Chestnuts (Arnesby) Limited

Queens Park Care Home

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

Summary of findings

Overall summary

About the service
Queens Park is a residential care home providing the regulated activity of Accommodation for persons who require nursing or personal care, for up to 16 people. The service provides support to people with mental health, learning disability, autism and physical health needs. At the time of our inspection there were 14 people using the service.

People's experience of using this service and what we found
Staff were not provided with enough clear guidance to support people safely. Lessons were not learnt when things went wrong. There were enough staff to support people safely. People were not always safe from neglectful care. Medicines were managed safely. Safe infection control processes were followed to reduce to spread of infections through the service.

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 the service did not support more effective practice. Staff had always not been provided with training to complete their roles effectively. We were not assured that safe end of life care would be provided for these reasons.

Staff were mostly kind to people and promoted their independence, however the poor safety culture of the service meant it was not always caring.

We saw that two healthcare referrals were not made in a timely way. However, other referrals had been made. Two visiting health professionals fed-back positively about their involvement with the service. Staff communicated with people using suitable language. Staff knew people's varied preferences.

Staff did not always keep records of what care was provided. There was a lack of oversight of these records. Due to the poor record keeping, we could not be assured that people were receiving the care they required . There was a lack of effective oversight at the service. This meant the provider would not be able to recognise when things had gone wrong or be able to quickly make improvements. The provider has given assurances that improvements will be made.

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 8 October 2021).

Why we inspected
We had received concerns that people using the service did not receive enough food to eat. We also received concerns that there were not enough staff. We therefore decided to inspect and examine these areas.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement and Recommendations
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 safe care, consent, staff training and governance. We have sent the provider a warning notice for the breach of regulation 12 (safe care). This warning notice gives them a specified time to make improvements. We will follow up to assess if improvements have been made.

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.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Queens Park 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
The inspection was completed by two inspectors

Service and service type
Queens Park 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. Queens Park 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there no registered manager in post. The provider told us that recruitment processes were in place to put a registered manager in the role. During the inspection, the nominated individual was available to talk to about our findings. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experiences of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 6 members of staff. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to two external health care professionals who had visited the service to gather their feedback on the care provided.

We reviewed a range of records. This included the relevant parts of 6 people's care records and multiple medication records. We looked at staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were also 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.

Assessing risk, safety monitoring and management

- Care plans did not provide clear and accurate information to guide staff on how to support people's behavioural, physical or mental health needs. For example, a person's care plan guided staff to restrain a person if needed. However, there was no clear guidance on how to restrain the person safely, which may have caused injury to the staff member or the person.
- Staff had also not been trained in how to complete this restraint safely.
- People who required support with enteral feeding were not supported safely. 'Enteral feeding' is when food and fluids are put through a tube that goes directly to the stomach or small intestine. We saw that this feeding was not provided in a hygienic way, this put the people at risk of infection. Staff also did not keep clear and accurate records of the food and fluids given to a person so we could not be assured that this care was provided in a safe way.
- Staff did not always provide safe care. A health professional had recommended one person should be sat upright after eating, this was to reduce the risk of their food entering their lungs after eating. This was in the person's care plan to guide staff. However, we saw this person lying flat twice after eating. Staff not following this professional advice, put the person at risk of serious ill health.
- Care plans guided staff to complete specific health related tasks. However, records did not evidence that this care was provided. For example, staff were guided to complete a 'bladder washout'. This is where, fluid solution is put into a person's catheter. This solution helps to remove any debris that may be in the bladder and improve urinary health. Records showed this washout and catheter care was completed sporadically, this put the person at risk of ill health.
- Staff were also required to check a person's enteral feeding device every week, however there were no records of this check taking place. Staff told us, this was carried out on different days of the week. Due to this inconsistency, we could not be assured this check was taking place.

Learning lessons when things go wrong

- Incidents were not recorded in a safe way. Staff did not always clearly record what happened during an incident. This poor recording meant the incident could not be effectively reviewed and lessons would not be learnt. The management team had not checked these records, which meant they had not identified this as being an issue at the service.
- Where incidents had been recorded, these had not resulted in improvements to care planning. For example, one person had been found by staff with a call bell around their neck. This risked impacting their breathing. However, no changes to care planning had occurred to ensure the person was not at risk of accidental strangulation in the future.

