed positive and attentive interactions at lunchtime.
● People and relatives generally spoke positively about the food, with feedback such as, "[Person] likes biscuits and snacks and has plenty of these outside of meals" and, "Food wise, [person] is well looked after and they get regular drinks too."

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider did not always comply with the principles of the MCA. We observed 1 person with a lap belt on their wheelchair. There was no evidence or record that this person had consented to this, and there was no mental capacity assessment or best interest decision documented regarding the use of a lap belt. Staff did not understand how to support this person safely.

There was a failure to comply with the MCA in respect of a method of restraint. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLS were in place appropriately. However, when we asked for sight of 1 person's DoLS, the provider was unable to locate a copy and had to re-request this.
● Documentation around mental capacity and best interest decisions was not always robust and did not always evidence involvement from appropriate parties. The provider was in the process of implementing more robust documentation in this area.

Adapting service, design, decoration to meet people's needs
● The environment did not fully meet people's needs. There were limited cues to help orientate people as to date, day, and time. Where someone did have a large easy to read calendar, this was not showing the right day or date. We shared this with the manager.

● On the first day of the inspection, there were no menus on display, so people did not know what was available at mealtimes. We shared this with the manager and picture menus were implemented for the second day of the inspection.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

● Staff had made timely and appropriate referrals to other agencies. However, where advice given from outside agencies was not clear, this was not always followed up by staff.

● People had regular access to a GP, optician and podiatry services.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with dignity and respect. We identified 1 safeguarding concern for a person who was not supported with their continence during the day.
- Other than the manager, staff did not call people by their preferred names.
- People were not always supported to be independent. We identified 1 safeguarding concern for a person who was restrained without appropriate legal authority. One person's care plan confirmed they were able to drink independently with appropriate equipment and support, and this was not provided.

People were not always treated with dignity and respect and were not always supported to be independent. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the second day of our inspection we observed kind, caring and attentive interactions between staff and people. Relatives and people told us staff were kind and caring. Comments included, "On my last visit, the care worker was supportive and caring, not only to [person] but also to me" and, "They are very kind, the staff."

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

- People were not always supported to be involved in making decisions about their care. Consent forms in people's care plans were often blank, and there was limited information recorded about discussions with people and their relatives. Attendance at relatives' and residents' meetings was low. This had been identified as an area requiring improvement and the manager was taking steps to ensure people and relative involvement was taking place and recorded.
- Relatives did not always feel involved in people's care. Where a relative had a lasting power of attorney (LPA) in place, this was recorded but no copies were kept and there was no record that these documents had been reviewed and verified by the service. One relative told us, "Despite having LPA and asking time and time again to see [person's] care plan, I have never seen it." Another relative told us, "I am not really involved and can't seem to get any answers about how [person] is progressing." However, other relatives told us they were involved with feedback including, "Yes, we are involved" and, "Yes, and we have recently reviewed [person's] care plan."

People and relatives were not always supported to be involved in decisions about their care. This was a

breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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 supported to take part in activities, engage in conversation and maintain links with the community and people around them. On our first day of inspection, there was limited interaction between staff and people using the service. No activities took place, and people were left with no stimulation, other than television and an 'Alexa', for significant periods of time.
- Staff did not take responsibility for activities and providing stimulation and engagement for people. Staff were observed standing around or completing paperwork and failing to engage with people. One person was supported to eat by a staff member who did not speak to them throughout.
- There was no evidence of a varied and engaging activities programme, and no evidence of meaningful 1:1 interactions. Staff told us, "There is not enough stimulation, there has been a long time without an activities co-ordinator, so people lose interest when they go so long without doing things" and, "Activities are a concern; if people got the appropriate stimulation this would impact everything."

People were not provided with appropriate engagement or stimulation. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had recruited a new activities co-ordinator who had not yet commenced their role at the time of the inspection.
- On the second day of our inspection we observed more interactions between staff and people using the service. This improved the atmosphere within the service. However, records reviewed did not evidence that this was common practice.

