Maven Healthcare (Cypress Court) LLP

Cypress Court

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

Summary of findings

Overall summary

About the service
Cypress Court is a care home providing personal and nursing care to 58 people at the time of the inspection. The service can support up to 60 people, in one adapted building across two floors. The home is located in a residential area, close to shops and local amenities.

People's experience of using this service and what we found
People told us they felt safe in the home, however, we raised concerns regarding the staffing levels. The deployment of staff within the home did not allow for care to be delivered in an effective and timely manner. People were left waiting for personal care to be met and their meals.

Equipment in place to keep people safe including call bells were not always within reach or responded to in a timely manner. There was an unpleasant odour within the home and there were concerns regarding the cleanliness and suitability of the equipment. Bedding was not always being changed and some bedrails were damaged.

Good practice regarding the safe administration of medicine was not always being followed. The oversight of medicine was not robust enough to ensure people were safely given their medicines.

People's care plans and risk assessments were not clearly updated, consistent and did not always reflect a person's current needs. People were not actively involved in their own care planning and care delivered was task focused. There were gaps in the recording of information, this meant we were not assured people were getting the care they required in line with their assessed need.

People were not always supported and encouraged at mealtimes; people were left waiting for long periods of time before receiving their meal. We observed people sitting in bed with their meal on their knee without cutlery. People were not always given a choice of when they wanted a bath or shower, there was a rota in place and people told us they were told when they could have a bath.

The provider employed 2 part time activity co-ordinators however, people complained about the lack of meaningful activities, one person told us the most they do is eat.

Governance processes were not always effective in the monitoring of the service. Whilst some of the concerns were identified through the service's own provider audits, they had failed to rectify the concerns raised. The provider sought feedback from people who lived at the service, their relatives and staff members however it is unclear how this is analysed and improvements made.

Safeguarding policies and procedures were in place and staff were clear on their own roles and responsibilities.

Health and safety checks were in place and were being monitored.

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.

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

Rating at last inspection
This service was registered with us on 03 May 2022 and this is the first inspection. The service was last inspected under previous provider 03 April 2020 and was rated requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and quality of care. A decision was made for us to inspect and examine those risks.

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 Safe, Effective, Caring, Responsive and Well led sections of this full report.

Enforcement and Recommendations
We have identified breaches in relation to care not being delivered in a person-centred way and how people's needs were risk managed. Governance systems were not effective in managing and monitoring the service and adequate staffing levels.

Recommendations have been made in relation to the recruitment procedure of overseas employees and for the provider review their systems for the recording of medicines including 'as required' medicines in line with good practice guidance.
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.

Follow up
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.

Please see our safe section below.

Inadequate

Is the service effective?

The service was not always effective.

Please see our effective section below.

Requires Improvement

Is the service caring?

The service was not always caring.

Please see our caring section below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Please see our responsive section below.

Requires Improvement

Is the service well-led?

The service was not well led.

Please see our Well Led section below.

Inadequate

Cypress 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 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 team was made up of 2 inspectors, an Expert by Experience and a specialist advisor who was a nurse. 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
Cypress Court is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Cypress Court is a care home with 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 a registered manager in post.

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. We used all this information to plan our inspection.

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.

During the inspection
We spoke to 8 people who lived at the service, 4 relatives and 7 staff members to gain their views and experience of the service. We spoke to external professionals. We reviewed numerous care records, multiple medication administration records, staff personnel files in relation to recruitment. We also viewed various records, policies and procedures in relation to the governance of the service and management.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. The service had been previously rated under a different provider. 'This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.'

Assessing risk, safety monitoring and management

● We were not assured the provider was keeping people safe through assessing and managing risks to their health and safety. People's current needs and risk were not always clearly assessed and managed.

● Care plans about how to manage risk were not always available or being followed. For example, one person had been assessed as requiring a Zimmer frame to mobilise, but staff were not seen to follow this. Another person was using a nicotine vaporiser but did not have a risk assessment regarding this in their care records.

● Equipment was in place to reduce risk such as sensor mats and call bells. However, call bells were not always accessible for people to use and were not always responded to effectively by staff. This meant people could not always get their needs met in a timely manner.

● Personal Emergency Evacuation Plans (PEEPs) were in place but were not easily accessible. This meant systems were not in place to safely evacuate people from the building in an emergency. The provider responded to our concerns immediately.

We found evidence that systems were not sufficiently effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Safe recruitment practices were being followed including checks with previous employers and the disclosure and barring service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. However, for those who had only been living in the UK for a short period of time checks with the equivalent of DBS in their home country were not always being sought.

