HC-One Limited

Maple Court Nursing Home

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 9 and 10 February 2016 and was unannounced. At our last inspection in January 2015 we judged that the service was good as the service had improved from the previous inspection in June 2014.

Maple Court Nursing Home provides support and nursing care for up to 80 people, some of whom may be living with dementia. At the time of this inspection 73 people used the service. The service is divided into three separate units. Elizabeth suite (ground floor) provides general nursing care and support for up to 35 people. Saunders and Sycamore suites (first floor) provide support for up to 45 people with more complex care and support needs.

The service had a registered manager. 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.

People were not always protected from the risk of abuse as people had been abused by other people who used the service. These incidents had not been identified as potential abuse; they were not reported or investigated.

Risks to people's health and wellbeing were identified and reviewed, but lacked detail of the action needed to mitigate the risks. People's management plans were not consistently followed.

There was insufficient suitable staff available to meet people's individual needs. People experienced delays when staff were needed to provide them with the care and support they required.

The provider had a recruitment process in place. Staff were only employed after all essential pre-employment safety checks had been satisfactorily completed. However there have been continuous concerns regarding the recruitment and retention of staff and the impact this had on providing safe and effective care to people who used the service.

People's medicines were not always managed safely, and some people did not receive their medicines in a timely way. Not all medicine monitoring documents were completed accurately and at the time of the administration.

Staff did not always receive the training they needed to be able to support people in a safe way. This meant some people's specialist needs were not met safely or effectively.

People generally told us they enjoyed the food and were provided with suitable amounts of food and drink of their choice. Not all records for the purpose of monitoring people's dietary needs had been fully

completed to ensure people's nutritional needs were fully met.

People had access to a range of health care professionals but the guidance from the professionals was not always consistently followed.

Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were being followed.

Leisure and social activities were provided, but not all people got the support they needed to engage in meaningful activity when they needed to. People did not receive the right care at the right time.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Staff did not always recognise abusive situations or take the necessary action to safeguard people from abuse. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. There were not enough staff to support people in a safe and timely way. People's medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff had not been provided with appropriate training to fully meet people's needs and promote people's safety, health and wellbeing. People's nutritional and healthcare needs were not always monitored as planned. The principles of the MCA and DoLS were followed to ensure that people's rights were respected.

Is the service caring?

Requires Improvement

The service was not consistently caring as we saw some staff working practices were not as caring as they should have been. Staff were aware of people's preferences but people did not always receive the support they required in the way they preferred.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plans were not always reflective of people's current care and support needs. Some people were being supported to participate in leisure and social based activities, but improvements were needed to ensure these met everyone's needs. People knew how to complain if they needed to.

Is the service well-led?

Inadequate

The service was not consistently well led. Systems were in place to assess and monitor the quality of care provided but these were not as effective as they should be.

Maple Court Nursing Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 9 and 10 February 2016 and was unannounced.

The inspection team consisted of two inspectors 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.

Prior to the inspection we looked at the information we held about the service. This included notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with 11 people about their experiences of living at the service. We observed the care and support people received. We spoke with six people who were visiting their relatives, the registered manager, the operations director, seven care staff, two nurses and two visiting health care professionals. We looked at seven people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Inadequate

Is the service safe?

Our findings

People were not always safeguarded from the risk of abuse. Although staff told us they would report any alleged abuse to a senior member of staff we saw that the necessary action to protect people from abuse was not always taken. Care staff had witnessed and intervened when a person had assaulted other people. They recorded the incidents in the daily reports and verbally reported it to the nurses in charge of the unit. The registered manager told us they met each morning with the nurses on each of the units to discuss any changes or concerns that had been reported to them the previous day and overnight. We saw seven such incidents had been recorded in the person's notes but six had not been reported to the registered manager or referred to the safeguarding department at the local authority. This meant that people were at risk of further abuse, because actions had not been taken to safeguard people from further harm.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that some people experienced periods of unease which resulted in exhibiting behaviours that challenged. They told us the action they took to support people during these times. Staff told us that some people exhibited inappropriate behaviour and were a risk to other people. We saw some people who presented this risk at times wandered around one of the units unsupervised. No attempt was made by the staff to offer the person something meaningful to do and the person was left to wander aimlessly around. Risk assessments had been completed but lacked the detail of the support people required to reduce the risk to them and to other people who used the service. Systems were not in place to ensure risks to people's safety and welfare were consistently monitored and managed.

