Healthcare Homes Group Limited

The White House

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

This inspection took place on 15 and 20 June 2016, and was unannounced.

The White House residential home provides accommodation and personal care for up to 33 people. At the time of our inspection there were 29 people using the service.

There had not been a registered manager in post for four months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current deputy manager in post had made an application to become the registered manager, and this was being processed.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During this inspection, we found that the registered provider was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The provider had not ensured that people were receiving safe and effective care provided by sufficient numbers of skilled and knowledgeable staff. Staffing levels were not always adequate to ensure that people were kept safe at all times. People did not always receive the time and attention they needed to fully meet

their needs. At times care was task focussed and hurried with staff unable to respond to people as quickly as they would like.

There were gaps in how the service assessed and monitored the quality of its provision. While there were some quality assurance mechanisms in place, these had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. Where issues were identified, such as equipment which was faulty and the need to increase staffing levels, action had not been taken promptly. The provider did not have robust oversight of the service's operations.

Risk assessments were completed to ensure that people were kept safe. These included risk assessments in relation to people's personal care, moving and handling and medicines. However, we found that the level of information held was not consistent across the service, and this meant that staff did not always have up-to-date and clear guidance to help them support people safely.

Care plans for people were not always reviewed or reflective of people's current needs. Information held in people's care plans was not consistent across the service and there was a risk that staff did not have the most appropriate information to enable them to tailor the care they provided to people.

Infection control procedures and audits were not effective, and did not identify the issues we found.

Activity provision was not sufficient to meet the individual needs of people using the service.

Staff were trained in areas relevant to their role, however, the induction for newly recruited staff was not robust enough to ensure they felt confident to do their job and care for people safely. Staff supervision was not routinely provided, which supports staff to improve their practice.

Whilst staff worked within the principles of the Mental Capacity Act 2005 (MCA), some MCA assessments and DoLS [Deprivation of Liberty Safeguards] authorisations were out of date and had not been renewed.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse, and who they should report this to.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

People's medicines were administered and stored safely.

People's individual needs were not met by the adaptation, design or decoration of the service, which could compromise the ability of people moving around the service independently. We have made a recommendation about how accommodation can be adapted to meet people's needs more effectively.

The dining experience was not conducive to an enjoyable mealtime and did not give opportunity for social interactions. We have made a recommendation about improving the dining experience for people.

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to. However, complaints and feedback received were not comprehensively recorded or used routinely as an opportunity to learn and improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing level arrangements were not sufficient to ensure people's needs were met at all times.

Risks assessments were in place, but some required more detailed information to ensure staff were provided with guidance on how to reduce risks to people. Risk assessments were not always reviewed in a timely manner.

Bathing equipment was unsafe for use.

Infection control procedures were not effective.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff induction training was not robust enough to ensure staff were confident in their roles.

Staff acted in accordance with MCA principles, but some DoLS authorisations and MCA assessments were out of date.

Peoples' nutritional needs were monitored. People had access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always have the time to provide meaningful interactions with people, which at times were task focussed and hurried.

We could not be assured that people were fully involved in the planning of their care.

Peoples' privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans held inconsistent information and were not always detailed enough to reflect people's individual needs.

Activity provision was not sufficient to meet individual needs.

People and relatives knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

There were not effective procedures in place to monitor the quality of the service. Where issues were identified these were not addressed.

The White House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15 and 20 June 2016, was unannounced and undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

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 speak with us, for example, people living with dementia.

During the inspection we spoke with nine people living at the service, three relatives, and one health professional. We spoke with the deputy manager, regional manager, and six members of care and catering staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met, we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

People, staff, and relatives told us they did not think there were sufficient numbers of staff on duty to meet people's needs. One person said, "They are short staffed. They are late getting people up. People have to wait and some get upset. Last night the night shift were getting people to bed at midnight". A staff member said, "We can't provide a high quality of care as we would like to, there just isn't enough of us". A relative told us, "They are very good, but definitely need more staff. They are rushing around all the time".

