Minster Care Management Limited

Hamshaw Court

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

Summary of findings

Overall summary

About the service
Hamshaw Court is a residential care home providing personal care for up to 45 older people, including people living with dementia. At the time of our inspection 41 people were receiving personal care in one adapted building.

People's experience of using this service and what we found
The systems and processes the provider used to monitor the quality and safety of the service were ineffective and placed people at significant risk of harm. This included fire safety procedures, management of risk and management of medicines.

The provider did not have suitable systems in place for staff to recognise and report abuse and injuries. The provider did not investigate incidents fully.

The environment was not always odour free. Systems in place in the laundry did not promote good infection control practice.

The environment was not dementia friendly with a lack of appropriate signage to support people to orientate throughout the building.

People did not receive person centred care relevant to their needs. People's care files were not kept up to date and relevant to their current care needs. People's records were not fully completed and there were gaps in people's daily monitoring charts.

The principles of the Mental Capacity Act were not always followed. 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 policies and systems in the service did not support this practice.

The lunchtime experience was not always positive. People had to wait for long periods of time before being served and did not always have their preferred choice of food.

Staff, people using the service and relatives shared their concerns about the recent high turnover of staff which the provider was acting to address. We have made a recommendation about reviewing staffing levels.

People's care plans were inconsistent in recording information about their wishes for their care and treatment at the end of their life. We have made a recommendation about this.

Professionals shared their concerns about poor communication and not following up on recommendations delaying the help required for people.

People using the service told us they knew how to make a complaint but some lacked assurance the registered manager would ensure the required changes were sustained.

Activities were provided which some people enjoyed. People who preferred to spend time in their rooms had less opportunities to engage in meaningful activities.

Staff morale was low and they were not provided with supervision in line with the providers policy.

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 requires improvement (published 27 March 2019) and there were multiple breaches of regulation. This service has been rated requires improvement for the last four consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hamshaw Court on our website at www.cqc.org.uk.

Enforcement

The service met the characteristics of Inadequate in four key questions of safe, effective, caring and well-led, and Requires Improvement in responsive. We have identified breaches in relation to delivering person-centred care, need for consent, dignity and respect, nutrition and hydration, records and notification of incidents and safeguarding at this inspection.

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

Since the last inspection we recognised that the provider had failed to make statutory notifications for three notifiable incidents within the service. Failure to make statutory notifications is a breach of Regulation 18: Notification of other incidents of the Care Quality commission (Registration) Regulations 2009. We are dealing with this outside of the inspection process.

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 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?

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 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

Hamshaw Court

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.

Inspection team
The inspection team consisted of three inspectors and an inspection manager on the first day of inspection and three inspectors on the second day of inspection.

Service and service type
Hamshaw Court 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced on the first day and announced on the second day of inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We looked at information we had received about the service since the last inspection such as notifications about incidents and safeguarding alerts. We sought feedback from the local authority and Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public

about health and social care services in England. We used all this information to plan our inspection.

During the inspection, we spoke with seven people who used the service and three of their relatives. We spoke with the provider's representative, the registered manager, the deputy manager, a team leader, two senior carers, three care workers, a chef, the activities coordinator and two agency staff members.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at ten 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 spoke with two professionals. We continued to seek clarification from the provider to validate evidence found. We looked at training data, cleaning schedules, daily records and meetings. Not all of the information we requested from the provider was made available to us.

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

Using medicines safely

- Medicines were not always managed safely. The providers medication policy was not always followed by staff.
- Staff did not ensure that sufficient stocks of medicines were available within the service.
- People did not always receive their medicines in a safe way. One person was administered a pain relief patch two days late and another person did not have their antibiotic administered as prescribed.
- Guidance for staff to safely and consistently administer medicines prescribed 'as and when required' (PRN) lacked important detail. This meant staff may not have full guidance to help them when making decisions about when and how much medicine to give to people.
- The controlled drugs register was not completed accurately when returning medicines to the pharmacy.
- There had been several medicines errors and people had not received their medicines as prescribed. Staff had received supervision and updates in training. However, the errors persisted.