We saw that some people were at risk of developing sore skin and pressure areas. Staff told us and we saw that some people were unable to move independently and required staff to support them with day to day life. One person had developed a sore area that required regular intervention by the nursing staff for the treatment and dressings to this area. This person was in bed during the first day of the inspection. The care plan for 'preventing pressure ulcers' instructed staff to ensure 'negative pressure' was applied to the area. We observed this person's care during the day and saw this person had not been supported with negative pressure to the specific area. Staff were not following the clinical guidance and the person was at risk of further skin damage and discomfort. We spoke with the nurse on duty who was unaware that this instruction had not been adhered to. Care staff were not being supervised by senior staff or nurses to ensure they provided safe care. This meant people could not be assured that their risk of further skin damage was being managed effectively.

We saw another person had been prescribed a specific dressing for the treatment of a pressure ulcer. Records showed that this prescribed dressing had not been routinely used and a different one had been applied to the affected area. This person was at risk of receiving treatment that was not prescribed for them and may not be the most effective for the treatment of the wound. The nurse we spoke with was unaware why this had occurred and was unable to tell us why the staff were not consistently following the management plans.

We looked at the way the service managed people's medication. It was the first time at the service for one of the agency nurses and they were allocated the morning medication round in one area within the unit. They told us this had taken them over three hours to complete. Some people therefore experienced delays in receiving their medication at the correct time. This meant that some people's medicines may not be as effective as they should be because they were late being given.
Some people had been prescribed external creams and ointments to help manage their risk of skin damage. We saw body maps had been completed to indicate the area where the external creams were to be applied. Care staff applying the creams signed a separate medication administration document to record they had applied the creams as prescribed. We could not be assured that people received their creams as prescribed because there were multiple gaps in people's cream recording charts.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not consistently protected from risks to their health and wellbeing.

People who used the service and visitors consistently told us that more staff were needed and that the service was short of staff. One person who used the service told us: "There is a shortage of staff most of the time, and quite a high turnover of staff, we start getting to know the staff and they us and then they leave and we have to start all over again". A visitor told us about the high turnover of staff and the negative impact this had on their relative. We saw many people who used the service were fully dependent on staff to support them with daily living activities, for example support with personal hygiene needs and mobility. One person told us they had to wait a bit longer than they would prefer and that at lunch time they felt the staff were 'quite pressed in trying to help several residents visit the toilet at the same time'.

We saw that lunchtime in one unit was clearly very challenging; staff were busy supporting people in the dining area and in other areas of the unit. At one time there were 10 people in the dining room all of whom needed some level of support. Some people sat at the dining table for over an hour and waited for staff to be available to help them with their meal. One person described this mealtime as 'chaotic'. We spoke briefly with staff; they told us this wasn't an untypical day. One staff member said: "It's a difficult job, morning, noon and evening, but we try our best".

We saw that each of the units was staffed separately and staff told us how they were allocated their work each day. One member of staff said that generally there were enough staff for them to deliver care and support to people, the exception being when staff called in sick at short notice. We saw a high usage of agency staff, and in particular nursing staff. At the time of the inspection three of the four nurses on duty were agency staff. Some people experienced delays in receiving their treatments because some of the agency staff did not know the support and care needs of people or the systems in place. There have been recurrent concerns at the service with the recruitment and retention of staff, particularly nursing staff, and the negative impact this had on providing safe care and treatment.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough suitable staff available to meet people's individual needs.

Medication was locked away when it was not required and checks were made on a regular basis to ensure an accurate account of medicines was kept. People had their prescribed medication given to them by the nursing staff. Some people had occasional medicines for example pain relief. We saw that separate administration instructions were available to ensure people received them in the correct way.

Staff told us and we saw that the provider had safe recruitment procedures in place. We saw two staff files which contained the required information needed to ensure the fitness of people to work at the service. The

recruitment procedure included carrying out relevant checks such as Disclosure and Barring Service (DBS). The Disclosure and Barring Service is a national agency that keeps records of criminal convictions. This meant that the provider checked staff's suitability to deliver personal care before they started work.