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

- Care was not person-centred. Individual care plans were not always followed. One person had a personalised exercise plan, created by an external healthcare professional, to help support their movement. Staff did not support this person to complete these exercises.
- People's needs and preferences were not always met. We identified 2 safeguarding concerns which demonstrated how people's individual needs were not being met. People's preferences, as set out in their care plans, were observed not always to be followed.
- People's support plans did not always contain sufficient information to guide staff to provide person-centred care. Care staff told us they did not have access to people's support plans to obtain information and relied on verbal instructions.

Care was not person-centred. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not always robustly considered or met. There was a recommendation in place for staff to use flash cards to communicate with 1 person. Staff confirmed to us this method was not effective, but this person's communication needs had not been reassessed and there was no evidence that other options had been meaningfully considered.
● One person's communication assessment stated that staff needed to ensure they wear their glasses. This person was observed without their glasses during our inspection.

People's individual communication needs were not always met. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day of our inspection, the manager had created picture menus to support people to know what was on offer at mealtimes.

Improving care quality in response to complaints or concerns
● The manager told us the service had not received any recent complaints.
● Information about how to complain was accessible to people who used the service, with information leaflets and easy read documentation available for people and relatives.

End of life care and support
● The provider had an appropriate end of life care policy in place.
● Where known, people's end of life wishes were recorded in their care plans.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

● The culture of the service was not person-centred. We identified multiple examples of people not receiving care that was based around their individual needs, we identified safeguarding concerns and examples of people not being treated with dignity and respect. Systems and processes in place had not identified these issues or taken steps to resolve them in a timely manner.

Systems and processes had not identified or resolved in a timely manner concerns around person-centred care, safeguarding and dignity and respect. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt more able to raise a concern now, than previously. One staff member told us, "I feel supported by management. Before, nothing got done when I told them about concerns, I got nowhere, and it got to the point where it was just pointless. I have seen improvements."

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

● The provider failed to implement and operate effective risk management systems and to assess, monitor and mitigate risks to people. We found various shortfalls relating to, for example, medicines management, infection control, recruitment, and assessing and monitoring risks to people's safety.

● The quality of the service had deteriorated since the previous CQC inspection (report published 28 September 2022). The provider's systems and processes were not established or operated effectively to assess and monitor the service, and to ensure continuous learning and the improvement of the quality of care.

● Accident and incident forms were not always completed, and analysis of incidents where people were displaying distress was not completed. This meant understanding triggers could not be identified.

● The manager was notifying the local authority and CQC when things were identified to have gone wrong. However, one relative told us they were not informed of a safeguarding concern and only found out when the local authority safeguarding team contacted them.

The provider's systems and processes were not established or operated effectively to assess and monitor

the service, and to ensure continuous learning and the improvement of the quality of care. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a new regional manager in post, and a project manager had also been appointed to support the service. The management team appeared committed to improving the service and an action plan was in place. The service was also receiving support from the local authority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

● The manager held residents' and relatives' meetings, although attendance was low. The manager had introduced 'resident of the day' to involve people more and gather feedback about their experience of the service.

● Staff made appropriate referrals to professionals when required. However, advice from professionals was not always clarified and made clear to staff, to enable them to support people safely and effectively.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Required recruitment checks were not always carried out. (1) - (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not trained so as to be fully competent in their roles. (1) and (2)

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 People's needs were not always fully assessed and were not always met. Mealtimes were not always person-centred. Care was not person-centred. People's individual communication needs were not always met. People and relatives were not always supported to be involved in making decisions about their care. People were not provided with appropriate engagement or stimulation. (1) - (3)

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 not always treated with dignity and respect and were not always supported to be independent. (1) and (2)

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

	Risks to people were not safely assessed, monitored, and managed. Medicines were not always managed safely. Infection prevention and control was not always managed robustly. (1) and (2)

The enforcement action we took:

Warning notice

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 People were not protected from abuse and improper treatment. There was a failure to comply with the MCA in respect of a method of restraint. (1) - (7)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to ensure all required recruitment checks were carried out. Systems and processes had not identified or resolved in a timely manner concerns around person-centred care, safeguarding and dignity and respect. The provider's systems and processes were not established or operated effectively to assess and monitor the service, and to ensure continuous learning and the improvement of the quality of care. (1) - (2)

The enforcement action we took:

Warning notice