SRJ Care Home Limited

The Old Vicarage

Inspection report

13-17 Breedon Street
Long Eaton
Nottingham
Nottinghamshire
NG10 4ES

Tel: 01159727454
Website: www.theoldvicaragecarehome.com

Date of inspection visit:
30 March 2022

Date of publication:
20 May 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Old Vicarage is a nursing home providing personal and nursing care to up to 30 people. The service provides support to older people, people with physical disabilities and people with mental health needs including those with dementia. At the time of our inspection there were 25 people using the service. The home is split over three separate floors and has two communal lounges and a dining space.

People's experience of using this service and what we found
There were shortfalls in the way the service was led by the provider. The delivery of high-quality care was not assured by the leadership, governance or policies in the service Audit systems failed to highlight the concerns we found during the inspection.

Risks to people were not always identified, assessed or managed effectively. We found documentation to guide staff on how to support people was either not in place or inconsistent, which placed people at risk of receiving unsafe care. Accurate and contemporaneous records were not completed of people's daily care.

Medicines were not managed safely. People did not always receive their prescribed medicines and records in relation to medicines were not always completed in line with best practice guidance. Effective action had not been taken to address issues with medicines management.

People were not always referred to healthcare professionals when required. We saw people had lost weight within the service but no records of consultations with the dietician or GP. Healthcare advice was not always followed, meaning people were at risk of further health deterioration.

The provider had not ensured all staff were up to date with the training they needed to carry out their role effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always answer call bells quickly, meaning people had to wait for their care and support needs to be met.

People, relatives and staff had opportunities to feedback and felt involved in the running of the service.

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

Rating at last inspection
The last rating for this service was good (published 22 June 2019).

Why we inspected
We received concerns in relation to moving and handling practice, staff training, inaccurate care records, infection prevention and control, staffing and the management of people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safety, governance, staff training and consent at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Old Vicarage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, a specialist nurse advisor 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.

Service and service type
The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old Vicarage is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection the manager was not yet registered with CQC, but was in the process of applying for their registration with us.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 11 relatives of people who used the service. We spoke with 11 members of staff including the manager, area manager, administration assistant, nurses, health care assistants, domestic staff and kitchen staff. We reviewed a range of records including eight people's care records, 22 medication administration records and some records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and looked at further documents and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not robustly assessed. We found risk assessments that were not dated, scored, signed or reviewed which meant it was not clear whether they reflected people's current needs, or how they were used to direct people's care and support.
- Risk assessments did not provide consistent guidance for staff. For example, one person had a falls risk assessment in place. The assessment stated they were not prescribed medicine that would increase risk of falls, however a review of other documentation within their care file contradicted this information. This placed this person at risk of falls.
- Care plans and risk assessments were not always in place where required. Two people at the service were noted to display behaviours that may challenge themselves or others within their care notes. We saw one person had been involved in an incident which caused harm to another person. No specific behaviour care plan was in place to guide staff on how to manage these behaviours, this continued to place people at risk of harm.
- We found inconsistent information within care files for people who required their fluids thickened. For example, we found conflicting information within one person's care file on how many scoops of thickener to use in their drinks. We also found another person's speech and language therapist recommendations within their file; this placed the person at risk of receiving unsafe fluids.
- Staff were observed to use other people's prescribed thickener in people's drinks. We spoke with staff about thickening fluids, they told us they knew how thick to make people's drinks as it's recorded on a whiteboard in the staff room. During inspection we saw this information was not written on the whiteboard.

Using medicines safely; Learning lessons when things go wrong

- Medicines were not managed safely. Some people at the service had missed doses of their prescribed medicines. For example, we found one person had missed their dose of prescribed statin on two occasions.
- Some people using the service required pain relief via a transdermal pain patch. We reviewed a person's medicine administration record (MAR) which was signed to say the patch had been administered, however the corresponding controlled drugs register had not been signed, and a stock check of the medicine confirmed they'd missed a dose.
- Medicines were not always documented in accordance with current guidance and legislation. Not everyone had a 'PRN protocol' in place. A PRN protocol ensures the medicine is given as intended and provides guidance for staff to refer to when offering and administering the PRN medicine.
- MAR's were not always accurately completed when people received 'as required' medicines to manage behaviour. For example, we saw someone who had been administered medicine prescribed for anxiety on nine occasions, but there was no record of why this was given, or whether it had been effective.