Requires Improvement

Is the service effective?

Our findings

Staff told us and we saw that some people who used the service exhibited periods where their behaviours challenged them and other people. Staff told us how they supported people through these periods but told us they had not received any specific training in this area. They went on to say how they protected themselves and other people from harm when people became challenging. Staff told us there were occasions when they and people who used the service were physically assaulted, scratched and punched, they were unaware of any techniques to protect themselves (breakaway techniques). They confirmed there was no debrief within the team or with senior staff following such incidents to discuss how to minimise the risk of incidents occurring again. The operations manager stated that the module of E learning for managing challenges had not been released for this service.

The above evidence shows that people were not always supported by staff who had received effective training to carry out their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who used the service and their visitors said the food was good, they had sufficient to eat and drink each day. One person said: "The food's really good", but another person told us they were 'not a great fan of the food'. One person said that on the rare occasion that they didn't like either of the main lunch choices they were 'always offered something else that was fairly substantial'. We saw there was a choice of meals. People were asked which main course they would prefer, staff did not offer people a visual choice, and we saw some people were unable to understand the choices available to them. These people were provided with a meal which the staff thought the person may like.

Some people were on soft and pureed diets and this was provided for them. We saw that staff were patient when they supported people with their meal although some people had to wait considerable periods of time before staff were available to provide this support. People became restless and agitated as they waited to be served and supported. One person became challenging and threw two glass tumblers on the floor one of which smashed. A member of staff offered assistance, without much effect, and the person left the dining room without eating the meal.

People considered to be nutritionally at risk were provided with fortified diets and food supplements to support them with adequate daily nutrition. Some people had fluid and diet charts to monitor their daily intake. We saw not all of the charts had been sufficiently completed so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs.

Staff supported people to access health care services should they become unwell or require specialist interventions. Two people who used the service confirmed that if they were unwell their doctor would be contacted and a visit requested. One visitor told us their relative had a visit from the doctor on Christmas Day when they were poorly. Referrals for advice and support were made when staff had concerns about people's health conditions. We saw people had been referred to external health professionals when it was needed, for example, speech and language therapists, tissue viability specialists and dieticians. However,

advice from the professionals was not always consistently followed. For example the negative pressure instruction for a person who developed a pressure ulcer had not been followed. This meant the person was at risk of further skin damage and discomfort.

Staff told us they felt supported by and liked the registered manager. The registered manager and clinical lead staff had plans in place to ensure all staff received formal supervision and an appraisal of their work performance. Some staff said they had a recent supervision with their line manager but not all. During this inspection we saw staff received competency checks in some areas of their work, for example we saw moving and handling checks being conducted.

Staff told us and we saw that some people would be unable to make specific important decisions that affected their lives. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff told us they were administering one person's medicines in a 'covert' manner. This meant their medicines were hidden in their food and the person's right to refuse their medicines had been removed. Staff confirmed and the person's care records showed that a best interest decision had been made for them to receive their medicines in this way. The person's doctor had agreed this course of action because the person needed this medicine for health reasons.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some people had legally been deprived of their liberty and had authorisations in place. The registered manager had systems in place to ensure the authorisations were still appropriate and people were not being unlawfully restricted of their liberty.

Requires Improvement

Is the service caring?

Our findings

There were occasions when people were not treated with dignity and respect. For example one staff member put aprons on everyone at lunchtime without asking if they would like one and referred to them as 'bibs'. Some people sat in wheelchairs throughout the mealtime and were not offered the opportunity to transfer to a normal chair. No action was taken to ensure the person was offered more comfortable seating. We saw one person had not been provided with utensils to eat their meal and so used their fingers. This person's dignity was compromised as they tried to eat the mashed potato and gravy with their fingers. No offer was made to provide the person with suitable cutlery or a napkin. One person complained about the state of the cutlery they had been provided with. The cutlery was tarnished and fully unsuitable for use. They were not provided with an apology when replacement cutlery was offered. The operations manager had identified that the dining experience for some people was poor and had plans to take action to affect the improvements that were needed. However no action had been taken to implement the plans and to improve the mealtime experience for people.