We recommend the provider reviews their policy in relation to recruitment of overseas employees.

● Staff were not always deployed effectively, which meant people did not always receive support in a timely way. One person told us, "They don't come straight away. I always have to wait. Someone eventually comes." A staff member told us, "More staff are needed to help with activities such as eating and drinking."

● People who used the service, family members, staff members and external professionals all raised concerns regarding the staffing levels. A relative told us, "There is not enough staff. You can be asking for something for ages. Sometimes [person] can be asking for the toilet for ages. Sometimes they haven't got the staff." A staff member said, "Only issue is when there is not enough staff, we can't get things done." A dependency tools was in place to assess staffing levels by the service. However, we were consistently told

there were not enough staff and people could not get their needs met in a timely manner and inspectors' observations throughout the days of inspection reflected this feedback.
● Staff did not always have the experience required to support people, this placed people at risk. One person who lived in the service told us, "Sometimes the agency staff don't know how to use the hoist with the sling. They do manage it. I help them."

We found evidence the service did not provide adequate staffing levels to ensure care was carried out in a safe and effective way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Good practice regarding the safe administration of medicine was not always being followed. We found that one person had several medicines they were recorded as being allergic to. They had recently been prescribed and were being administered one of these. The person had not had an adverse reaction, but this had not been escalated by the staff administering medicines. The provider responded quickly to our query and took steps to review everyone's allergy status regarding medicines to ensure they were accurate.
● A system was in place to make sure that medicines administered in a patch formulation were rotated but did not guide staff to rotate them in line with the manufacturers' directions.
● Written guidance was not always suitably robust for staff to follow when medicines were prescribed to be given "when required". For example, where there was a choice of dose, insufficient person-centred detail about when, and how to administer and ensure it was effective was in place.
● Thickening powder and supplement drinks were not always being securely stored.
● When staff identified the need for a medicine such as topical cream, this was requested appropriately to the relevant health profession but was not always followed up in a timely way to ensure it arrived and was being used.
● Systems were in place to monitor the temperature at which medicines were stored. However, a system was not in place to take action when the temperature went above safe levels. This meant that the effectiveness of people's medicine could be compromised.

The oversight of medicine was not robust enough to ensure people where safely given their medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines counts were correct, and staff were recording that medicines were given in the medicine administration records. However, in line with best practice staff were not maintaining a running count down of medicines which helps identify any errors or if people are running out of their medicines. Staff were not recording a time of administration for medicines which are time sensitive, such as paracetamol, which meant there was a risk of the doses being administered too close together.
● The clinic room was tidy, and people had sufficient stocks of medication which was securely stored.

Preventing and controlling infection
● The home was not always clean and tidy although domestic staff worked hard throughout the day. We found peoples bed linen was not always clean and some people's bedrooms and areas of the corridors had unpleasant smells.
● Toiletries were found in shared communal bath and shower rooms. We could not be certain that these were not shared between people.
● Bedrails were in poor condition in some people's bedrooms which presented an infection and control risk.

Visiting in care homes.
There were no restrictions in place at the time of the inspection. This is working in line with the Government's guidelines.

Systems and processes to safeguard people from the risk of abuse
- People told us they felt safe. One person said, "I am well looked after. I feel safe."
- Safeguarding policies and procedures were in place.
- Staff understood their roles and responsibilities in relation to safeguarding.

Learning lessons when things go wrong
- The registered manager completed groups supervisions with staff when things had gone wrong. We saw recently there had been several supervisions regarding some of the concerns which had been raised with us prior to the inspection. However, these had failed to remedy the issues, and we found a number of these concerns continued over the days of inspection.

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.

This is the first inspection for this newly registered service. The service had been previously rated under a different provider. This key question has been rated Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People did not always have easy access to drinks. We observed several people cared for in their bedroom not having drinks within reach and not everyone had jug of water or juice in their room. People told us they had to wait for a drink particularly during the night. One person said to us before breakfast, "I have not had a drink since 8pm last night."
- People did not always get the encouragement they needed to drink enough and there were no fluid target sheets recorded and no clear systems for the oversight of this. We could not be certain that fluid records were being accurately maintained.
- The service had received feedback during relative and resident meetings and through surveys that people were not always happy about the quality of food. It was not clear that suitable action had been taken on this. Not everyone appeared to be enjoying their food and one person said, "It tasted horrible."
- Those who were cared for in their room or required support at mealtimes, had to wait a long time to receive their meals and were not always supported or given the encouragement and prompts they needed.
- Some people positioning for eating was not always correct and we observed people eating in their bed with their meal on their lap.
- People's dietary care plans were not being followed. We noted one person could tolerate a normal diet under strict supervision due to being assessed as a risk of choking. We observed this person was left with their breakfast unsupervised.

Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. 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

- People needs were not always appropriately assessed and their needs were not clearly reflected within their care plans.
- We were not assured people were receiving the right support in relation to their assessed need. This was due to gaps in recording and care plans not being updated when people's needs had changed.

People were not always supported to make choices about their care and they, or their representative were not always involved in decision-making or reviews. This placed people at risk of harm. 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
● There were records of supervision and appraisal. These were mainly task focused and did not evidence how staff were supported to reflect, learn, and develop within their roles.
● Staff who handled medicines had completed assessments of their competency. However, it was not clear that this was robust enough as the shortfalls in practice we found had not been identified.
● It was not clear that all staff had received there mandatory training. Therefore, we could not be assured that all staff had received the appropriate training to enable them to care for people safely.
● Staff induction files were available, this evidenced staff had received an induction prior to starting their employment.
● Staff told us they felt supported, and management were approachable.

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 have good oral care. We found limited evidence that where people had toothbrushes that these were used, and some people had very dirty teeth. Some people had oral care plans in regard to the use of dentures, but these were not personal, and staff were not ensuring that people were using their dentures or that these were still comfortable for the person to use.
● Staff did not always work with other agencies effectively. One professional told us, "I normally have to go and try and find staff which is a waste of my time."
● There was evidence that referrals to other professionals were made as and when required. However, external professionals' input was not documented, and guidance not always followed. One person who required district nurse input had no care plan or risk assessment in place. We found this person was not being supported as recommended.
The above issues were a further breach of Regulation 12 (Safe care and treatment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● There was a strong unpleasant odour within the home.
● The lack of storage presented a risk as equipment was stored in communal areas and corridors.
● People had the option to personalise their own room.

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.

● Capacity assessments were in place and where people lacked capacity there was evidence that DoLS had been applied for and best interest decision were being completed. However, it was not clear that capacity

assessments and best interest decision were completed for all relevant decisions.

● Consent was not always obtained. Staff did not always request consent from people where supporting them with daily care tasks, and records did not always show that consent to care had been given by the person or authorised person where a person lacked capacity.

● Where DoLS authorisations had been granted and were subject to conditions, these were incorporated into the care plan, but it was not evident how these conditions were being met. For example, one person had a condition that they should see a specific health care professional regularly, but this was not evidenced in their records relating to health care input.

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.

This is the first inspection for this newly registered service. The service had been previously rated under a different provider. This key question has been rated Requires Improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity, Supporting people to express their views and be involved in making decisions about their care

- Care was not always provided in a person centred way, one person told us, "One of the carers sounds like she is in a hurry all the time. She rushes me".
- Observations showed some staff provided positive interactions however, some of the staff were observed not to be talking to people when supporting them. This meant care was not always person-centred and people were not provided with the reassurance they might need.
- The provider held resident meetings and actively encouraged people to be involved however, it was not clear if actions had been taken following on from the meetings.

Respecting and promoting people's privacy, dignity and independence

- Care plans contained information about what people could do for themselves and how to promote independence around mobility for example. However, care was not always being delivered in line with the care plans and independence was not always promoted. People did not always have access to the equipment they needed to maintain independence. For example, we found several people were eating meals with their hands, and we were unable to find that any cutlery had been provided to them.
- Not all staff respected people's privacy. We observed a staff member entering a person's room without knocking.
- People did not always have a choice when they could have a shower or bath. One person said, "I am told when I can." Another person told us, "There is a rota for the bath. You could ask for one but if the staff was not available you would not be able to have one." There was a file in place for staff to monitor people's bathing. However, this was not always effective. There were gaps in people's personal hygiene records therefore, we could not be assured people were receiving support with their personal care needs.
- The deployment and schedule of staff did not always respect people's dignity and wishes. One person told us, "They did put me in for a man to give me a shower. I refused and they took it out. I would have been horrified to have a man shower me."

The above issues are further evidence of a breach of regulation 9 (Person Centred Care) 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.