● Diabetes was not safely managed. Some people with diabetes required their blood glucose levels monitoring. Readings were not always recorded or missed key details such as the time of the reading, which meant staff would not have been able to identify whether people's blood glucose levels were normal, or required medical attention.
● Lessons had not been learned when things went wrong. Action to address medicine errors was to display a poster in the clinic room as a reminder of good practice for staff. We found this had not been effective.

Risks relating to the health safety and welfare of people were not robustly assessed and medicines were not managed safely, placing people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded following the inspection and told us they had implemented daily medication audits to monitor medicines at the service.

● Maintenance and safety checks were completed regularly within the service.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes did not always ensure people were kept safe from abuse. The provider's safeguarding policy did not provide guidance for staff on local safeguarding procedures. Please see the well-led section of this report for more information.
● Not all staff had received up to date safeguarding training. However, staff we spoke with were able to demonstrate understanding of how to recognise and report types of abuse.
● The provider made safeguarding referrals when required. We saw the manager worked with the local authority and completed investigations when abuse had been reported.
● People felt safe and relatives felt family members were safe from abuse. One relative told us, "[Relative] has been there years. I don't worry about her there. I trust them with [relative]."

Staffing and recruitment
● Staff were not always visible around the home. We observed communal areas to be unsupervised during parts of the day. This was because staff were busy supporting other people in their bedrooms. One person asked inspectors if they could go to the toilet and had to wait whilst two staff were located to support them. Another person then requested the toilet and then had to wait until staff were available.
● Call bells were not always answered quickly. We heard a call bell which was not answered for ten minutes, this was triggered by a person walking the corridors, however no staff attended to the bell or check if this person had fallen as they were busy supporting other people. One person told us "Staff do answer call bells mostly, but I have to wait, sometimes it takes ages."
● The provider's dependency tool used to calculate staffing levels did not take into consideration all relevant factors when determining how many staff were required, such as supervision of communal areas, or the layout of the home. This meant it was not always clear how the provider had deemed the number of staff on shift was safe to meet the needs of people using the service.
● The provider followed safe recruitment practices. This included Disclosure and Barring Service (DBS) checks, which provide information including details about convictions and cautions held on the Police National Computer.

Preventing and controlling infection
● The provider's infection, prevention and control policy was not dated and did not reference COVID-19. Therefore, it was not clear how the provider was making sure COVID-19 outbreaks could be effectively prevented or managed.

● Some areas within the service were in need of cleaning. We found some equipment people used, such as pressure cushions and rotunda's that were unclean. This placed people at risk of infection. We found gaps within cleaning schedules which meant we could not be assured all areas of the service had been cleaned.
● Not all staff had completed infection, prevention and control (IPC) training.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● The provider was facilitating visits for people living in the home in accordance with the current government COVID-19 guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Not all staff had completed their mandatory training. A new programme of training had been introduced; however, this had not been effectively implemented as there were gaps in the provider's training record. For example, most staff had not completed safety related training such as infection prevention and control or safeguarding training, this placed people at risk of receiving unsafe care.
- Not all staff had received moving and handling training. The manager told us moving and handling training had not been sourced for new starters. Many people who used the service required support with moving and handling, such as hoisting. This placed people at risk of unsafe moving and handling.
- Staff told us they struggled to complete the required training as they were expected to do this in their own time. Some staff said they found online training more difficult.
- Some relatives felt the staff were not always trained to understand people's specific needs. One relative told us about their loved one's diagnosis and how it can impact on them, they said they felt staff did not always demonstrate an understanding of this.

The provider had failed to ensure staff received appropriate support and training to enable them to carry out the duties they are employed to perform. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded following our inspection and told us they would continue to concentrate on staff training.

- Staff received an induction which considered their previous training and experience. Senior staff told us they mentor new staff when they start with the service.
- Staff received regular supervisions from the manager or ongoing support to review their practice.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider did not act in accordance with the MCA. Mental capacity assessments were not always in place when required. For example, some people using the service shared rooms and were not considered able to consent to this. We found no records of mental capacity assessments, or relevant best interest decisions to support the decision to place people in shared rooms which could impact on their privacy and dignity.

● Mental capacity assessments were not always decision specific. For example, we reviewed a mental capacity assessment for 'communication' for one person using the service. It was not clear what this assessment was specifically regarding, what the person was deemed unable to consent to and therefore how a decision had been made in the best interests of this person.