People who used the service told us the staff were kind and caring. One person who used the service said: "The staff look after me lovely". Another commented: "The nurses and carers are lovely, they look after you well". A visitor said that staff were very caring and when visiting they would 'often see staff hugging confused and upset residents'. They said: "This is genuine and wasn't just for show. The carers really do care". We saw some staff were very kind and caring in their approach with people. Staff provided people with assurances when they became anxious regarding their personal circumstances. We observed some people during the lunch time were upset and anxious, staff provided support to people by speaking quietly with them and touched their hands and arms, people became visibly less anxious by this close contact. However we saw some people did not receive such a caring service. For example, people had to wait for periods of time to receive the help and support they required, people's comfort, respect and wellbeing was at times compromised.

Staff were aware of people's individual preferences. However people were not always provided with the support at the time of their preference, for example, one person had to wait for over three hours to be supported with their personal hygiene. One person had been provided with a specific fruit juice they particularly liked. People who did not eat meat were provided with a fish alternative and one person who preferred a certain style of dress received the support they needed. One person liked to have a cigarette, we saw they enjoyed this short period of time out of the unit doing what they liked to do, and enjoyed being in the company of the staff member.

Visitors told us they were free to visit at any time. One relative said that a family member would visit their mother every day at different times depending on their work patterns. They went on to say a small lounge had been made available for a family party to celebrate her mother's recent birthday. Another visitor said that the service allowed her to bring her dog in with her when she visited and that her relative enjoyed these visits.

Requires Improvement

Is the service responsive?

Our findings

Many people who were accommodated in Saunders and Sycamore suites had complex care and support needs. We saw that there was very little stimulation, recreational facilities or sensory equipment provided for people in this area. People were not supported to engage in activities that met their preferences when their behaviours indicated the need for engagement in meaningful activities. For example one person who was observed to be restless and walking around the home was not supported to engage in any activities. Other people who were not independently mobile sat for long periods of time in the lounge, they were disengaged and listless. There was very little for them to do and interactions were limited except when staff were providing care and support. Some people remained in their bedrooms; sometimes they had the radio or television on. We heard one person in their bedroom and in bed shouting. This person was unable to make their needs known to us so we asked the staff to help the person. They told us the person was on bed rest and 'always shouted like that'.

Staff told us that some people sometimes entered other people's bedrooms and removed personal belongings. Some photographs had been positioned on bedroom doors to prompt people with finding their bedrooms, however, many of the photograph frames were empty and there was no indication whose room belonged to whom. It would be difficult for some people who were living with dementia and who may have problems with orientation to find their own bedrooms without the prompts and reminders to guide them to the different areas around the units and especially to their own bedrooms.

Staff told us at midday that two people still needed support with their personal care. We looked at the preferences recorded in the care plan for one person it recorded the person liked to get up between 9am and 10am. This meant this person's personal preferences had not been met due to staff being unavailable to provide the support at the required times.

Some people's care plans were not always up to date and reflective of people's current needs. One person's care plan stated they could mobilise with a frame, whilst the risk assessment recorded the person was immobile and required the mechanical hoist for all transfers. This meant staff did not have the information they needed to meet people's individual care preferences and support needs.

The above evidence illustrates that people did not always get care that met their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff had been employed to arrange and facilitate leisure and recreational activities. They told us they tried to see people in all of the units but at times this was difficult because of the numbers of people who used the service. Group activities were planned and arranged and people were encouraged to attend these activities. The activities person told us that much of their time was spent providing activities on a one to one basis: "Many of the residents are living with dementia and so I do a lot of one to one activity with them. We very often have the same conversation but people seem to enjoy this". They told us that another person has been recruited to work with them; they would then be able to provide more activities to more

people.

Other people told us they liked to knit and crochet. One person said that if she needed wool or patterns then the staff would go out and buy it for her. Another person liked to read and said: "I can borrow books from the library here at the home, it's good". Other people told us they enjoyed watching television and either watched in the lounges or in their rooms.

No one we spoke with voiced any concerns with the service, staff or management but one person who used the service said that if they had any cause to complain then they would not hesitate to raise it. We were aware of some complaints that had been raised by relatives of people who used the service with the provider. The registered manager told us the actions they had taken to address these concerns. This included full investigations into the concerns, face to face meetings with the complainants and actions put in place to reduce the risk of a recurrence of the concerns. The provider's complaint procedure was displayed on notice boards in the units so that people were aware of where they could raise their concerns.

