Camelot Care (Somerset) Limited

Acacia Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Acacia Nursing Home on 23 and 24 October 2018. This inspection was undertaken in response to multiple, significant concerns we had received about the service from a variety of sources. The concerns primarily related to people receiving safe care and treatment, staffing levels and leadership and governance.

The inspection team inspected the service against two of the five questions we ask about services: is the service well led and safe. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At the last inspection in August 2018, the service was rated inadequate. We had found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. These were all repeated from the February 2018 inspection. We identified significant concerns with the safe care and support of people including ongoing medicine management and pressure care issues. Staffing levels and training were not adequate to keep people safe. There was a lack of governance by the management to monitor the quality of care people were receiving. Legal notifications had not been received by the Care Quality Commission as required.

Following the inspection in February 2018, we imposed some conditions on the provider's registration to drive improvement in the home. After the August 2018 inspection, we continued to restrict admissions to the service because there had been little improvement. The provider was still required to send us a monthly report of how they were improving those concerns we had found. There had been a delay in us receiving the latest report and this was provided during the inspection. The service remained in special measures due to a lack of improvement between February 2018 to August 2018.

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.

At this inspection, there had been small improvements with the provider notifying us of significant events and with medicine management. However, substantial concerns were still found which placed people at significant risk of harm or actual harm. Most staff, including senior staff, told us they felt people were not safe at the home. Staffing levels were potentially dangerous at times including a high use of agency staff and there were periods of time people were not supported to keep them safe. People with specific health conditions were not having their needs met including pressure care and those at risk of seizures. The management continued to fail to identify and improve the service people received. Some concerns which had been resolved between February 2018 and August 2018 had returned. Staff were no longer being recruited safely. People who were at risk of choking were not always being supported safely.

Acacia 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. The service can accommodate up to 39 people. There were 26 people living at the home during this inspection. The building is purpose built and has a courtyard garden in the middle. There are three floors with communal spaces such as lounges and dining rooms on each floor. At this inspection everyone had their own individual bedroom.

There was now a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently returned to work after a period of being absent. This meant there was a period between the August 2018 inspection and this inspection where one of the directors, who was a nurse, was acting as the manager.

The service was not well led. There was a lack of communication between management. People, relatives and staff did not always feel listened to. Shortfalls identified during this inspection had not been identified by the quality assurance processes. Documents which should be readily available during the inspection were not always. There was still disorganisation by the management and systems in place to audit the service people were receiving were not always acted upon. The provider failed to have a monthly audit ready until the second day of inspection.

People were at significant risk of harm because they did not receive care and treatment in line with their health needs. Risks were found for people in relation to pressure area care and some people had suffered harm since the last inspection. Some people were placed at potential risk of choking and aspiration. Although small improvements had occurred with the storage of medicines we found medicines were not always managed safely.

Staff had not received training to have the skills and knowledge required to effectively support people. New staff did not have adequate training to keep people safe if they had not previously worked in care before and come with experience. Although thickening agents were now being stored securely, some people who required special diets and drinks did not have their needs met. At times, people were placed at risk of choking and aspiration.

There were not enough staff to meet people's needs and keep them safe. Most permanent staff told us they were planning to leave or had a leaving date. There was a high use of agency staff. People were not always protected from potential abuse because systems had not ensured measures were put in place when allegations had been made. Staff understood how to recognise signs of abuse and knew who to report it to. The recruitment procedures were not ensuring people were protected from unsuitable staff supporting them.

People's care plans had some improvements to make them personal. However, they still contained inconsistencies and there was sometimes a lack of specific information to guide staff to people's needs and wishes. Guidance which was in place was not always known about by staff or followed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some of these breaches were repeated from the previous inspections in February 2018 and August 2018.

Following this inspection, we identified significant risks to people's safety and welfare. The local authority and other agencies took action to keep people safe and support people to move to other care homes. The provider decided they would close the home. The home is now closed.

You can see the actions we took at the end of this 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 safe.

People's medicines were not managed safely and people were not always receiving safe care and treatment.

People were not supported by enough staff to meet their health and care needs and there was a high use of agency staff.

People were not always protected from risks of abuse or harm because systems were not always followed for raising concerns and managing concerns.

People were not supported by staff who had the skills and experience to meet their needs and keep them safe.

People were not always protected by a recruitment system which protected them from potential abuse.

Is the service well-led?

Inadequate

The service was not well led.

