Hornby Healthcare Limited

Shoreline Nursing Home

Inspection report

2a Park Avenue
Redcar
Cleveland
TS10 3JZ

Tel: 01642494582

Date of inspection visit:
12 November 2019
13 November 2019
19 November 2019
21 November 2019

Date of publication:
09 November 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Shoreline nursing home is a care home which provides nursing and residential care to older people and young adults with physical health conditions and dementia. The service can support up to 43 people. At the time of the inspection 40 people were using the service.

Shoreline is a large adapted building over two floors. There are two units for people with nursing and residential care needs and there is one unit for people living with dementia.

People's experience of using this service and what we found
People were not supported in a safe way. An incident had not been dealt with safely. Staff did not carry out observations of people for safety within agreed timeframes. These actions increased the risk of harm to people. Staff at all levels did not understand risk and were not responsive to risk. Records to keep people safe were not always accurate and needed to be improved.

The quality of the service had deteriorated since the last inspection. Action plans and quality assurance measures had not resulted in improvement. Staff failed to follow the policies in place and a system of reporting incidents had not been robustly followed. There was an overall lack of oversight of the service which increased the risk of potential harm to people.

Staff were not supported to carry out their roles safely. The failings at the service demonstrated that staff did not understand or apply their training. Decisions were made to people's care without support from health professionals and recommendations from them were not applied correctly. Improvements to the environment had been taking place; continued improvements were needed.

Staff did not have a sound understanding of the Mental Capacity Act 2005. 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.

Care records did not support the delivery of care. People said they were happy with the activities in place. Staff raised funds to provide activities. Positive feedback had been received in relation to end of life care.

There was a lack of recognition when people were non-compliant with their care. This meant care was not consistently dignified. Some people experienced gaps in their hygiene because staff with the necessary skills were not on duty to support them. People and relatives said care staff were kind and compassionate. People were involved in their care; however records did not always support this.

People were very positive about the care and support which they received from staff. They said they were happy with all aspects of their care. Relatives were generally positive. Where concerns were raised from relatives, they had started to be addressed during inspection.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (Published 10 October 2018). We met with the provider following the last inspection. They completed an action plan to show what they would do and by when to improve.

At this inspection we found the service had not improved. This meant the provider was still in breach of regulations. Please see the safe, effective, caring, responsive 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.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to providing safe care to people and ensuring care is dignified; ensuring staff with the right knowledge and experience are on duty and support for staff to carry out their roles. We also identified breaches in relation to record keeping and maintaining the quality and oversight of the service.

Please see the action we have told the provider to take at the end of this 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 have requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider and registered manager to review progress since the inspection. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information 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.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our safe findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our safe findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our safe findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our safe findings below.

Inadequate

Shoreline Nursing 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. 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 Care Act 2014.

Inspection team
One inspector carried out this inspection.

Service and service type
Shoreline Nursing home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the Redcar and Cleveland local authority and professionals who work with the service, such as South Tees CCG and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people, five relatives and one person's friend. We also spoke with an advocate for one person and a best interests assessor who was visiting the service on the day of inspection. We spoke with ten staff including the registered manager, deputy manager, two care co-ordinators, one nurse, two care staff, the chef, a laundry assistant and an activities coordinator. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and six people's medicines records. We looked at six staff recruitment and induction records and ten staff supervision and appraisal records. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found. We continued to speak to stakeholders involved in the service to discuss the concerns identified during the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people and records relating to fire evacuation. This was a breach of regulation 12 (Safe Care and Treatment) and regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. The provider was no longer in breach of regulation 17.

- A serious incident had occurred at the service. Staff dealt with the immediate risk of harm. There had been missed opportunities to manage this potential risk of harm before the incident occurred. The risk following the incident was not appropriately managed.
- Observations to support people at risk of harm were not completed in line with risk assessments. Risk assessments and reviews of risk were limited.
- Records to support the management of behaviours were not sufficiently detailed. Incidents involving behaviours were not routinely recorded.
- Missing locks for doors required to be locked for safety and window restrictors were put in place during inspection.

This failure to manage the risk of harm people has led to a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the risks relating to infection control had not been managed. Carpets and furniture were worn and could not be cleaned effectively to reduce the risks of cross infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still breach of regulation 12.

- Further improvements were needed to ensure the risks to infection control were safely managed. Some carpets had been replaced and some beds had been repaired.
- Staff did not practice good infection control measures. Staff wore jewellery and acrylic nails when providing care. A linen trolley with dirty laundry was left in the corridor on each day of inspection.
- Staff training in infection control was up to date. A champion was in place to share good practice.