Inadequate

Is the service well-led?

Our findings

People's care plans did not always offer an accurate reflection of people's current needs. Staff told us that some care and support plans had recently been reviewed by the nurses to ensure the correct information regarding people's support needs were documented. However in each of the seven care plans we looked at we saw inconsistent information that would not support people with receiving reliable and consistent care. For example people at risk of developing sore skin and tissue breakdown were not consistently receiving the care and treatment they had been assessed as needing. Risk assessments recorded inconsistent information regarding the mobility status of people and the use of equipment. The nurses and senior staff were not monitoring the support care staff were providing to ensure people received effective care and treatment.

Staff told us and we saw that some people required regular monitoring with some aspects of daily life. We saw not all of the charts had been sufficiently completed to provide an accurate account of a person's daily fluid intake when they had been assessed as being nutritionally at risk. The registered manager and provider had not effectively addressed the concerns relating to the risk of malnutrition and dehydration. People's risk of malnutrition and dehydration was not effectively managed in a consistent manner.

We saw some gaps in some of the documents care staff should complete when they administered people's prescribed creams and ointments. People at risk of developing pressure ulcers and sore skin were not consistently being offered the support needed to reduce the risk for them. The nurse we spoke with was unable to tell us why the staff were not consistently following people's management plans. People were at an increased risk of harm because their care and support needs were not being effectively monitored by the registered manager, the clinical lead or the provider.

Systems were in place to monitor the quality and safety of the service provided but they were not effective to mitigate any risks relating to the health, safety and well-being of people who used the service. Incidents, accidents, pressure sores, weight loss and other health information were inputted onto a data system and reviewed by several managers. We had concerns with the inconsistent information in care plans, the unreliable monitoring of people's nutritional and health care needs and the recording and managing incidents, as staff did not report all incidents of challenging behaviour. The audits did not give a true reflection of the service. People continue to be at risk of harm and abuse because the necessary action to keep people safe had not been taken.

The service did not have sufficient permanent nursing and senior staff to effectively monitor the care and support that was provided to people. The lack of clinical leadership meant staff were not effectively managed to ensure people's health, safety and wellbeing were consistently met. Communal areas were frequently left unsupervised when people present displayed signs of agitation and restlessness. People were at risk of harm from altercations and sustaining injuries. The registered manager informed us of the recent recruitment drive which resulted in the possible appointment of trained staff, however in the meantime people remain at risk because of the lack of monitoring and leadership in the units.

Staff were not trained to effectively and safely support people who experienced challenges with their behaviour. This resulted in people and staff being assaulted and sustaining injuries. The provider had not arranged for training in this area even though some of the people exhibited behaviours that challenged. Staff did not receive any support or debrief to discuss and learn from the incidents with the staff team, senior staff or managers.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection in January 2016 there have been changes to the management of the service. The new registered manager is working closely with the provider's operations directors to affect the changes and improvements needed. They have completed an assessment of the service which identified improvements were needed and have started to plan and make changes to improve. The registered manager explained that recruitment for nurses and care staff was on-going and that the latest recruitment drive had been successful with people being offered positions within the service. However in the meantime, there is not enough staff to fully meet the needs of the people who used the service.

Training for staff is planned in areas such as managing behaviours and dementia awareness. However, it is not in place and people continue to be at risk of harm as staff do not know how to support people safely. It is also planned for some staff to receive training to be a 'nursing assistant'.

Staff told us they liked the new registered manager and say she was approachable, one staff member told us: "Things have improved since she's been here". Visitors at the service said that the management team of the home were very responsive when issues were raised. Another relative said: "They're proper on the ball".

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 always get care and support that met their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have systems and processes established and operating effectively to act, report or refer immediately upon becoming aware of, any allegation or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of all people who used 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not consistently provided in a safe way for service users.

The enforcement action we took:

We served a warning notice to ensure the provider took action

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality of the service were not effective to assess, monitor and improve the quality and safety of the services provided. The provider did not always have accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.