Staff on duty reflected the levels reported on the rota, however, we found that there was no system in place to ensure that staffing levels and skill mix were being reviewed continuously, and adapted to respond to the changing needs and circumstances of people. The deputy manager was unable to demonstrate if they had considered the different routines of the day against the fluctuating staffing levels and how this affected people's care. In addition to this, two staff members and the deputy manager told us that people could only be offered a bath when there were five staff on duty. This was because there was not enough staff to support other people and this would take too long. The deputy manager confirmed that a high proportion of people would prefer to take a bath. Given that this option was only available in the morning due to staffing levels, the deputy manager and provider were unable to demonstrate how they ensured these needs were being met.

The deputy manager told us there were 12 people who needed 'double assistance' [two members of staff] to support with care needs. We were concerned that given the number of people requiring two staff, there had been no consideration of the impact on others who may need assistance at the same time particularly during the night. If two staff were needed to assist a person to move or to use the toilet, there would be no one available to monitor the welfare of other people in the service. The provider told us that they had identified the need for a third member of staff on the night shift and were interviewing on the second day of our inspection. Given that this shortfall had been identified, there was no procedure to follow in the interim where only two staff were working during the night. This did not ensure sufficient and suitable staff were deployed to cover both the emergency and the routine work of the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have asked the provider to take at the back of the full version of this report.

Risk assessments provide staff with guidance on how risks to people are minimised. Risk assessments were completed in relation to pressure ulcers, mobility, and nutrition. However, we saw that the information held in care records was not consistent, particularly in relation to moving and handling plans. Some plans did not provide adequate instruction which would ensure that people were moved safely and comfortably. Additionally, some assessments relating to the risk of malnutrition and the risk of developing pressure ulcers, had not been reviewed for several months, and people's needs may have changed in this time. This meant that people may not have been receiving care in line with their current needs. We brought this to the attention of the deputy manager, who said they would take prompt action to update people's risk assessments and moving and handling plans.

Infection control procedures were not effective. Audits were being completed by the deputy manager, however, they had been ineffective in identifying the issues we found requiring attention. For example, overflowing bins, equipment with rust, and no hand towels available in some areas for staff to ensure effective hand hygiene. We were also not confident that commodes were being sanitised thoroughly as staff told us this was inconsistent, for example, some go to the sluice room, and others are washed by hand. We also saw some commodes with ingrained soiling. We brought this to the attention of the deputy manager who told us they would address this, and agreed for the local infection control team to visit the service in July 2016, who would carry out a full assessment.

Only one bath was in working order. There was a bath seat which staff used to assist people into the bath, however, we found the bath seat was cracked, and the crack had been taped over. When we brought this to the deputy manager's attention, they told us they were aware of this, but said the seat was still being used. We advised them to take this out of action as it was unsafe for people to use. Providers are required to ensure that equipment provided is safe for use.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People had Personal Emergency Evacuation Plans (PEEP) recorded within their care records. These showed the support people required to evacuate the building in an emergency situation, and were filed close to one of the two entrances. Staff were aware of these and the level of support people required. Maintenance records were kept by the maintenance person, and checks such as water temperatures were carried out weekly. Checks for water borne viruses such as legionella had also been checked by an external company. However, the faulty bath seat we found had been taped over by the maintenance person, leaving the seat unsafe for use.

Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people in the service.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "If I come across issues I report this to the manager or social services. I wouldn't hesitate". Details of whistleblowing [the reporting of poor practice] were displayed in the service. One staff member said, "I wouldn't let staff carry on working if they were doing a poor job, I'd report that". A safeguarding log was in place which documented a recent event and a meeting with the safeguarding team. .

Systems were in place for managing medicines and people received their medicines in a timely manner. People's medicines, including controlled drugs, were stored safely. One person said, "I like to know what it is I'm taking, and I like to ask. They [staff] bring them to me, it seems to work quite well. Wherever I am they come with the medication".

Medicines which needed to be taken at a particular time of the day were highlighted within medicine administration records [MAR]. Details of medical conditions, such as diabetes, were also documented in MAR charts and described what action to take if a person's blood sugars dropped. This ensured staff had guidance to follow in such events.

Creams for external application were held centrally, and staff documented when this had been applied in people's daily notes. We discussed with the deputy manager about having a specific cream chart and body map in place so it was clearer where the cream was to be applied and could therefore be monitored more effectively, and they took action to implement this.

Requires Improvement

Is the service effective?