People continued to live in a service where scrutiny by the management and external consultants organised by the provider had not ensured they were receiving care and treatment in line with their needs and keeping them safe.

There were no clear systems identifying actions taken to shortfalls identified and many concerns had not been identified.

People were supported in a service which had poor communication between management. The principles of openness and transparency were not always being followed.

People lived in a service where the provider was failing to make improvements when concerns had been found by external agencies.

The provider tried to ensure other agencies were kept informed in line with their statutory duties. However, they had failed to

meet the current requirements on their registration

Acacia 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focused inspection was prompted by concerns we had received about the service from multiple sources relating to staffing levels, leadership and governance, pressure care, staff training and how people were supported with transfers due to low mobility.

The inspection took place on 23 and 24 October 2018 and was unannounced.

This inspection was carried out by two inspectors and one inspection manager.

Prior to the inspection we looked at records we already held about the service and spoke with other agencies. During the inspection we spoke with 12 people at the level they could communicate with us due to some verbal communication difficulties. We also spoke with five visitors including people's relatives and other health and social care professionals about their views on the quality of the care and support being provided.

Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also completed other observations around the home.

We spoke with the two directors, the registered manager, deputy manager and 18 members of staff including the registered nurses, care staff and ancillary staff. Many of the care staff we spoke with were from a variety of care agencies.

We looked at the care records for nine people living at the home. We also reviewed records in relation to medicine management, recruitment, staff training, rotas, accidents and incidents, safeguarding, the

measures in place to check on skin care and prevent pressure damage and the provider's governance systems.

Inadequate

Is the service safe?

Our findings

At our inspection in August 2018, we identified that people were still not safe living at the home. This was because there continued to be a wide range of concerns found including the management of medicines, pressure area care issues, assessing risks and staffing. New concerns were found in relation to people with specific health conditions such as seizures.

Following the inspection, actions we had already taken to drive improvement remained. Restriction to admissions at the service was still imposed. The provider was still expected to send us a monthly report of how they were improving the ongoing concerns we had. During this inspection, in October 2018, we found some small improvements had been made to the storage of medicines and systems to prevent the spread of infection had improved.

However, the service remained in breach of the regulations and people continued to be at significant risk of harm. We found concerns in relation to some medicine management, pressure area care, staff training and staff levels. New concerns were identified around the management of allegations of abuse. Some issues which had been present at the inspection in February 2018 had returned. These included unsafe recruitment practices and people being placed at risk of choking. There was a mixed opinion from people and relatives about how safe they were living at the home. Most staff, including senior and clinical staff felt people were no longer safe living in the home.

People were still at risk of developing pressure ulcers. Since the last inspection, in August 2018, five people had developed pressure ulcers. Some of these wounds were healing whilst others remained. There was confusion about the extent of one person's pressure ulcer. One member of staff who had administered personal care the day before said it still existed, whilst the registered manager thought it had healed. Records did not clearly demonstrate how the wound had been managed and one nurse had incorrectly identified the severity of the pressure ulcer in the initial wound record. This had not been identified by members of management.

The same person, who had previously been nursed on a special air mattress was found to be lying on a foam mattress. They had recently sustained a pressure ulcer and were at very high risk of more pressure ulcers. The air mattress was designed to evenly distribute pressure over the body to mitigate risks of damage to their skin. The director, who was a nurse, gave an explanation why this change had been made. No other clinical members of staff, including the registered manager, knew about this or why it had happened. By the second day of the inspection this person had the special air mattress.

A second person, at very high risk of pressure ulcers, had a serious one on their ankle. There were inconsistent explanations told about how it had originally occurred. This included the relative providing us with some information. Records did not always reflect what we had been told during the inspection and prior to the inspection. The first time the pressure ulcer had been documented was when it had already started to be of a size to cause pain. There was no indication staff had taken action to prevent the wound deteriorating.

A third person, also at very high risk of developing pressure ulcers, was found sitting, eating their breakfast in a wheelchair without a pressure relieving cushion. This meant they were being placed at risk of developing a pressure ulcer. One member of the inspection team alerted a member of staff to the issue. The member of staff thought the person had already been in the wheelchair for at least 15 minutes. After another 30 minutes the person was found still sitting in the wheelchair without a pressure relieving cushion. We then spoke with the deputy manager who arranged for the person to be moved to a more comfortable seat. They checked the person at the request of the inspection team and we were informed no pressure ulcer had started developing.