This is the first inspection for this newly registered service. The service had been previously rated under a different provider. This key question has been rated 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

- People were not involved in their care planning which meant they lacked control over how their needs were met. One person told us, "I have never actually seen a care plan." People's relatives were not involved in care planning and one relative said, "The office has one [care plan]. I have not seen it. It might have been reviewed. They will have written it. They deal with it."
- People did not always receive person centred care. One person told us, "You don't see the staff. They just come in and bring you juice or to move people from one place to another but that's it."
- People's preferences in relation to preferred staff gender was not always clearly documented, people had to states this at the point of care being given.
- Daily notes were task centred and lacked personal detail, there was gaps in recording which meant we were not assured that people's needs were being met.

The support people received was not person centred, did not consider people's individual needs, or promote choice and control. This was a breach of regulation 9 (Person Centred Care) 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 met. Some people had communication care plans in place, but they lacked person centred details on how best to support people.

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

- The provider employed two part time activity co-coordinators to encourage people to join in activities, however there was limited activities available. One person told us, "There is nothing going on. The biggest job I do here is to eat." Another person said, "There are no activities. I just read. Sometimes the carer fetches a quiz round on a bit of paper."
- People did not feel the staff had the time to talk to them. One person said "The staff don't talk to me a lot.

They haven't got time."
● People who are cared for in bed received limited interaction with people.

Improving care quality in response to complaints or concerns
● There was a complaints policy and procedure in place.
● When concerns were raised, management would discuss this with staff during meetings. However, these issues were not rectified, and it was not clear that management were following up action to ensure it was completed or embedded.

End of life care and support
● Where people had end of life care plans in place these lacked personalised details about how to support the person to remain comfortable when they reached the end of the life.
● Information about practical arrangements and decisions regarding resuscitation were recorded within the 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.

This is the first inspection for this newly registered service. The service had been previously rated under a different provider. 'This key question has been rated 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

- Due to staffing levels the manager was required at times to support the carers in his role as a nurse. This was included in his working hours, which provided him with less opportunities to complete the tasks needed of them as a registered manager.
- The registered manager completed several audits of the service. These were not always robust enough to identify the issues we found during this inspection. These included issues relating to the safe management of medicines, and the delivery of good quality care.
- Daily records were not being suitably maintained to ensure people's care needs were being met. We observed several examples where people were not receiving the care they needed including positional changes and sufficient fluids. Where support had been given, records were not always being updated by staff in a timely way and gaps were identified in the recording of people's needs. We therefore could not be certain of the accuracy of any records held regarding people's daily care.

'The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service.' This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There were mixed views on the support from management, the majority of the staff told us they felt supported, and the manager was approachable. However, one staff member said, "I can tell them [management] but it won't make a difference, they do nothing."
- People did not know who the manager was or had not been introduced to them. One person said, "I've not had anything to do with him." Another person said "I don't know his name. I know him to look at." However, people did know other staff members that they felt they could speak to. One person said "I haven't met them [registered manager] so I would speak to one of the carers."

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 Care Quality Commission (CQC) was informed of incidents and events which occurred within the service in line with regulatory requirements.

● The provider was responsive to feedback and took immediate action to address some of the concerns raised. The next inspection will determine the effectiveness of these actions.

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

● Surveys had been completed with staff and relatives. Feedback from these was mixed in some areas. It was not clear how these had been analysed and used to improve the quality of the service. Some of the concerns raised were still evident during our inspection.

● There were a variety of meetings held with staff, residents and relatives. These showed that discussions had been held with staff regarding complaints and safeguarding, such a prompting choice about bathing and showering, changing bedding and the importance of regular checks. However, this had not led to the required improvements being made and embedded within the home, and there was no documented evidence to show that following these initial conversations actions were followed up by the registered manager or provider.

● The registered manager was available to speak to people Monday to Friday if they needed to discuss anything.

Continuous learning and improving care

● Action plans have been implemented by the provider following on from the inspection. The effectiveness of these will be measured at the next inspection.

● The provider has recently employed a deputy manager and a quality lead.

Working in partnership with others

● Some professionals that we spoke to did not always feel there was enough staff to support them. This meant time was spent trying to source current information about people in order to make suitable assessments and review individual's progress.

● There was evidence the provider was working with other professionals and relevant referrals were made. Numerous professionals visited the service during the 2 inspection days.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The support people received was not person centred, did not consider people's individual needs, or promote choice and control. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.' People were not always supported to make choices about their care and they, or their representative were not always involved in decision-making or reviews. This placed people at risk of harm. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found evidence the service did not provide adequate staffing levels to ensure care was

carried out in a safe and effective way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found evidence systems were not sufficiently effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The oversight of medicine was not robust enough to ensure people where safely given their medicines. This was a breach of regulation 12 (Safe Care and treatment) of the health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 'The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service.' This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice