Mr & Mrs M Ellis

Woodthorpe View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Woodthorpe View Care Home is a residential care home. It is registered to provide a service to older people. At the time of the inspection 15 people lived at the home.

People's experience of using this service: The service was not safe. People were placed at risk of harm as risks associated with their care and support and the environment were not managed safely. Opportunities to learn from accidents had been missed which meant people had been exposed to the risk of avoidable harm. People were not protected from the risk of infection. There were not enough staff employed and safe recruitment practices were not followed. Although people told us they felt safe, a lack of leadership and systems meant there was a risk safeguarding issues may not be identified or addressed.

People were supported by staff who did not have the required skills or competency to provide safe and effective support. People's health needs were not always met and their needs were not reassessed when their health changed. Care and support was not properly planned and coordinated when people moved between services. Care was not always delivered in line with current legislation and standards. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The environment was not well maintained and this posed a risk to people's safety.

People told us that staff were kind and caring. However, care plans lacked information about people which meant staff did not always have enough information to provide person centred care. There was an inconsistent approach to involving people in decisions about their care and support. People's right to privacy was respected.

People did not consistently receive personalised care that met their needs. People were not provided with opportunity for meaningful activity. There was a risk that complaints and concerns may not be identified or addressed.

The provider had no oversight of the home and there was no management team in place. Consequently, there had been a failure to identify and address serious issues with the safety and quality of the service at Woodthorpe View. Systems to monitor and improve the quality of the service were not effective. Where audits had identified areas for improvement action had not been taken to address issues. The provider had not implemented learning from serious incidents. Failings in leadership and governance placed people at risk of harm.
Rating at last inspection: Requires Improvement (Report published on 15 August 2018). This service has been rated as Requires Improvement, or Inadequate, at our last four inspections. This demonstrates a failure to make and sustain improvements to the quality and safety of the service.

Why we inspected: This inspection was conducted due to concerns we received about the safety and quality of the service provided at Woodthorpe View Care Home.

Enforcement: You can see what action we told the provider to take at the back of the full version of the report. 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: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received 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.

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.

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.

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

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 caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Woodthorpe View Care Home

Detailed findings

Background to this inspection

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

Inspection team: This inspection was carried out by two inspectors and an assistant inspector.

Service and service type: Woodthorpe View is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. We cancelled the registration of the previous manager in September 2018. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided. The provider did not have plans to recruit a manager.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection site visit we reviewed any notifications we had received from the service and information from external agencies such as the local authority. This was a responsive inspection based upon risk and therefore the provider was not asked to complete a Provider Information Return (PIR). This is information we require providers to send us to give key information about the service. We gave the provider the opportunity to share this information during the inspection.

During our inspection visit we spoke with five people who lived at the home. We also spoke with five care staff, a member of the domestic and catering team and the provider.

We reviewed records related to the care of seven people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, four staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information about safety and leadership from the provider. This was not provided within the requested timeframe.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely; Preventing and controlling infection

• People were not protected from risks associated with their care and support. Risks such as falls and choking were not always assessed and action had not been taken to reduce risks. For example, one person fell in late 2018. An external health professional had recommended a movement sensor was implemented to reduce risk. However, during our inspection, this was still not in place. Staff told us risk assessments were not useful and said that very often they did not exist. This failure to assess and mange risks placed people at risk of harm.

• Opportunities to learn from incidents had been missed. Incident records were not always completed. For example, there were no incident records for two falls sustained by a person. Where incidents records had been completed, they had not been reviewed by anyone to check that staff had followed correct procedures and identified any areas for learning. An incident form had been completed after a person sustained fall, but it had not been reviewed. Consequently, risk reduction measures were not implemented. This failure to learn from incidents placed people at continued risk of sustaining injuries.

• There was a risk people may not receive their medicines as prescribed. We found gaps in signatures on medicines records which indicated that people had not received their medicines. There were gaps on five of the six medicines records we reviewed. Furthermore, records of topical creams were also not competed as required. This could have had a negative impact on people's health and wellbeing as we could not be sure people were receiving medicines as prescribed.

• Medicines were not stored in line with national guidance. Room and fridge temperatures were not recorded regularly, as required. This posed a risk that fluctuations in temperature may not be identified or addressed and this could have had a negative impact on the effectiveness of medicines.

• People were placed at risk of harm as environmental risks were not managed safely. An insufficient fire risk assessment, structural issues with the environment and unsafe storage of flammable items increased the risk of fire. Inadequate fire detection systems, issues with escape routes, absence of an evacuation plan, a lack of training, poorly maintained fire doors and a failure to conduct regular drills increased the risk of people sustaining harm in the event of a fire.

• People were not protected from the risk of contracting Legionella. There was no legionella risk assessment and no records of regular checks to reduce the risk of legionella developing in the water support. This failure to control the risks of legionella placed people at risk of harm.

• There was no evidence that other environmental safety checks had been completed including; gas and electrical safety and servicing of lifting equipment. This further increased the risks to people and staff.

• People were not adequately protected from the risk of infection. There were no systems or policies in place to ensure the prevention and control of infection. Consequently, hygienic practices were not followed. For example, there were no cleaning or laundering protocols in place for equipment, we observed some wheelchairs to be marked and dusty and slings were odorous. This placed people at increased risk of

infection.
The above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Safe recruitment practices were not followed. The required preemployment checks were not always completed when staff started work at the home and steps were not taken to assess conduct in previous posts as adequate references were not sought. Furthermore, staff told us they were not interviewed for their roles and records confirmed this. This placed people at risk of being supported by unsuitable staff.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Overall, people told us there were enough staff to keep them safe. One person commented, "I am sure there are enough staff." However staffing levels were not based upon people's needs and there was no formal way of assessing how any staff were required to ensure people's safety. Records confirmed there were usually three staff on shift, however, staff told us that there were sometimes only two staff on at weekends. This was not enough to ensure people's safety and meet their needs. This placed people at risk of harm.
• Furthermore, records showed and staff told us, there were not enough staff employed at Woodthorpe View. This had resulted in several members of staff working long shifts back to back. This posed a risk that staff may become exhausted compromising the safety of the service.

Systems and processes to safeguard people from the risk of abuse
• Overall, people told us they felt safe. Staff knew how to recognise and report abuse. However, a lack of up to date training for staff, the absence of any management or leadership and no formal systems meant there was a risk safeguarding concerns may not be identified and addressed as required.

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
• Staff did not have sufficient training to enable them to provide safe and effective care and support. The training matrix had not been kept up to date which meant we were unable to ascertain what training staff had received. There were no records of training for some staff. Two recently recruited staff told us they had no training before starting work at Woodthorpe View and there were no training records for either member of staff. One member of staff said, "I would like more training."
• Staff did not have training in key areas such as care planning or risk assessment. Staff told us they did not feel confident in completing care plans or undertaking risk assessments. Consequently, care plans and risk assessments were out of date or poor quality. Staff did not have up to date moving and handling training. This posed a risk of poor moving and handling practices. Several people had diabetes but records showed staff did not have training in this area. During our inspection we found staff did not have sufficient knowledge in this area.
• Staff did not have any supervision. There were no records of staff supervision since 2017. This meant opportunities to support staff development and to address performance issues may have been missed.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Risks associated with eating and drinking were not managed safely. Information available to kitchen staff about people's dietary needs was out of date and incorrect. Consequently, catering staff did not all have a good knowledge of people's dietary requirements. For example, the cook told us no one had diabetes. However, care plans documented that two people required a 'diabetic diet'. These people were served a normal diet. This placed them at risk of harm because an uncontrolled diet could affect their health condition.
• People were not protected from the risk of choking. Specialist professional advice had not been incorporated in to a person's care plan and the cook was not aware of the specific consistency of food required to prevent choking. This placed the person at risk of harm.
• Food safety and hygiene procedures were not followed. The member of staff responsible for preparing lunch and dinner did not have any food hygiene training and this was confirmed by records. This had a negative impact upon their practice and led to potentially unhygienic practices. For example, we observed they did not wear appropriate protective equipment, such as a hair net or hat, during food preparation, this could have led to contamination of the food. There were no cleaning records for the kitchen areas and some

surfaces, such as the cooker were observed to be dirty. There were no records kept of fridge temperatures, which meant posed a risk food may not be stored at the correct temperature. These issues placed people at risk of eating food which was not suitable for consumption.

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

• Despite the above, people were positive about the food. One person described the food as "Absolutely marvellous." However, staff told us people did not get a choice about what they ate as the cook decided upon this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not thoroughly assessed before they moved into the home. Staff told us they had not had any information about some people and there were no assessments in some people's care plans to show their needs had been considered before they moved in. This posed a risk that people may not receive support that met their needs or reflected their preferences.
• Although nationally recognised assessment tools were used, these were not used consistently or effectively. For example, risk assessments had not been completed when people were at risk of falls. Where risk assessments had been completed recommended actions had not always been followed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care;
• Staff did not always have a good knowledge of people's health conditions. Some staff did not have a good knowledge of conditions such as diabetes. In addition, care plans did not contain clear, personalised information about people's health conditions. This meant there was a risk that people may not receive the support they required to maintain their health.
• Although there was evidence that advice had been sought from external health professionals, such as speech and language therapy and the falls team, this was not always followed. This failure to follow professional advice placed people at risk of receiving unsafe support that did not meet their needs.
• There were no systems in place to share information across services when people moved between them. For example, one person had been admitted to hospital with only very basic information about their medicines. This posed a risk people may not receive person centred support.

Adapting service, design, decoration to meet people's needs
• The home was not adequately maintained and this had increased the risk of fire and infection. We have reported on this fully in the, 'Is this service safe,' section of this report.
• The home was adapted to meet people's needs. Aids and equipment had been installed throughout the home. This enabled people with mobility needs to navigate around the building and there was a call bell system to ensure people could request staff support. There were communal lounges and dining areas which meant people had space to spend time socialising.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• There was a risk people's rights under the MCA may not be respected. Capacity assessments had not always been completed to reflect people's decision-making abilities. For example, staff told us one person was reliant upon staff to make several day to day decisions on their behalf. Despite this there had been no formal assessments of their capacity.
• Applications for DoLS had been made where appropriate. However, where DoLS had been authorised there was no information about the nature of the authorisation or any conditions imposed to ensure people's rights were upheld. This meant there was a risk people's rights may not be protected.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
• People were at risk of receiving support that did not respect their preferences. Staff told us they were not provided with enough information about people to enable them to provide person centred care. For example, staff told us they had not been provided with any information about a person when they moved into the home. A member of staff had tried to speak with them about their history which had led to them becoming upset due to recent traumatic events. This lack of information about people placed them at risk unnecessary distress.
• In contrast with the above, people told us staff knew them well. However, care plans lacked information about what was important to people. This placed people at risk of inconsistent support.
• Throughout our inspection we saw staff treated people with kindness and compassion. We received feedback from people which supported this. People described staff as, "Very pleasant."

Supporting people to express their views and be involved in making decisions about their care
• People told us they were involved in day to day decisions about their care. However, there was no evidence that people and their families were involved in care planning. One person commented, "Staff used to sit down and talk … but not as much now." Staff told us they did not have time to chat with people.
• Further work was needed to ensure care plans contained clear information about how to communicate with people and how to involve them in decision making.
• There was a risk people may not have access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. There was no information available about local advocacy services and no one was using an advocate at the time of our inspection.

Respecting and promoting people's privacy, dignity and independence
• People told us they were treated with respect and said staff upheld their rights to be treated with dignity.
• People's privacy was respected. For example, staff were discreet when asking people if they required personal support.
• People were supported to maintain and develop relationships with those close to them. People's relatives and friends were welcome to visit anytime.
• There was very little evidence to show that people's independence was promoted. Care plans did not clearly reflect what support people needed in this area. This posed a risk that people may get inconsistent support.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

• Care and support provided at Woodthorpe View Care Home did not always reflect people's preferences. There was a significant lack of meaningful activity. Other than visits from friends and relatives, many people lacked occupation. The home did not employ an activities coordinator and staff lacked the time and leadership to provide people with opportunities. Consequently, we observed routines were dominated by meals and personal care, and, the remainder of the time, people spent time in their bedrooms or communal areas listening to music, watching TV or sleeping. The lack of meaningful occupation and activity did not meet people's needs.

• Several people spent long periods of time in their bedrooms alone. Although staff interacted with them to provide care, staff did not have the time to interact with these people socially or provide the opportunity for activity; this did not meet their social needs and may have had a negative impact on their wellbeing.

• People were at risk of receiving inconsistent support. Some people did not have personalised care plans in place, information was general and did not clearly describe their needs. Other care plans were confusing, contradictory and not up to date. For example, one person had specific dietary needs but this was not recorded in their care plan. Another person needed support with their mobility, this was not in their care plan. This meant staff did not have access to information to guide their practice. This placed people at risk of inconsistent and potentially unsafe support.

• There was no evidence that people's rights under the Accessible Information Standard had been considered. This is a set of standards to ensure people have equal access to information regardless of disability or impairment. Information was not available in different formats and we did not observe any adaptations made to accommodate people's individual communication needs.

• People's end of life needs and wishes were not planned for. One person was nearing the end of their life. There were no plans in place about their end of life wishes. This posed a risk that their end of life needs in relation to pain management, hydration, nutrition and care may not be met. End of life care plans for other people were basic and some were generic. Staff told us they had not received any training in this area. This posed a risk that people's needs may not be met.