Although there had been some improvement with medicine management people were still not receiving medicines safely. Mini audits were completed weekly and there was an in depth monthly audit. However, two people had been prescribed emergency rescue medicine for their seizures. Staff had not received either any or recent training in how to safely administer this. One nurse informed us another nurse had asked them how to administer the rescue medicine because they had never administered it before. This meant the people were at potential risk of harm if they had a seizure.

At previous inspections concerns had been raised about 'as required' medicines not having protocols in place. These were to provide guidance for staff to ensure they were administered consistently and safely. Five protocols were still not in place for three different people. Another person was being administered an 'as required' medicine daily without a referral to the GP to review this and consider changing it to regular medicine. This meant the medicine was not being used in line with their current prescription.

One person with diabetes had five occasions their medicine administration record stated they had received their insulin whilst on the reverse it was recorded they refused. There were no records that their GP had been contacted. Neither was it clear whether their blood sugar checks had been completed to judge the impact of the missed insulin. This meant there was a risk their health could deteriorate significantly placing them at risk of harm.

There were some gaps found in the medicine administration records indicating there was a potential risk medicines had not been administered. There were few records following this up to ensure people were safe and had received their medicines. One person had records indicating one medicine had not been administered because they were, "unable to locate medication". This meant they were at potential risk of a decline in health. No impact was found for the person at this inspection.

Where people had been identified as at risk of choking or aspiration, the care they received did not always mitigate this risk. One person was at higher risk of choking due to a medical condition. They required their mouth to be cleaned after each meal to ensure food had not been pocketed in a cheek. On the first day of inspection no staff had completed this task following lunch. At 3pm two staff, including one from an agency, started to support the person to clean their mouth out. This was after being instructed to by a senior member of staff. Neither had been trained to complete this task safely nor did they know what the guidance was in the person's care plan. The person's relative had to show them how to complete this task safely. The person also had a suction machine should they begin to choke or aspirate. Staff had not received training to safely use this piece of equipment. This meant the person would not be supported safely if they started to choke on food.

On the second day, one person on a specialist diet of softened food and thickened drinks was placed at risk of choking and aspiration. The director, who was a nurse, told one member of agency staff the person needed three scoops of the drink thickening powder. The agency staff used two scoops and went to serve the drink to the person. The director had not recognised this mistake. One member of the inspection team

had to speak with another nurse to prevent the person from being placed at risk of choking or aspiration. The nurse then ensured the correct thickness of drink was provided.

A third person was seen by a member of the inspection team coughing after each mouthful of food they had eaten. The staff member supporting them tried to check if they were alright. They told us it was their first time assisting this person to eat. We raised our concerns with a nurse. They informed us it had not been reported to them. They did inform us the person had recently had a chest infection. There was a potential risk the person could choke or aspirate on their food due to changing clinical needs and lack of guidance for staff.

People were placed at risk of harm because all health and safety risks had not been identified by the provider and staff. On the first day of inspection some maintenance was being carried out in the ground floor corridor near the lounges. Large panels had been removed leaving exposed hot water pipes, an electric drill and screwdriver. Maintenance staff were not present and the area was not cordoned off. People, relatives and staff were moving up and down the corridor. The danger this exposed people to had not been identified. One inspector stepped in to highlight the danger. Whilst talking with the registered manager an unaccompanied person with dementia came holding a butter knife and stood in front of the exposed pipes. The registered manager made the area safe.

People were placed at risk because equipment to help them call for help had been unplugged. One person was found in their bed stating they, "were about to burst" and had "bubbles running up and down their tummy". They explained they had been waiting for staff to support them with intimate care for about 15 minutes. Their call bell was on the other side of the room and the batteries had been removed. We told a member of staff who immediately went to resolve the issue. The registered manager indicated this was not the first occasion this situation with batteries removed from call bells had occurred in the home. They had not begun an investigation at the time of the inspection in relation to this pattern. By people not having accessible call bells there was a risk they would not have their needs or safety met in a timely manner.

Another person at very high risk of falls had a special 'sensor' mat to alert staff if they were moving about unaided. This should have been plugged into the call bell system to alert staff if it was activated. The correct paperwork had been completed for this potentially restrictive practice and confirmed it was in their best interest. However, on the second day of inspection at approximately 11am this mat was found unplugged from the call bell system whilst the person was in bed next to it. We spoke with senior staff who was unable to explain why this had happened. They immediately plugged it in and went to check with maintenance that it was working. This meant the person was at risk of falls and staff would not have been alerted if they needed assistance.

There were not enough battery packs for all the hoists in the home. The management told us another battery was on order. Staff informed us they needed to remember to transfer batteries so they were ready when needed. This meant there was a potential risk a person may need transferring with a hoist which had no working battery. One member of staff informed us they had witnessed an inappropriate transfer that day by other staff which placed a person at risk of harm. Another hoist was found with a "service required" alert being displaying prior to the arms moving. We spoke with the maintenance staff who was unaware this might be an issue. This meant there was a risk staff were not reporting equipment which was potentially faulty. The maintenance staff immediately went to make sure the hoist was safe.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by enough staff to keep them safe and meet their needs. One relative told us, "I don't think there are enough staff. A lot of agency ones". One staff member said, "Staffing levels are awful" and went on to describe lots of agency staff being used who lacked experience. We found there was a significantly high use of agency staff. This included agency staff inducting newer agency staff because there were not enough permanent staff to do this.

There were not enough staff to meet people's needs and be available when people needed support. On the first day of inspection there were up to 13 people plus two relatives in a small lounge for over 16 minutes with no staff present. As a result, some people did not get their needs attended to quickly to keep them safe, including preventing them from falling. Some people remained in other areas of the home for large proportions of the day and at times no staff monitored them. For example, one member of staff came to relieve a member of staff for a break. The new staff member then left the area where there were people in their bedrooms, unsupported.

The care and support people received was recorded on the electronic care plan system. However, there were no systems in place for the management to monitor people's dependencies. This meant the management did not understand how many staff were required to support people to meet their needs and keep them safe.

People were not supported by suitably skilled staff to meet their needs. Examples of this were seen around eating and drinking, use of rescue medicines and pressure area care. Staff had not recently undertaken practical training to learn how to safely transfer people. This meant there was a risk people would be hurt by being inappropriately transferred. Prior to the inspection this had been a concern raised about training. One new member of staff told us they had completed 28 training DVDs in four days.

Staff new to care were not undertaking the Care Certificate or a similar level of training. The Care Certificate is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. One member of staff new to working in care told us they had started their Care Certificate at a previous workplace. When they transferred to this service they did not complete it despite being told they would. Another new member of staff told us they had not worked in care before and had not started working on their Care Certificate. This meant there was a risk new staff did not understand how to deliver safe and good care. At the time of the inspection there were no systems in place by the management to deliver the Care Certificate or similar.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previous concerns about safe recruitment from the February 2018 inspection had returned. We found the recruitment process now did not always protect people from possible harm and abuse. We looked at the recruitment records for four new staff members. Three had been employed since the last inspection. Foreign staff new to the country did not have adequate pre-employment checks completed to ensure they were safe to work with vulnerable people. Police checks had been completed in this country. However, if they were new to living in this country no police checks had been completed for the country they had previously resided in.

There were several occasions when references had only been obtained from family and friends. This meant there were no independent views that the person was suitable to work with vulnerable people. Some of the new employees did not have full employment histories available in the recruitment file. By not having a full history it would be difficult to determine what the staff member was doing in the gaps of employment.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not always safe from potential abuse because systems were not always followed when allegations had been made. Some staff we spoke with did understand what was potential abuse and how to report it.

During the inspection senior staff raised their concerns with us about the safety of individuals living at the service. They had not always raised this with the local safeguarding authority or external organisations who monitor services. This indicated they were not always following the provider's safeguarding policies or procedures, or those of the local authority.

A recent safeguarding incident had been investigated by the directors on behalf of the local authority safeguarding team. Disciplinary action had been taken during the investigation relating to staff involved. Senior staff and the registered manager were not kept informed about these actions. Neither had the provider updated the local authority safeguarding team. No measures identified by the provider following the outcome were put in place to protect people living at the home or mitigate risks of it happening again. Some staff informed us they were uneasy about the decisions made and actions taken by the provider. The person's relative told us how upset it had made them feel thinking their family member was being placed at risk of harm.

This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our inspection in August 2018, we found there continued to be significant concerns around the management of the home. Documents which should have been readily available in the home then, were still not available. The quality assurance systems had been inconsistently completed and shortfalls identified had not been improved. One of the directors, who was a nurse, and acting manager at the time of the inspection, did not have full knowledge of the clinical needs of people. Areas which we were told were improved had not always been the case. The provider had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities.

Following the inspection, actions we had already taken to drive improvement remained. Restriction to admissions at the service was still imposed. The provider was still expected to send us a monthly report of how they were improving the ongoing concerns we had. The provider had failed to send the most recent monthly report in the required time scale. An extension had been granted which was due during this inspection. It was provided by the second day of inspection.

During this inspection, in October 2018, we found some small improvements. A new manager had been registered with CQC. There were some systems in place to monitor the quality of care and keep people safe. Notifications had now been sent to CQC in line with legislation. Some people and relatives thought the new registered manager was doing their best to improve the service. One relative said, "The new manager is fabulous".

However, people continued to be placed at significant risk of harm and their needs were not being met because the service was not managed effectively. At this inspection, we found the safety of the service had deteriorated since the last inspection. There was a high use of agency staff and most permanent staff were leaving or planning on leaving. This staffing mix meant that there was an increased risk that staff would not know people's needs. It also meant agency staff were not receiving adequate inductions when starting to work at the home. Although, the directors and management were attempting to replace the staff leaving they were failing to train new staff effectively or give them adequate guidance. The management did not have systems in place to monitor the competency of staff to ensure practices were safe. Nor were there robust methods of identifying the dependency of people using the service to ensure staffing levels were adequate to meet people's needs.

There was poor communication between the directors and the registered manager and staff which impacted on people's care. Examples of this were seen during the inspection when concerns were raised with the directors by the inspection team. Staff and relatives told us, and we saw, one of the directors would undermine the registered manager and clinical staff. For example, the changing of an air mattress for a person with high risk of pressure ulcers. Little explanation was given and there was a lack of communication to senior staff, including clinical staff, about this change. Another example, was most people moved downstairs during the day to reduce the amount of staff required. By not having a clear line of accountability staff, people and relatives were confused by mixed messages. In turn, this had caused some relatives to become upset.

Quality assurance systems being used by the management still had failed to identify all the concerns found during this inspection. For example, they had not identified the issues with pressure area care, medicine management and eating and drinking. A consultancy firm who had completed an audit at the request of the provider had also failed to identify concerns identified during this inspection. For example, there was no mention of concerns around 'as required' medicine administration. Nor had they identified people's safety being compromised due to lack of staff training, staff levels and poor pressure area care.

Following the inspection in February 2018, some conditions were placed on the provider's registration by CQC to drive improvement in the home. These were kept in place after the August 2018 inspection due to a lack of satisfactory, sustained improvement to keep people safe and meet their needs. One of the conditions was to provide CQC with a monthly audit to allow us to monitor people's safety and whether the service was improving. Although the audit covered some things, it did not cover all areas required as part of the provider's registration conditions. This meant they had not provided adequate information to allow CQC to monitor the service, nor met the provider's statutory obligations.

Accurate records were not in place to monitor the quality and safety of the service effectively. There were continued issues with some documents which should have been readily available during the inspection having to be requested multiple times. This was a concern at previous inspections in February 2018 and August 2018. For example, recent recruitment records were asked for by an inspector. The inspector then witnessed members of staff going through the records to organise them prior to handing them over. Safeguarding records were requested and not given immediately so had to be requested more than once. Staff rotas from the week prior to the inspection could not be located during the inspection.

The provider had not improved the service people were receiving to ensure it was in line with current legislation. As a result, people at the inspection in October 2018 were found to be at significant risk of harm. The service had been repeatedly found in breach of the legislation at consecutive inspections between June 2017 and October 2018. There had been a large amount of input from other agencies such as the local authority and health professionals. This demonstrated an inability that the service could provide people with safe care and treatment which met their individual needs.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had failed to ensure care and treatment was provided in a safe way for service users.

The enforcement action we took:

We had already begun the process of slow closure. Following this inspection this was concluded. The Home is now closed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were protected from harm.

The enforcement action we took:

We had already begun the process of slow closure. Following this inspection this was concluded. The Home is now closed.

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 had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance.

The enforcement action we took:

We had already begun the process of slow closure. Following this inspection this was concluded. The Home is now closed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	proper persons employed The provider had failed to undertake robust and safe recruitment of staff.

The enforcement action we took:

We had already begun the process of slow closure. Following this inspection this was concluded. The Home is now closed.

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 there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. The provider had failed to ensure staff received appropriate support, training and supervision.

The enforcement action we took:

We had already begun the process of slow closure. Following this inspection this was concluded. The Home is now closed.