People were not always kept safe from harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual gave assurances that action would be taken to improve the safety of care. We will review what action has been taken at our next inspection.

●At the last inspection, we recommended the provider consider current guidance on the use of appropriate language when working with people with learning disabilities and autistic people and take action to update their practice accordingly. Records showed this had occurred.

Systems and processes to safeguard people from the risk of abuse
● During the inspection, we were concerned that people were not always safe from neglectful care. As a result of neglect concerns, we made safeguarding referrals to the local authority to investigate. (Examples of neglectful care are listed in the 'Assessing risk, safety monitoring and management' section above)
● People told us that they felt safe.
● Staff had received training in how to keep people safe from abuse.

Staffing and recruitment
● We saw there were enough staff to support people safely. People also told us there were enough staff.
● Staff told us that there were usually enough staff. However, last minute absence could impact staffing levels. We reviewed staff rota's and saw last minute absences were rare and the provider worked to cover any last-minute staff shortages with agency staff if needed.
● The provider had not always gathered character references from staff's previous employers. This means they could not be assured of the character that the person had in the previous employment. However, staff had undertaken Disclosure and Barring Service (DBS) checks. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions when considering a staff members conviction past.

Using medicines safely
● We saw medicines were stored safely.
● Staff clearly recorded when medicines were given to a person. Medicines were given as prescribed.
● Staff had clear guidance on when a person might need to take their 'as needed' medicines.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. The government's visiting processes followed government guidance.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was 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 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 people's care, support and outcomes.

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.

- Where people may have lacked the ability to make decisions, then capacity assessments were not always completed.
- Multiple people at the service had motion sensors that would supervise their movement. People also had seatbelts on their wheelchairs to restrict their movement. One person had a deep chair designed to prevent the person getting out of it. Mental capacity assessments had not been completed to assess these people's decision making on free movement. In addition, best interest decisions and care planning had not been completed to assess less restrictive options available.
- Where capacity assessments had been completed, best interest decision making documents did not describe what less restrictive measures had been explored.
- Deprivation of Liberty referrals were made. However, one was authorised on the condition that the service took certain actions. These actions had not been completed as required.

People's human rights were not always respected with appropriate mental capacity assessments and best interest decision making. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual gave assurances that action would be taken to work in line with the mental capacity act. We will review what action has been taken at our next inspection.

Staff support: induction, training, skills and experience

● Staff had not received training in how to remove themselves from a situation safely if they were at risk from a person's behaviour. Staff had sustained injuries when providing support.

● Staff had not received training in how to restrain a person safely. Care records guided staff to restrain a person if needed for personal care and medicine administration. Not training staff on how to hold a person safely, risks both staff and the person sustaining an injury.

● Staff had not received training in how to complete a 'bladder washout' or provide catheter care. A bladder washout is a specialised task, whereby a person's catheter is flushed with a solution. This solution helps to remove any debris that may be in the bladder and improve urinary health. Not training staff, risks catheter care being completed unsafely.

● Some staff had not received training in how to support enteral feeding care. These staff were providing support with enteral feeding. Enteral feeding is when food and fluids are put through a tube that goes directly to the stomach or small intestine. Not training staff, risks this care being completed unsafely.

Staff were not provided with enough training to complete their roles safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual gave assurances that staff would be provided with this training quickly. We saw evidence that some of this training was completed within a few days of our inspection. We will assess the impact of this at our next inspection.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff did not always keep clear records of what people had drunk, while we saw people had drinks available for them; the poor recording means staff could not be assured how much a person had drank each day.

● There was a lack of effective action taken in response to weight loss at the service. Some people at the service had lost weight. Staff did not keep regular records of people's weights to monitor this. One person had lost a lot of weight, but this had not triggered more regular weighing to monitor this weight loss or provide a higher calorie diet.

● Before the inspection, we received concerns that meal portion sizes were too small. We saw portion sizes were ok and people told us that they had enough to eat.