Failure to follow procedures to manage cross infection increased the risk of harm to people. This is a

continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Staff failed to follow the correct procedures to deal with an incident. Review of accidents and incidents was limited.
● Lessons learned exercises had been carried out following an increase in pressure area concerns. This resulted in some improvements in this area.
These concerns demonstrate a lack of effective systems to ensure the safety of people using the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff did not follow the recruitment policy. Risk assessments were not in place when insufficient references had been obtained. Interview records to determine candidate's suitability had not always been completed.
● No checks of recruitment records had been carried under the providers quality assurance framework.
● People were involved in the recruitment process. This action was put in place following a meeting for people and relatives. People said they were happy about this new role.

Although the registered manager had started to address these shortfalls in recruitment during the inspection, quality assurance systems were not in place to support safe recruitment. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough suitability skilled, competent and experienced staff on duty. This had led to gaps in people's care, such as not carrying out checks of people when needed gaps in providing personal care where people were non-compliant.

This failure to have the right staff on duty to meet people's needs safely increased the risk of potential harm to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection the provider had failed to oversee the risks relating to medicines because records were not up to date. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17 for medicines.

● A new system was in place to support people with cream application. This had resulted in records being regularly completed. Records were in place to support medicines which were given as required.
● People received their medicines when they needed them. There were good supplies of medicines and people received them on time.

Systems and processes to safeguard people from the risk of abuse
● One safeguarding alert had not been raised. This related to a specific incident. Staff had not followed the correct procedure.
● One safeguarding alert had been substantiated in respect of record keeping. The registered manager had started to carry out improvements following this.

● People said staff made them feel safe. Relatives said they were reassured they loved ones were kept safe because staff looked after them well.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection the provider had failed to robustly assess and manage the risks relating to nutritional intake because records were not up to date. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 for records relating to nutrition.

- Food and fluid balance records still required improvement. Staff were not accurately recording fluid intake. There was no evidence to show what action had been taken when intake was low.
- Staff changed one person's diet without consultation with a health professional. The person had not come to harm. These were recording and training issues.

This failure to have up to date records in place has led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The chef understood people's dietary requirements. Food moulds were used for people who received a soft diet. These made foods more appealing to people.
- Mealtimes were relaxed. People were positive about the food provided. Comments included, "The food is much better than I expected. It's even better now the new chef has started."

Staff support: induction, training, skills and experience
- Records did not evidence a program of support during staff induction. This was not in-line with the providers policy. We observed experienced staff mentoring new members of staff. They were responsive when new staff needed support.
- Staff received supervision and appraisal. The registered manager had not received supervision or appraisal. However, they did receive guidance and feedback about their role.
- Staff received training. However, the findings of inspection identified that's staff were not always putting their training into practice.

Lack of effective records and oversight to support staff to care for people safely has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
● One person did not receive a diet in line with a dietician's recommendations. Staff were not aware and care records had not been updated.
● Care plans for oral health were in place. Care plans did not identify the action taken to meet people's needs when they were non-compliant with their oral care.
● People had access to a variety of health professionals. This included GP's, district nurses and opticians.

Failure to implement dietary recommendations and have accurate and care records has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff did not work in line with the MCA. Records did not evidence how people were supported. Care plans were not individual to people.
●. Best interest decisions had not always been carried out when needed. Staff had signed consent records for some people who lacked capacity.

Effective systems were not in place to support staff to work within the principles of MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Many aspects of the service needed to be updated. Some work had been completed. Red toilet seats and hand rails were in place to increase visibility.
● Frosting on a window had become worn. This meant aspects of the window were visible. This did not meet people's privacy needs when receiving personal care in the bathroom.

We recommend the design and decoration of the service is reviewed to ensure it meets people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-admission assessments were completed. Additional information was sought from local authority commissioning team to make sure they could meet people's needs.
● Not all aspects of people's care were effectively examined during care plan reviews. Care plans were not consistently updated when needs changed.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● Some people did not receive regular personal care when they were non-compliant with their care. This had led to significant gaps in people's hygiene because they were not supported to regularly bathe, change their clothing or carry out oral care.
● Staff who had the right skills and experience were not always on duty to support people who were non-compliant with their care. Staff had not recognised people's gender preferences of staff to deliver personal care was a contributing factor to some people's non-compliance with their personal care.
●There were not enough male staff employed to meet people's gender preferences of staff. The registered manager had taken action to address this during inspection. Recruitment was ongoing.
● Care staff supported people when they experienced distress. However, leaders were not always responsive in seeking assistance from health professionals to support people with their health and well-being.
● Further improvements were needed to protect people's personal information. Staff needed to be vigilant to ensure records were stored appropriately.

These concerns have led to a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● Staff treated people with kindness and compassion when providing care. Comments included, "The girls [staff] look after me and this makes me feel safe." We observed one person telling a staff member how much they had missed them. The staff member was kind-hearted and sincere in their response.
● Staff knew people's needs well and were able to anticipate when support was needed. Comments from relatives included, "They [staff] listen to what people want." And, "Staff are really nice and [person] is well looked after."
● Relationships between people and staff were warm and friendly. We observed laughter and banter between them. Staff made time to chat with people. Relatives said they could visit at any time. Staff had developed good relationships with them.