● Staff we spoke with were not able to demonstrate an appropriate understanding of the mental capacity act. We reviewed the training matrix which showed not all staff had not completed MCA training. This meant we could not be assured staff were lawfully obtaining consent before any care or treatment was provided.

The provider had failed to act in accordance with the requirements of the MCA. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made appropriate DoLS applications for people who required them. The provider was aware of who's DoLS had been authorised. DoLS were monitored using a matrix, allowing the provider to see when a DoLS had been authorised, when it would expire and any other relevant information, such as if the person had any conditions attached to their DoLS.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Directions from healthcare professionals were not always followed. One person using the service had been prescribed medicine to support with bowel movement. A healthcare professional had requested staff record the person's bowel movements, however during our inspection these records had not been completed. This meant it was not clear whether the medicine had been effective, or if the person was continuing to have restricted bowel movement.

● We reviewed the topical MAR for one person who was prescribed moisturiser, which staff were directed to apply daily to prevent dry skin. The document had not been completed and therefore there was no record of the moisturiser being applied. This placed this person at risk of harm, as they were considered high risk of skin integrity issues.

● Referrals to healthcare professionals were not always made when required. For example, some people at the service had lost weight and had not been referred to the dietician or GP. One person's care records said they should be referred to the falls team if they had two or more falls, however had not been referred to the falls team after records showed they'd had two falls. This meant any possible underlying health issues had not been explored.

● Some relatives felt their requests for people to see healthcare professionals were not addressed quickly. One relative told us "I have suggested [relative] has their eyes tested at the end of February, it has not

happened yet. It is not as tight as it should be."

The provider did not refer to healthcare professionals where required in a timely manner or follow healthcare professional advice. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were not always appropriately assessed. We found dates were not always recorded when assessments were completed. This meant it was not always clear if assessment's reflected people's current needs and choices.
● Some documentation was not age appropriate for the people using the service. For example, within people's care files was an overview sheet of cartoon images intended to provide a summary of the person and their likes and dislikes.
● Nationally recognised tools were not always used to inform care. For example, we reviewed a tool which established nutritional risk for one person, the tool guided the reader to review overleaf to see the required actions to support the person in relation to this risk, however, overleaf was blank. As this person was considered high risk, lack of guidance placed them at risk of malnutrition.
● The provider informed us they were in the process of reviewing and updating care plans for all people after identifying improvements were required. However, we reviewed care plans of people whose records had been updated and found they were still missing key details regarding people's needs and choices. The provider told us they plan to review all care plans again.
● Care records were not always completed. We found daily logs were not completed for some days, meaning there was no record of the care delivered. The manager had implemented new documentation to improve records of people's day to day care, but we found this new system had not been embedded at the time of our inspection.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider did not support people to maintain healthy weights at the service. Whilst staff weighed people regularly, action was not always taken to address significant weight loss. For example, we found some people at the service who had continually lost weight over a period of three months with no specialist intervention.
● People did not always have an enjoyable mealtime experience. During lunch time, people we spoke with did not know what was on the menu that day. We asked a staff member who was also not sure. The menu on display within the dining room was incorrect.
● People felt the choices of meals were sometimes limited. During our inspection, the two options available for people were beef stew or beef curry. One person told us there was not much choice for people who did not want the meat option.
● Kitchen staff were knowledgeable about people's dietary needs. They had records of people's dietary requirements which also listed who needed additional support to eat or required a softer or modified diet.
● Staff ensured people had plenty to drink. We observed staff to regularly ask people if they would like a drink and drinks were placed within reach for people with limited mobility.

Adapting service, design, decoration to meet people's needs
● The service was neutrally decorated and accessible for people. Some areas of the environment needed attention; however, we saw evidence these were being addressed. For example, the provider replaced the stair gates to improve safety during inspection.
● Specialist equipment was available on all floors for people who needed it, such as hoists, rotunda's and wheelchairs. The second floor of the service had narrow corridors, but we saw a small hoist was available to

ensure people could get up and access all parts of the home.

● Bathrooms and toilet facilities were accessible for people with physical disabilities, this meant people's dignity and independence could be promoted.

