Gables Care Home (Market Harborough) Limited

The Gables Residential 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 inspected The Gables Residential Home on 11 July 2017. This was an unannounced focused inspection following concerns we received about the care being provided to people living in the home and in receipt of the home care service. We undertook this focused inspection to check that they had followed and met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Gables Residential Home on our website at www.cqc.org.uk.

At our last inspection on 28 February and 2 March 2017 we found two breaches of legal requirements. We took enforcement action and placed a condition on their registration. The Registered Provider must not admit any service users to the location The Gables Residential Home, without the prior written agreement of the Care Quality Commission. The term "admit" includes re-admit and this restriction should be understood to include any person who has been resident at the home at any time. The service was also placed into special measures. Following the inspection the provider was required to submit an action plan to say what they would do to meet legal requirements in relation to the breach in Good Governance and Safe care and treatment. We also requested additional information from the provider about their service. The provider failed to provide us with the information we requested.

At this inspection we found that the provider had made some of the required improvements. However, we continued to find the service was not meeting the regulations and further improvements were required. There continued to be breaches of the regulations we inspected against and safe and well led domain remained inadequate. Therefore the service remains in special measures.

The Gables Residential Home provides accommodation for people who require personal care for up to 10 people and personal care for people living in their own homes. At the time of the inspection seven people were living in the residential home and eight people were receiving care in their own home. However, one person was in hospital on the day of the inspection meaning there were only six people who were currently using the service. The home is located on two floors with a stair lift to access both floors. The home had a communal lounge and dining room. Most people who received care in their own homes lived in flats that were on the same grounds as the residential home. The same staff group worked between both the residential home and flats.

The service had a registered manager who was registered to manager both accommodation for people and personal care. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from risks relating to their health and safety. Some assessments had been carried out but had not been reviewed when people's needs had changed. Assessments to determine what

support people needed had not been carried out since our last inspection placing people at risk of harm.

Staff could identify the potential signs of abuse and knew how to report any concerns. Where incidents had occurred that may cause concern these had not always been investigated to determine the cause. Measures had not been put in place to protect people from the likelihood of reoccurrence.

There were not enough staff deployed to keep people safe. Staffing levels had been assessed based on incorrect information. People did not have their needs assessed and it was not known how many staff were needed to meet their needs safely.

People living in the flats did not receive their medicines in a safe way or as prescribed by their GP. Medicine records had not been completed correctly.

Staff had not been recruited appropriately. Pre-employment checks had not been carried out before staff started to work at the service placing people at risk from unsuitable staff.

Equipment that people used had been checked to make sure that it was safe to use.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. However, these did not identify concerns that we found during this inspection.

The provider was receiving support from the local authority; however, they continued to fail by not implementing the changes being requested of them. They had not taken action following feedback from professionals to improve the delivery of the service that had been provided.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This could 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."

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 were not protected from risks relating to their health and safety. Where people's needs had changed risks had not been assessed.

Incidents had occurred and the cause of these had not been identified to try and reduce the likelihood of them happening again.

Staff had not had pre-employment checks completed before they started work. Staffing levels had not been assessed effectively to ensure there were enough staff to meet people's needs safely.

People did not always receive their medicines safely. Medicine records were not completed correctly.

Is the service well-led?

Inadequate

The service was not well-led.

Actions that had been identified at previous inspections had not been completed. Feedback that had been given had not been used to improve the service that was delivered.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. These did not identify or address concerns we found during this visit.

Staff usually felt supported in their role and they could approach the registered manager.

The provider failed to submit information we requested following their inspection.

The Gables Residential 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.

We undertook an unannounced focused inspection of The Gables Residential Home on 11 July 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 28 February and 2 March 2017 inspection had been made and also following concerns from other health and social care professionals. The team inspected the service against two of the five questions we ask about services: is the service safe and well led. This is because the service was not meeting some legal requirements.

This inspection was carried out by two inspectors.

Before our inspection, we reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We reviewed a range of records about people's care and how the service was managed. This included six people's plans of care and associated documents including risk assessments. We looked at two staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the registered manager, one senior carer and three care staff.

We spoke with two people who used the service. This was to gather their views of the service being provided.

We observed staff communicating with people who used the service and supporting them throughout the day.

Inadequate

Is the service safe?

Our findings

At our last inspection carried out on 28 February and 2 March 2017 we found one breach of the regulations. Regulation 12, Safe care and treatment. We required the provider to make improvements. However, they failed to submit an action plan setting out what they were going to do to make the necessary improvements. We also took enforcement action following that inspection and placed a condition on their registration.

At this inspection we found that the provider had made some of the required improvements. However, we continued to identify a number of areas of concern where improvements had not been made.

Most control measures that had been identified to reduce risks in the environment had been followed. At our previous inspection in December 2015 the radiators were very hot and presented a risk of burns to people. The provider took action to ensure that covers that were in place were not broken and provided protection. Where it was not possible to cover the radiators it had been agreed that the temperature would be reduced and this would be monitored. At the inspection in March 2017 we found four radiators that were very hot to touch and painfully hot to hold. This presented a risk to people, particularly those at risk of falling and who would have been unable to recognise or respond to the danger of the temperature. We discussed this with the registered manager. At this inspection one of the radiators had been removed and one had been covered to reduce the risk. There was a risk assessment in place for one of the radiators. The control measures were not effective as they identified that the radiator would not come on until the temperature in the room was at a certain level. The risk assessment identified that the person whose room it was would be supported by staff into the room. This did not remove the risk of the hot radiator. The other radiator remained uncovered. The heating was not on during our inspection as it a very hot day. It was not possible to identify if the control measure of lowering the temperature was in place when the heating was on.