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

● People's social, mental and physical needs were not holistically assessed. Care plans did not always provide clear guidance to staff, to ensure that people's diverse needs could be effectively met. For example, one person's care plan explained that their mobility had changed. However, there was contradictory guidance on how staff could effectively support the person to have a wash.

● People were supported with the use of assistive technology. For example, people at the service had access to call bells, so they could easily call for staff support. We saw this call bell system was used effectively.

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

● People were not always supported to live healthier lives. This is because care plans did not give staff enough guidance for staff to follow. For example, one person's care plan stated the person had a history of mental ill health and that this put them at high risk of harm, however staff had not been provided with guidance on how to support this person's mental health needs effectively.

● We had concerns about two people's referrals not being made quickly enough. One person was referred to a dietician a month after significant weight loss had occurred. This delayed referral of a month would impact the person receiving professional advice on their weight loss in a timely way. Another person was described

by staff as unwell. The inspector suggested a medical referral on the morning of the inspection and found it had not been completed as expected at the end of the inspection visit.
● Other than the above examples, we saw people were mostly referred to health professionals when needed. We spoke to two visiting health professionals, who told us that staff had referred a person to them for appropriate reasons and had then followed the advice given.

Adapting service, design, decoration to meet people's needs
● People had individual bedrooms, that they had decorated according to their preferences.
● The service had equipment to meet people's needs, for example a specialised hoist to support someone to stand.
● The layout of the service was easy to follow and signposting was available to guide people as needed.

Requires Improvement

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 requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

- We saw one example of non-caring support. A staff member raised their voice and said "no, stop that" repeatedly to a person experiencing mental ill health. Staff had been given guidance to not use this approach for this person. Their raised voice was seen to increase the person's agitation. The inspection team raised this with the nominated individual, who advised they would take action to speak to this staff member. Other than this example, we saw that staff were kind to people and treated them well.
- While staff were kind to people, the management oversight of the service meant staff were not always well trained and care was not always given in a safe way. This culture impacts the caring nature of a service.
- Staff knew people's diverse needs well, for example staff explained the words one person used to request their favourite drink. This understanding of the person's diverse communication meant staff were able to provide caring and responsive support. However, these details of people's diverse needs were not always described in people's care plans. This risks people not being as well treated by new staff, who are reliant on care plans to guide them.
- People told us that staff were kind to them. One person said "They are polite and kind. They are always nice. I really like the staff here. They know me well."

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

- People were involved with decisions about their daily routines. Staff had meaningful conversations with people about their day to day needs
- We saw that people were offered choices of what they would like to eat. People told us that this was usual, and that staff knew their meal preferences well too.
- People made decisions about their daily routine. Including when they would like to wake up, bathe and watch on TV. Staff supported one person to engage with a colouring book and listen to their favourite music.

Respecting and promoting people's privacy, dignity and independence

- Staff were seen to knock on people's doors before they went in.
- People's dignity was promoted. For example, one person had spilt something on themselves and staff were quick to notice and offer support to the person to change their clothes.

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.

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

- Care plans did not provide up to date information on people's needs. This could impact staff's ability to provide personalised care. For example, a care plan described the importance of a person wearing a certain type of shoe to prevent them falling. However, this person was no longer able to walk so no longer wore any shoes.
- While people could make decisions on their daily choices (for example, what to eat), people were not always consulted in the writing of their care plans. This means they were not always consulted on how they would most like to be cared for.

End of life care and support

- No one at the service was receiving end of life support at the time of the inspection. If end of life care was provided, we would be concerned about the quality of this end of life care. This is because care plans did not provide good quality guidance to staff and clear records were not kept on what care people received. To provide high quality end of life care, we would expect these processes to be in place.

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.

- Staff spoke to people using language they could understand.
- The nominated individual explained that written records could be printed in different fonts and easy read formats, however no one at the service would benefit from this at the time of this inspection.

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 had previously received support to engage in a variety of community activities. However, the staff member responsible for this social engagement had recently left. The nominated individual explained that recruitment processes were already underway to employ another staff member for this role.
- People told us that they enjoyed the activities that they took part in. One person told us that in the last few weeks the variety of activities had reduced (this was in line with the staff member leaving). The person told us that they had instead enjoyed more activities inside the home – like arts and crafts and watching their favourite TV programmes.