Our findings

People's views about the skills and experience of those providing their care varied. One person said, "I'm fairly satisfied where they [staff] are concerned, and quite a few are young, but I do get the impression that most have had some sort of training". Another said, "Some are better than others".

Staff told us they felt well trained to do their job, and had received training in areas such as Mental Capacity Act, safeguarding, and dementia awareness. However, staff told us that they did not always receive regular supervision sessions to support them to improve their practice and identify further training needs. Staff meetings were held to share information on a six weekly basis. Within the minutes of the staff meeting it stated that, 'Any chats or staff meetings that take place can be classed as supervisions". The deputy manager also said that training is classified as 'supervision'. Informal chats and group meetings do not provide an appropriate setting to discuss individual needs, and therefore it was not clear how the service ensured that staff were supervised adequately to ensure their competency and learning was effective.

One staff member told us that they had not received an adequate induction. They had not worked in care previously and said they, "Didn't feel confident" when they had to perform the role independently. We brought this to the deputy manager's attention and on the second day of our inspection, dates for staff to attend individual supervision had been arranged. Following the inspection, the provider told us that observational assessments for new employees would also be carried out. This will ensure that staff are supported appropriately and are competent in their roles.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff we spoke with understood the importance of consent. One staff member said, "I ask the person if they want help, I don't just do it". We observed staff asking people if they would like help to eat, where they would like to sit, and what they would like to do.

Best interest decisions and MCA assessments and were in place for some people, which included information on decisions a person could still make for themselves. However, some had not been dated, and it was not always clear why MCA assessments had been carried out. The deputy manager told us that a new form relating to MCA is to be implemented, and will identify more clearly what decisions are being made which require a test of capacity.

We saw that for some people, DoLS authorisations were in place. However, one person's had expired, and another was nearly 10 months old. The need to review DoLS is important to determine if they are still required, and this had not been considered. When we spoke to the deputy manager about legislation relating to DoLS they did not demonstrate sufficient understanding in this area, meaning there was a risk that people were being unlawfully deprived of their liberty. The deputy manager arranged for an experienced colleague within the organisation to come and review each person and ensure requirements were being met.

We observed the lunch time meal. The dining area was small and cramped with only four tables available for formal dining. Some people had to eat in the lounge area which formed part of the main thoroughfare where staff, visitors and people were moving about continuously. It was therefore not conducive to a relaxing, sociable or positive dining experience. Some people chose to eat in their rooms. Improvements were needed to ensure that the routines of the service took people's individual needs into account. For example people may benefit from choosing their food closer to mealtimes. One person said, "They [staff] put the menu on my tray, I have it [lunch] in my room as it gets a bit full up in here [dining room]". People did not remember what was for lunch as they had ordered it the day before. One person said, "What we do now is we are filling out choices for the next day, it doesn't confuse me, but some people can't work out why they are being asked something but they can't get it now".

People asked for drinks, and a jug of blackcurrent squash and water was brought through. There were no other choices available. One person said, "I'm not keen on either". We also saw very hot plates being placed in front of people who may not realise and burn themselves. We brought this to the attention of the deputy manager who took action to ensure the temperature was reduced.

We recommend that the service explores current guidance from a reputable source to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

We spoke to the chef, who showed us a file they had in place which contained individual diet sheets and details of people's food and drink preferences. They had gained knowledge of people's dietary needs, and were familiar with health needs such as diabetes. Food supplements were used to increase nutrition and people who had problems with swallowing were served softer diets and thickened fluids.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. One person told us, "There's a system here where the doctor comes on a Tuesday and sees everyone who the staff feel need to be seen". Another said, "If I've got something wrong, management make me an appointment for a doctor". A visiting health professional said, "I always find the staff very helpful. The referrals I receive from the home are appropriate".

The services' Statement of Purpose says that premises will be designed, built and maintained in accordance with the requirements of regulatory authorities and any good practice guidance which may exist. People's individual needs were not met by the adaptation, design or decoration of the service. Some corridors lacked adequate lighting, and handrails were absent in places. The entrances to people's rooms were not clearly marked, and did not benefit from visual reminders. This could compromise the ability of people living with dementia to move around independently.