The provider had failed to ensure the safe management of medicines. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not properly assessed or managed safely.
- Risk assessments were not always updated following incidents or a change in people's needs.
- There was a lack of detailed behaviour management support plans to support staff with information to identify potential triggers or how they should support or redirect people in different situations. For example, declining personal care, verbal aggression and disinhibited behaviours.
- Fire safety systems at the service were not always safe and as a result, people were put at risk of significant harm.
- Not all staff had completed fire safety training, fire drills or evacuation training. This meant they may not know how to support people safely in an emergency situation.
- Records relating to fire safety such as zone plans, evacuation plans and guidance for staff to follow in the event of an emergency were not up to date.
- We reported our concerns to the fire service who visited the service after our inspection. They have asked the provider to provide a plan of how they will address the concerns we identified.

Preventing and controlling infection control

- An effective system was not in place to prevent cross infection.

● There was no separate storage within the laundry room for clean laundry where soiled clothing was laundered.
● Wooden shelving in the laundry was found to have paint flaking off, making it difficult to clean effectively.
● Strong urine odours were detected in two bedrooms.
● Kitchen units in some flats were damaged and could not be effectively cleaned and posed a risk of cross contamination.

The provider had failed to assess and manage risks to ensure the health, safety and wellbeing of people. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Although staff had completed safeguarding training and policies and procedures were accessible, we found three separate incidents had not been reported to the local authority or to CQC.
●Safeguarding reporting systems in the service did not ensure that prompt action and information sharing took place.
● Accidents and incidents were not fully analysed to identify emerging patterns or trends. Recorded actions did not show what actions had been taken following incidents or accidents.

The provider had failed to ensure systems and processes were established and operated effectively to investigate, immediately upon becoming aware of any allegation or evidence of abuse. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There had been a significant turnover of staff within the service resulting in people being supported by a number of newly appointed staff and agency workers which did not provide consistency for people.
● Staff told us they felt staffing levels needed to be increased as a high number of people using the service required the support of more than one carer.
● One person told us they felt staff forgot about them sometimes and they felt sad and lonely. Another person told us that following the staff turnover they didn't feel they had any rapport with staff.

We recommend the provider review people's dependency levels and staffing levels currently in place and update their practice accordingly.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

- No pre-admission assessment was made of people's capacity.
- Records did not always demonstrate staff worked within the principles of the MCA. The registered manager was unable to provide records of best interest's meetings.
- A relative told us they raised a concern with the registered manager when they visited the service and found their bedroom door locked, with their family member inside. Despite raising the concern, this happened again on a further occasion. There was no record to support why the bedroom door was locked or how this had been agreed.

The lack of appropriate documents around people's capacity to consent to care and the failure to review meant people were at risk of receiving care without their consent or having a restricted lifestyle without appropriate authorisation.

This was a breach of regulation 11 Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional needs were not always met.
- Our observation of the mealtime experience for people was that was chaotic and uncoordinated.
- People gave negative feedback about the food. One person told us that their preferred option had ran out,

another person told us the food was warm but didn't taste nice. A third person told us the portions were small and they were sometimes hungry. Others told us, "The food is below standard, there is a poor selection and breakfast at a weekend is poor."
● On the first day of inspection, people were left unattended for up to 55 minutes before being provided with a meal.
● One person was not provided with the correct equipment as directed in their care plan to maintain their independence, so was having to sit side ways to access their food.
● The chef told us people were not consulted in the planning of menus as they did not feel they could not or would not be able to cater for everyone's preferences.
● Fluid intake records were not routinely completed or reviewed, nor did they have targets to be achieved for people's fluid intake. This put people at risk of dehydration.

The provider failed to ensure people received adequate hydration and nutrition to sustain good health. This was a breach of Regulation 14 Meeting nutritional and hydration needs of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
Supporting people to live healthier lives, access healthcare services and support
● People did not always have hospital passports or information that could be quickly passed onto emergency services or healthcare professionals in the event of an emergency. This meant people were at risk of their medical needs not being met.
● Staff had not always been proactive in identifying changes in needs and subsequent health concerns. For example, two people did not have care plans in place for health conditions they had developed.
● Where oral hygiene assessments had been carried out, there was no care plan in place to identify what support the person required with managing their oral hygiene.