Supporting people to express their views and be involved in making decisions about their care
● Care records did not show how people were involved in making decisions. Reviews of care plans did not show if people had been asked for feedback. However, records showed that people were asked for feedback about the wider aspects of care during meetings about the service and through surveys.
● Some people had advocates involved in their care. Relatives said they were asked for feedback about

people's care.

● Regular meetings for people and their relatives took place. Actions were carried out as a result. This included people being involved in interviews of potential staff and planning events in-line with people's requests.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the risks relating to the care of people received were not mitigated because records relating to the provision care were not up to date. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Care plans needed further improvements to ensure they were individual to each person. For example, care plans needed to include specific details about people to support staff to recognise when people were unwell. This was important because some people had limited verbal communication skills.
- Care plans were not routinely updated when there were changes to people's health needs. This meant we could not be assured staff were accurately monitoring, supporting and reviewing people's care needs to make sure it was in line with their needs and preferences.
- Where guidance was in place to support people, care plans did not correctly outline this guidance. There were continued gaps in records relating to people's personal care.
- Reviews of care plans were limited. For example, reviews of falls care plans did not indicate if the people has experienced any falls.

Failure to have accurate and complete records to support the delivery of care increases the risk of potential harm to people. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were identified within the care records. Staff had good knowledge of people. They had developed a good rapport with people who had limited communication skills.
- Information was available in different formats for people if they wished. Staff also supported people to read letters when needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Activities and events were discussed during meetings with people. Feedback was sought and used to plan future activities.
● An activities coordinator arranged group activities for people such as bingo and arts and crafts. People who spent time in bed were provided with one-to-one activities. One person said they liked staff to read to them and assist with their knitting.
● Staff carried out their own fundraising to provide activities for people. This money was used to buy in external activities such as 'Mr Motivator' and pet therapy. Or spent on buying supplies to provide in-house activities,

Improving care quality in response to complaints or concerns
At our last inspection the provider had failed to robustly review and respond to complaints. This was a breach of regulation 16 (Receiving and acting upon complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

● Complaints had been dealt. Records were in place to show they had been appropriately investigated. Information about how to make a complaint was on display at the service.
● We spoke to relatives who had raised concerns. They said they had been satisfied with the response to their complaint.

End of life care and support
● Staff had received end of life care training. Care plans were in place to show people's preferences about their end of life care. Further improvements were needed to these care plans to ensure they were in-line with up to date guidance.
●Staff used specialist equipment and support to provide end of life care. They had recently started to use a device which changed foam into flavoured air to allow people to taste food and drinks. This foam quickly dissolved leaving no liquids/solids in the mouth.
●The registered manager had carried out a review of end of life care when people passed away. This identified areas of good practice as well as areas for improvement. Positive feedback had been received from relatives about the service prior to inspection about the standard of end of life care.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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. Continuous learning and improving care

At our last inspection the provider had failed to manage the risks to people because the systems in place to monitor the quality of the service were not effective. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- A lack of robust oversight had led to deterioration at the service. The service had been in breach of regulations since 2015.
- Staff failed to robustly follow the policies in place. This increased the risk of harm to people.
- There was a lack of oversight to manage a serious incident. The policy was not followed. Both the provider and local authority safeguarding team were not made aware of the incident.
- Quality assurance systems remain ineffective. Resources were in place, but not always used to drive improvements. Information from incidents was not always sufficiently analysed to ensure lessons were learned or to drive improvement.

This lack of oversight has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Some staff lacked the knowledge and competence to support the delivery of safe care. Systems in place were not robust enough to address these shortfalls.
- Failure to improve the quality of records had increased the risk of potential harm to people. People were not always supported in a way that achieved good outcomes.
- Action plans shared with the Commission following the last inspection had not resulted in improvements.
- Staff felt able to raise concerns. They were open and honest during inspection.

Failure to support people to receive safe care which leads to positive outcomes has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● A notification about a serious incident had not been submitted when required.

This failure to submit a notification led to a breach of regulation 18 Care Quality Commission (Registration) Regulations 2009.

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

● Staff meetings took place. Records did not show how staff who did not attend those meetings reviewed the minutes. Staff meetings did not support staff to drive improvement.

● People and staff attended meetings to share information. Feedback was obtained as part of these meetings. A recent survey had taken place which showed people were happy with their care and how the service was run.

● The service had links with the community. This included local parks, shops and schools.

Working in partnership with others

● The service was open and transparent during inspection. Information was provided to stakeholders when required.

● The service took on board feedback. Although this was used to make improvements, they were not done so at a service level.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1) People did not always receive dignified care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent (1) Staff did not work in-line with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) People did not receive safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Staff were not appropriately supported to carry out their roles. There were insufficient appropriately trained staff on duty to provide individualised care to people.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	(1) The systems in place to deliver a safe service was not effective.

The enforcement action we took:

We issued a warning notice.