We recommend that the service explores current guidance from a reputable source on improving the design and decoration of accommodation for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Staff told us, and we observed, that they did not have time to interact with people in a meaningful way. We observed that staff were kind and spoke respectfully about people, however the routines of the service and tasks they were expected to undertake did not allow them time to spend with people other than when they were providing care. One staff member said, "I feel awful, I want to sit and chat with people, but there just isn't the time".

Some trusting relationships had been formed between staff and people, and people looked relaxed in the presence of staff. We asked staff if they had read people's care plans to ensure they were well-informed about their needs. One staff member said, "I haven't had time". Another said, "I rely on the handovers for information". Handovers provided specific details relating to appointments, medicines, and people's current health. They did not provide details about people's preferences and individual characteristics. There were not enough opportunities for staff to learn about people to fully understand people's social, emotional or physical health needs. Understanding this helps staff to provide empathetic and compassionate care.

We received mixed views about how people were involved in their care. One person said, "They [staff] have got a care plan, but I don't know what's in it". Another person was unsure if they had seen their care plan. The content of some care plans did indicate that people had been involved due to the personal nature of some of the information. We told the deputy manager what people had told us, and they acknowledged that this needed improvement, and told us that they intended to implement a more robust system where people and their families are encouraged to take part in developing their care plans.

People's views were listened to in quarterly resident meetings. Relatives and advocates were also invited to attend these. We reviewed the minutes of the most recent meeting and saw nine people and five relatives had attended. Items discussed included activities, future trips out and improved communication. Several action points were logged within these and the name of the person responsible for completing the action, which meant that this could be reviewed at the next meeting.

People's privacy and dignity was respected, for example, one person had become unwell in the communal area of the lounge. Staff provided privacy screens so they could attend to their personal care whilst maintaining the person's dignity. On another occasion, we saw staff asking a person if they "wanted some privacy" before closing their bedroom door. The 'do's and don'ts' of dignity were displayed in the service as a reminder to staff. One person said, "They [staff] always tap on the door, ask if it's ok to come in". Another said, "Part of the pleasure is respect. That definitely is there".

Relatives told us that they were always made to feel welcome when they visited and that they could visit at any time. This meant that people were able to socialise with family and friends as they chose and this reduced the risk of social isolation. We saw relatives who were visiting, making themselves drinks, and chatting comfortably with staff. One relative said, "Its great here, we [relatives] come in and make ourselves comfortable. We have our own little area to make ourselves a cup of tea".

Requires Improvement

Is the service responsive?

Our findings

Some people's care plans contained information about their physical, mental and emotional needs, and reflected people's personal preferences in terms of how they would like their care to be delivered, for example, gender preferences, what time they chose to get up, and how they liked to dress. However, the level of information held on each care plan was not consistent. For example, some people's care plans were very detailed and contained information on their life history and social interests. Others were incomplete, for example, in one care plan it asked, "What is important to you?", and this had not been answered. In another care plan the section named "This is your life" had not been completed. Care plans did not always provide up to date and complete information, which meant that opportunities were being missed to tailor care for the individual needs of people. It also demonstrated that the services' approach to regular reviews of people's care was inconsistent.

The approach to supporting people with their interests and have meaningful and fulfilled days was not effective. There was an activity co-ordinator who worked in the service 16 hours per week. This provision was split across three days, which meant that there was minimal activity provided for people on the days that the activity co-ordinator was not present. Care staff did not have time to provide meaningful activity to meet people's needs in addition to their care duties. One person said, "I'd like more to do, get a bit bored up here [In bedroom]". One person said, "I do stay in my room, I'm a very avid reader. I feel depressed if I go down there [communal area], they're all asleep". Another said, "There's a lady coming tomorrow to talk to me about a day centre. It's a bit limited here because people are not able to express themselves". Some people in the service were living with dementia, and were not always able to join in with conversation or verbalise their needs fully. Whilst activity was taking place people were seen to be engaged and mentally stimulated, however, when there was no activity on offer, staff did not have the opportunity to engage in conversation with people, or provide people with activities of their choosing.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed activities taking place in the main lounge. This area is the main thoroughfare for staff, visitors, and access to people's rooms. This did not provide an appropriate setting for activity to take place, particularly if it was a quieter activity, such as reminiscence. The activity co-ordinator said, "Activities in the morning here don't really work [referring to the busy environment]". The provider told us that they planned to increase the activity co-ordinator role to 26 hours per week, as they had also identified that the current provision was not sufficient to meet people's needs.

People told us they knew how to complain or raise a concern. One person who had raised concerns previously told us, "I did mention it to [name of deputy manager], and my [relative] and I had a meeting in my room with [name of deputy manager]". A relative said, "I know where the office is and if there was a problem I'd be down there". There was a log of complaints recorded, and we saw that concerns which had been raised were addressed, and meetings with family and people had been carried out where necessary. The date that complaints had been resolved was not always documented so the records did not

demonstrate whether there had been a timely response to people's feedback. Additionally a more comprehensive description of the complaint was needed, as it was not always clear to see exactly what the concerns were about. The service can then use this feedback as an opportunity to learn and improve.

Inadequate

Is the service well-led?

Our findings

The service had not had a registered manager in post for four months. The deputy manager had started the application process to become the registered manager, and in the last six weeks had begun to informally manage the day to day running of the service with the support of the provider. These arrangements were not effective to maintain people's safety and welfare in the interim. There was a lack of oversight which resulted in no action being taken to ensure improvements were made immediately. For example, they knew staffing was insufficient but nothing had been done in the interim period to mitigate risks until they recruited more staff.

There was a lack of regular auditing and analysis of quality assurance systems to continually monitor the service provided to ensure people received safe and effective care. Whilst some audits had been completed in areas such as infection control and health and safety, these had proved ineffective in identifying where improvements were needed, for example, rusted and unsafe equipment. Accident and incident logs gave no information other than the name of the person and a date. There was no information as to what incident had occurred and what action was being taken as a result, for example, the need to identify emerging themes such as the time of day a person may have fallen. Spot checks of staff and audits of care plans were not being assessed and monitored effectively to ensure people were receiving good quality care. Improvements were not acted upon in a timely manner. For example, we found faulty bathing equipment which the deputy manager was aware of, but had not taken action to remove.

People knew who the deputy manager was as they had been working in the service for a long period of time, however, one person told us that until recently they didn't know who the manager was. Minutes of the 'resident' meeting we reviewed did not refer to the management structure and changes that were taking place in the service, and therefore we were concerned that people were not involved in developing the service and being made aware of changes which were taking place.

Staff told us they felt able to raise issues with the deputy manager, and spoke positively of them. One staff member said, "[Deputy manager] has been left with a bad situation, but they're doing alright". Another said, "[Deputy manager] is approachable and they work hard". However, some staff told us that they did not receive regular communication from the management team or provider to ensure they were all kept informed of changes in the service and knew the roles and responsibilities expected of them and others in the organisation. Staff were not actively involved in developing the service; given that the management structure had changed there was a greater need to develop an inclusive and open pathway of communication and involvement with staff. Staff told us that the staffing levels needed to improve and that they had raised this to the management team, but no changes had been made. This left staff feeling that they weren't being listened to and frustrated that they could not spend time with people, other than to provide task based care. Staff also told us that management support at the weekends was poor. They said there was an 'on call' phone number to contact, but "No one ever answers it". This left staff feeling unsupported.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us they felt supported by the provider and their wider network of colleagues within the organisation who communicated regularly with them. They had a mentor who they could go to for advice and guidance, and the provider had arranged for them to commence leadership training which would develop their knowledge in their new role.

Following receipt of the warning notice we issued, the provider has been pro-active in sending us weekly action plans informing us of how they are working towards making necessary improvements to the service. Provider representatives assured us that they would continue to support the management team to achieve these improvements, and acknowledged that they should have taken action earlier to rectify the issues highlighted during the inspection.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that met their individual care and support needs. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not completed and reviewed regularly. Equipment intended for use was unsafe. Regulation 12 (2) (a) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not adequate to monitor and improve the service provided. They did not identify where quality and safety were being compromised. Regulation 17 (2) (a)

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 HSCA RA Regulations 2014 Staffing Staffing level arrangements were not sufficient to ensure people's needs were met at all times. Regulation 18 (1)

The enforcement action we took:

Warning notice