Adapting service, design, decoration to meet people's needs
● The personalisation of people's rooms was inconsistent. Some were very personalised while others were not.
● There was a lack of dementia friendly signage throughout the service to support people living with dementia to find their way around.
● Areas of the service required refurbishment, for example damaged kitchen units in flats and bedroom doors requiring re painting.

Staff working with other agencies to provide consistent, effective, timely care
● People were not always supported to access effective timely care. One person discharged from hospital with pressure damage did not have access to a district nurse for five days.
● People who had experienced falls were not always referred to the falls team in a timely way.

The provider failed to ensure assess people's needs and provide person - centred care. This was a breach of Regulation 9 Person–centred care of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had a training plan in place to identify when staff required training. However, records provided showed new staff had not completed an induction, or fully completed mandatory training including fire safety and manual handling.
● Not all staff had received supervision in line with the providers policy.

- Staff did not feel supported by the registered manager.

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.

● Due to the concerns identified during the inspection, we could not be assured the provider ensured people received a high-quality compassionate service.
● People told us their experience of care at the service was not positive. Comments included, "No one comes to check on you, carers do not check during the day." "Carers are often late, I am left waiting for a shower, and sometimes they forget to come." Another person told us how they 'felt low' and although carers popped in sometimes it was not often, they told us, "I feel they forget I am here sometimes, and I feel sad and lonely."
● Professionals told us that not enough was done to support people who declined care. They had clients who had moved from the service due to poor care experiences and their concerns were shared with safeguarding.
● People did not always have their own clothing returned to them and on occasion were supported by staff to wear other people's clothing despite this identifying who this belonged to.
● We received mixed feedback about staff's approach. People told us staff were kind and tried to spend time with them, but they were busy. Relatives told us carers were pleasant and they had a good understanding of their family member. Others told us that staff appeared overstretched and carers were well meaning, but they were too busy to demonstrate their knowledge and skills.

Supporting people to express their views and be involved in making decisions about their care
● One person told us they had informed the manager they were unhappy and wanted to move. They had been trying to contact the local authority to discuss this and had received no support to explore this further.
● People told us they were able to make decisions and had choices. However, their preferred choices for example, meals could not be provided.
● Residents meetings were not held regularly to give people an opportunity to raise concerns or offer suggestions as to how their experiences could be improved.

People did not receive person centred care and treatment that was appropriate to meet their needs and reflect their personal preferences. This was a breach of Regulation 9 Person-centred care of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
● People were not always treated with dignity and respect. During the inspection we overheard and had conversation with staff who referred to people disrespectfully based on the level of support they required rather than as individuals. We also observed staff entering five different bedrooms without knocking first.

● One relative told us their family member had not had their hair washed for three weeks during the Christmas period. Feedback from other people's relatives included that staff often spoke amongst themselves rather than engaging in conversation with people.
● People told us there were times they had to wait to get a response when they used their call bells. The area manager told us response times to call bells could not be monitored, so we could not be assured that people did not have to wait for long periods of time.
● One professional told us they had received concerns from visiting healthcare professionals about people being left wet, soiled and uncomfortable when they visited.

The failure to promote dignity and respect was a breach of Regulation 10 Dignity and respect 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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

- People's care plans did not always reflect their current needs. Information relating to people's care needs had not been included when staff formulated their care plans.
- Not all care plans contained information about people's life histories, important events and people who were important to them. People's preferred gender of staff to support them were not always detailed.
- Care plans for some people, contained information that was not consistent within their risk assessments.
- The provider had not ensured people's needs had been regularly assessed or reviewed.
- Staff told us they did not have time to read people's care plans. Others told us they were not person centred or in enough detail and they did not feel they would be able to deliver care based on the information contained in care plans.
- Professionals told us people had complained to them about their call bells not being answered when they called for support. Relatives told us staff did not always pay close attention to their family member's personal care needs. This included nail care.

Staff did not have the time or information to meet people's needs in line with their preferences. 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

At our last inspection the provider had failed to act on complaints. This was a breach of Regulation 16 Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

- Following the last inspection, the area manager had taken on the role of dealing with complaints and relatives felt they had good communication with them.
- People using the service told us they knew how to make a complaint but some lacked assurance the registered manager would ensure the required changes were sustained.

End of life care and support

- At the time of inspection no one was receiving end of life care.