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

Improving care quality in response to complaints or concerns

• People's complaints and concerns may not be identified or addressed. The system for identifying, handling and responding to complaints was not effective. No one was able to tell us if there had been any recent complaints and there were no recent complaints recorded in the complaints record. However, we found evidence of two separate complaints in care records. Despite this, there were no formal written records of

recent complaints and no evidence of action being taken to address concerns and complaints.
• The provider had no oversight of complaints and concerns and as there were no management staff employed at the home, no one took responsibility for dealing with complaints.
• The above issues posed a risk that people's complaints and concerns would not be addressed.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

• At our past four inspections we have found concerns in relation to leadership and governance of Woodthorpe View Care Home. This has been an ongoing a breach of the legal regulations. At this inspection we found continued concerns in this area.
• The provider did not have oversight of the running of the home. There was an absence of systems to ensure the safe and effective running of the home. The provider did not review any paperwork related to the home or delivery of care. No audits had been completed since November 2018. Because the provider had no quality assurance systems they had not identified serious concerns about the quality and safety of the home which are detailed in this report.
• Where audits had been completed, action was not taken to address issues. For example, medicines audits identified the same issues for six months prior to our inspection. However, no action had been taken to rectify issues.
• There was no leadership or management oversight of Woodthorpe View Care Home. There were no management staff employed at the home. The home was being run by a member of care staff. They did not have adequate time, expertise, competency or support to fulfil these management duties. Consequently, the local authority had been visiting the home daily from mid-February 2019 to ensure people's safety.
• The lack of management support meant there was no one to investigate concerns raised about staff. During our inspection, concerns were raised about the conduct of a member of staff. There were no senior staff employed to deal with this. This meant there was a risk poor staff performance may not be addressed.
• There were no clear lines of accountability within the home. For example, at the time of our inspection no one was responsible for care planning and consequently care plans did not reflect people needs. No one was responsible for auditing, so there were no governance systems and consequently issues we have reported on had not been identified.
• The provider did not have any way of keeping up to date with good practice, this had a negative impact on the quality of care provided. For example, the provider told us they did not see the point of keeping records as they could just tell people were okay by looking at them. This demonstrated a lack of understanding of the principles of good quality, safe care.
• There were not adequate policies or systems in place to ensure the quality and safety of the service. The provider and staff were unable to locate any policies. Although we found some policies these were out of

date. There were no policies in key areas such as; health and safety, medicines, falls or recruitment. We found concerns in all these areas.
• Opportunities to learn from incidents, address poor performance and improve practice had been missed. Analysis of falls and other incidents had not been conducted since November 2018. This meant themes and trends of incidents had not been identified to consider the prevention of risk.
• There was no evidence of learning from serious incidents. On 10 March the CQC prosecuted the provider for a failure to provide safe care and treatment. The case identified a range of failings in leadership, management, policy and process. Despite this, during our inspection we found almost identical concerns. This demonstrated a complete failure to make, or sustain improvements to the safety of the service.
• Records of care and support were not consistently accurate or up to date. Missing information in care plans and incomplete risk assessments put people at risk of receiving inconsistent and unsafe care.
• The administration of the home was disorganised. The provider was unable to find key documents such as the fire risk assessment, the legionella risk assessment and policies. This lack of oversight and disorganisation meant there was no evidence of compliance with the legal regulations in some areas.
• Action had not been taken in response to known issues. Nottinghamshire Fire and Rescue Service served a notice of deficiency of February 2018. During our inspection the provider told they had not seen the notice – despite it being displayed in the main office. Consequently, the provider had not planned any actions to reduce the most urgent risks. This failure to take action meant people and staff were not protected from the risk of fire.
• There were not always adequate resources to ensure people's needs were met. Staff told us there had been occasions where there had not been enough money to pay for food, so they had paid for the food themselves. This meant there was a risk people's basic needs may not be met.
• There were no opportunities for people, relatives or staff to feedback on the running of the home. There were no records of meetings for staff or people living at the home since 2017. This meant opportunities for improving the service may have been missed.
• Following our inspection, we wrote to the provider outlining our most serious concerns and requesting that action was taken to address this. The provider did not respond to this and told us they did not have the resources, and did not know how, to make the required improvements. This demonstrated the provider did not have the skills, competency or resources to run Woodthorpe View Care Home.

All of the above information was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service did not have a manager registered with the Care Quality Commission. We took enforcement action to cancel the registration of the previous registered manager, they were deregistered in September 2018. The provider did not have any plans to recruit a new manager.
• The provider did not understand their legal duties. They were not aware of conditions on their registration, such as a restriction on admissions. Consequently, people had been admitted to the home with our consent and during our inspection we found concerns about their safety and welfare.

This was a breach of section 33 of the Health and Social Care Act 2008.

• It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home, they did not have website. We checked our records which showed the provider had notified us of events in the home as required. This helps us monitor the service.

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	Section 33 HSCA Failure to comply with a condition The provider had not complied with conditions imposed upon their registration.

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with person centred care that met their needs. Regulation 9(1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at serious risk of harm as action was not taken to makes risks associated with care and support or the environment. Opportunities to learn from accidents and incidents had been missed. Regulation 12(1) (2)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate leadership and management had led to a systemic failure to ensure the safety and

	quality of the home and services provided. Regulation 17 (1) (2)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not followed. Regulation 19(1)

The enforcement action we took:

We took action to cancel the registration of the provider.