Improving care quality in response to complaints or concerns

● We saw that one written complaint had been received since the last inspection. This complaint had been responded to thoroughly.

● People told us that they were happy at the service, however if they wanted to complain they felt they would be listened too.

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.

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

- Staff did not keep clear records on what care was provided. Staff did not always record when drinks were provided to people, when catheter care was supported, what incidents occurred or people's weights.
- There was no regular auditing of these staff records. The failure to audit, risks this poor recording not being identified and investigated. For example, we saw that staff did not regularly record when a person's catheter bag was drained. As there was no audit, there had been no checks as to whether this was a recording issue, or whether the person was not provided with this catheter support and therefore at risk of ill health.
- Care plans were reviewed; however, these reviews were not effective at creating improvements to care plan guidance. One person's care plan described that the person could walk independently. However, staff told us that that person had not been able to walk for eight months and remained in bed for most of the time. Monthly care plan reviews had occurred, but these reviews had not recognised this poor care planning and had not changed the guidance for staff. Not updating this guidance, risked new staff not understanding the person's needs and supporting them unsafely.
- There was no registered manager at the service. However, there was a nominated individual. The nominated individual is responsible for overseeing the safety of the service on behalf of the provider. The nominated individual had not completed their own audits on the service. This would impact their ability to oversee the safety of the service. There had been three different managers at the service in the last year, the nominated individual could not find audits completed by these managers during the inspection process. There has been a lack of oversight at the service to ensure risks are identified.
- The management team did not have clear oversight of what training staff had received. They gathered this information and sent it to us after the inspection. We saw that staff had not received training that would be required to provide safe care. The poor oversight of staff skills meant staff were not suitable skilled to support people at Queens Park Care Home.

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

- There was a risk of a closed culture forming at the service. Staff told us that they were concerned about talking to us and implications on their role. When we asked staff, "What would you change about the service?", staff did not respond. It is expected that staff feel confident speaking to external stakeholders about their experiences, in order to allow improvements to be made at the service.

● People may not have good outcomes. This is because the provider did not ensure care plans were kept up to date, staff did not have sufficient training and there was a lack of oversight at the service.

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

● Before the inspection, we had received three concerns about people losing weight. We contacted the nominated individual about each of these concerns and received assurances. However, during the inspection, records showed that people's weights were not regularly recorded. Records that were kept, showed some people had lost weight. The nominated individual or management team had not completed audits of people's weights at the service. We are therefore concerned that despite raising concerns three times about weight loss, people's weights were not effectively overseen at Queens Park Care Home.

● There was a lack of management oversight at the service. This would impact the provider's ability to improve care. For example, one person's health condition meant they were unable to regulate their own body temperature. Their environment needed to be kept at a specific temperature. We observed that this person's room was colder than required, which could impact their health. Despite staff being guided to monitor the temperature, they were not provided with a method to monitor and record the temperature.

The provider failed to have oversight at the service, to ensure care was high quality and improvements were made. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual gave assurances that action would be taken to improve oversight of the service. We will review what action has been taken at our next inspection.

● We saw that one complaint had been recorded. This had been responded to appropriately.

● The nominated individual recognised that some improvements were needed to the service. They had therefore arranged for an external consultant to support with making improvements at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were engaged with day to day decisions at the service. We saw people were given a choice in what they would like to eat, and what activities they would like to do.

● The service had an equality, diversity and human rights policy to protect people from discrimination. Staff had received training on how to recognise and support people's diverse needs.

Working in partnership with others

● Two visiting health professionals advised that they were not concerned about the service. They advised the referral had been made in a timely way, and their guidance had been followed.

● We observed that people were mostly referred to health professionals in a timely way (this has already been reported under the safe question).

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 11 HSCA RA Regulations 2014 Need for consent People's human rights were not always respected with appropriate mental capacity assessments and best interest decision making

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective oversight to ensure high quality care was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the required training to complete their role safely.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always kept safe from harm.

The enforcement action we took:

We have sent the provider a warning notice for the breach of regulation 12 (safe care). This warning notice gives the provider a specified time to make improvements. We will follow up to assess if improvements have been made.