● People's care plans were inconsistent in recording information about their wishes for their care and treatment at the end of their life, whilst others had more detailed information.
We recommend the provider consider best practice guidance in relation to documenting people's end of life wishes.

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.
● The manager understood their responsibility to comply with the AIS and could provide information about the service in different formats to meet people's diverse needs.

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
● We saw evidence of activities taking place and some people engaging with them.
● A hairdresser visited the service weekly.
● The activities coordinator told us they did their best to spend some time with people who preferred to stay in their rooms, but this was difficult.

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 Requires Improvement. 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

- Serious shortfalls identified at this inspection, had not been identified by the provider's quality assurance system. Eight breaches of regulation were identified during the inspection.
- Management staff had not effectively identified and managed risk therefore, people were placed at risk of avoidable harm.

- The provider did not have adequate systems in place to ensure people received person centred care. The shortfalls in the delivery of person-centred care highlighted during the inspection had not been identified by management systems.
- There were basic communication shortfalls, which impacted on care delivery. For example, staff told us they had not had time to read care plans.
- Feedback from people and their relatives about the quality of the care provided was consistently negative. This included staff approach, the provision of food and the lack of opportunity to be involved in their care.
- Professionals told us the service did not always communicate effectively with them and this needed to improve.
- There were shortfalls in the quality of recording information. For example, daily notes were not always detailed.
- Despite numerous requests for information to be sent to us during and following our inspection, we did always receive information that we had asked for.

The failure to embed robust quality assurance systems and operate effectively the systems for maintaining accurate records was a breach of Regulation 17 Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had not offered regular meetings to staff, people or relatives. Surveys were completed and returned, there was no recorded actions of how the provider would act to improve the service based on this feedback.
- Staff morale in the home was low. The culture within the service over the last three to four years had been inconsistent. There was a continuous turnover of staff.
- Supervision systems were not well planned which meant staff were not fully supported in their roles. Staff

told us they had received little or no supervision and when supervision had been provided it had not been with their line manager. One staff member told us, "I can't remember the last time I had a supervision."
● Not all relatives felt they would be listened to by the registered manager and when reassurances were given these were not always carried out. Relatives told us they had more confidence the area manager would be responsive.

Continuous learning and improving care; Working in partnership with others
● A culture of high quality, person-centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this inspection.
● An effective system to learn from accidents and incidents and prevent any reoccurrence and improve people's care was not in place.
● Professionals told us the service was slow to act on their recommendations and there was often a delay in contacting other professionals when this had been suggested. This meant there was a delay in people being supported to get the help they required.
● The management team worked in partnership with commissioners, health and social care professionals. For example, physiotherapists and district nurses.
● Staff liaised with specialist nurses for specific conditions such as diabetes and end of life.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● We found the registered manager had failed to notify us of three notifiable incidents. One of these was submitted to CQC retrospectively after bringing this to the managers attention.

The failure to inform CQC of notifiable events is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. This is being followed up outside of the inspection process and we will report on any action once it is complete.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The lack of appropriate documents around people's capacity to consent to care and the failure to review this meant people were at risk of receiving care without their consent or having a restricted lifestyle without appropriate authorisation.

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 The provider had failed to ensure systems and processes were established and operated effectively to investigate, immediately upon becoming aware of any allegation or evidence of abuse.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to make statutory notices for three reportable incidents within the service.

The enforcement action we took:

We did not proceed with enforcement action on this occasion.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured all service user's needs were met in a safe and person-centred way.

The enforcement action we took:

We took enforcement action and following an appeals process at tribunal stage the court imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured there was a safe system of medication management to ensure people received their medicines as prescribed. The registered provider had not ensured risk was properly assessed and taken steps to mitigate the risk of accidents and incidents occurring.

The enforcement action we took:

We took enforcement action and following an appeals process at tribunal stage the court imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

	The provider failed to ensure people received adequate hydration and nutrition to sustain good health.

The enforcement action we took:

We took enforcement action and following an appeals process at tribunal stage the court imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not established systems and processes to effectively monitor the quality of the service and respond to shortfalls. The provider failed to evaluate and improve their practice and operate effectively the systems for maintaining accurate records.

The enforcement action we took:

We took enforcement action and following an appeals process at tribunal stage the court imposed a condition on the provider's registration.