● People's rooms were personalised, and we saw the provider support people to make their spaces comfortable and homely for them. For example, one person was observed to be sat in the communal lounge with photos of their family around them.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's governance systems were not effective in identifying risk. There were no specific audits for infection prevention and control (IPC) or call bell audits at the service. This meant there was no system to monitor, analyse or improve these aspects of the service.
- Audits were completed for some aspects of the service, however we identified areas where audits had not picked up on issues. For example, a medicines audit did not identify some of the issues we identified on site. Please refer to the safe section of this report for full details.
- Action plans were not always implemented following an audit, or did not have clear designation, timeframes or evidence the required action had been completed. Therefore, it was not always clear how the provider was addressing any identified risks or area's for improvement.
- The provider did not have effective oversight of people's weights within the service. A Malnutrition Universal Screening Tool (MUST) score and weight tracking tool completed monthly by the manager did not calculate total weight loss, did not record service user's weights. It failed to identify all people who had lost significant weight and required a dietician referral.
- The provider did not effectively analyse accidents and incidents at the service. Accidents and incidents were analysed on an individual basis rather than as a whole service. This meant trends and themes were not always identified to ensure swift action to mitigate any risks to people using the service.

Continuous learning and improving care

- The provider had identified areas for improvement and implemented an action plan. However, we found actions had not been completed by the required dates or though noted as completed, some issues remained as we found them during inspection. This meant we could not be assured the action plan was effective in driving improvements.
- There was no oversight of clinical competence by the provider. For example, staff medicines competencies were not completed at the service. We reviewed an accident and incident document which highlighted an additional clinical training need for staff, however the manager confirmed this was not considered. This meant opportunities for learning and improving care were not identified.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The provider's policies did not promote good outcomes for people. None of the provider's policies we viewed were dated, meaning it was not clear when they were written, or if they had been reviewed to reflect

the up to date needs of the service.
● The provider's medicines policy did not follow best practice guidance. For example, it did not cover PRN medicines or covert medicines. This meant there was no record of the provider's expectations, or guidance for staff on administering these types of medicines.
● Policies were missing key details. The provider's safeguarding policy did not guide staff on the different types of abuse, it did not signpost to relevant authorities or contacts in the event a person was subjected to abuse.
● Some policies were not always followed. The provider's infection prevention and control policy stated risk assessments will help to prevent the spread of infection and cross-infection, however we found there to be no COVID-19 risk assessments completed for people living at the service.
● The provider had recognised the culture within the service needed improving, and whilst some improvements had been noted, further work was needed such as addressing incomplete daily logs. This resulted in some people's daily care and support not being recorded for some days.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection and reviewed and analysed accidents and incidents for the whole service over the last two months. A number of audits were completed following the inspection.

● Staff we spoke with reflected on the culture within the service and whilst they felt some improvements had been made, some work was still needed, particularly with completing documentation. One staff said "Morale is getting better." Another member of staff told us "Certain staff have got to be reminded, it's not a case of assisting somebody, when you've given them personal care, if it's not documented it's not happened."
● Relatives generally spoke positively about the care staff at the service. One relative told us, "The best thing is the care and interaction with residents", another said "The carers are very kind to [relative] and that is important to me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider created opportunities for people to provide feedback. Resident meetings were held, and people were supported to complete resident surveys which explored aspects of the home such as the staff and ideas for activities.
● Staff had regular meetings which they told us they found useful. We reviewed meeting minutes and saw staff had opportunities to feedback into the running of the service and make suggestions. Staff said they felt listened to. One staff member said, "The manager is really good, she asks how we are. If I've got any queries, I know I can go to [the manager] and it would be dealt with."
● Relatives recognised there had been some changes within the service but generally felt informed and involved.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager understood their responsibilities under duty of candour and requirement to submit statutory notifications to us when certain incidents occur, such as when a person dies, or if a person sustains a significant injury. We reviewed records against the notifications we had received and saw this was done.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the MCA. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received appropriate support and training to enable them to carry out the duties they are employed to perform. This placed people at risk of harm.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe management of medicines, the safe management of risks to service users and ensure timely referrals to healthcare professionals when required. The provider failed to ensure advice from healthcare professionals was followed. This placed people at risk of harm and health deterioration.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems and processes were in place to assess, monitor and mitigate risks and make improvements. The provider's policies failed to ensure service user's safety. This placed people at risk of harm.

The enforcement action we took:

Warning notice