People who received care in their own home did not have assessments of their needs completed when their needs had changed. At the previous inspection in March 2017 we asked the provider to ensure that assessments were completed for four people whose needs had changed significantly to make sure that there was a record of what the person's current needs were and how to meet these safely. This was an outstanding action from the inspections in December 2015 and September 2016. The registered manager told us that care plans were being updated to reflect changes in needs. The required updates had not been completed and people remained at risk of harm through injury.

Assessments in people's care plans had not been updated to reflect people's changing needs. For example, one person's care plan had a handwritten note to say that it needed to be fully updated. The person had gone from being independently mobile to needing two staff to support them to move safely in September 2016. The care plan had last been reviewed on 14 September 2016 and had not been updated to reflect this significant change in the person's needs. All information in the care plan was out of date. An assessment had not been completed to identify if the service could still meet their needs. We found that this was the same for the three care plans we looked at where people were receiving care in their own home. The provider had not completed an up to date assessment for all three people despite significant changes in needs. This was despite telling us these actions had been completed since our last inspection. Another person had a note in

their care plan to say that the district nurse had visited and identified sore areas on the person's bottom. This was recorded as being due to being wet for too long. The advice was that the person required support with going to the toilet more frequently. Clear guidance had not been provided for staff to address this increased need. One person had spoken and acted in appropriately in front of staff on seven occasions. There was no risk assessment or guidance for staff about how to meet this need. This meant that the staff did not have guidance about how to meet people's current care needs as guidance was not up to date or relevant to the people being cared for.

When people had incidents or accidents these were not always investigated and measures were not put in place to avoid the likelihood of reoccurrence. One person had an assessment completed before they moved in. They were not identified as being at risk of falls although a relative had asked for a sensor mat to be used to keep the person safe. The person had one fall after moving to the service. They did not sustain any harm on this occasion. However, it was then identified that the person sustained an unexplained fracture. The cause of this could not be identified. Following this incident measures were put in place at the local authorities request to keep the person safe by using a sensor mat to alert staff if the person stood up so that they could attend to them. The person then had a further two falls, one resulting in an injury. On the day of our inspection the sensor mat was on the person's chair. However, it was not turned on and was not moved for 30 minutes when the person was supported to move to another chair. The registered manager told us they had reminded staff of this previously. There were checks in place to make sure the equipment was being used as it should be to keep the person safe. However, these were not documented and had not identified that the sensor was not turned on or moved. It was not evident if staff were following the guidance put in place by the local authority as the information in the person's care plan was inconsistent. In an assessment about how to support the person with moving it identified they needed one member of staff and a walking frame to move safely. In their care plan it said that two carers were needed. Staff had not been given the guidance they needed to support the person to mobilise safely. The registered manager confirmed this was an error and they would change the care plan to reflect that one carer was needed.

Another person had a fall and sustained a large cut to their head. The cause of the fall was unknown, as it was not witnessed, and the person was found on the floor. They were also found to have bruising on their hand and arm. All of these incidents were recorded on accident forms. However, there was no investigation to identify what had happened and if any changes were needed to keep the person safe. A different person was noted to have six bruises and eight marks on them. This was six days after they had a fall and were admitted to hospital. The marks were recorded. However, how these happened could not be identified. There was no investigation to see if any measures were needed to avoid the reoccurrence and to keep the person safe and avoid the risk of harm.

Where people had been identified as being at high risk of malnutrition assessments to review the risk had not been carried out. For example, where a person was shown to be at high risk of malnutrition their risk assessment should be reviewed monthly or when their needs changed. This is important so that there is an accurate record of what has been done to reduce the risk and if this is effective. However, these reviews had not been completed. One person had been identified as being at high risk of malnutrition. There was a handwritten note on their care plan guiding staff to follow a plan for someone identified as being at lower risk. The person was being cared for in bed and the most recent review of their care plan identified they may need support with eating and drinking. It did not detail the assistance needed. A member of staff on the day of our inspection told us the person now needed a soft diet to enable them to eat. However, this was not reflected in their care plan so we were unable to establish if they received the appropriate diet at each meal time.

People did not always receive their medicines safely when they received care in their own home. A member

of staff told us that they required less training to be able to give medicines to people in their own home. They said, "I do not give meds in the house [The Gables Residential Home] as you have to have level three training. I can give them in the flats." We looked at the medication administration records (MAR) for three people who received support with their medicines. These had been handwritten and only been completed by one member of staff. It is good practice that two staff sign the entry to confirm that it is correct in line with the guidance on the medicine label. Some medicines had been typed onto the MAR chart. These did not have doses or instructions on to provide staff with guidance on how to administer. For example, one person was prescribed Codeine Phosphate. This was to be taken as and when required. There was no information about the dose or when it could be taken. Another person had lactulose prescribed. This was to be taken once a day. There was no dose identified. Staff did not have guidance that they needed to support people to take their medicines as prescribed by their doctor.
Changes had been made to MAR charts without written guidance from the prescriber. For example, one person took ½ a tablet in the morning. The MAR chart was changed to add another ½ tablet at tea time. The MAR chart had signatures to say this medicine had been administered 3 times a day for a period of time. There was a note in the person's communication records to say the GP increased the medicine to three times a day. There was no written prescription to show that the GP had made this change and the MAR chart was not updated to reflect this. Staff then reduced the dose to two times a day. There was nothing recorded to say the GP had agreed to this.

MAR charts had a number of missed signatures on them where it was not possible to determine if the staff had supported the person to take their medicine. Where people had cream prescribed for use there was no guidance for staff as to where to apply this or how often.

People had medicines that were taken as required and there was no guidance in place to explain when this should be used. Concerns about medicines practices in people's own homes had been raised at our inspection in March 2017. The registered manager told us they would implement checks and audits on the medicines. This had not been done.

The provider and registered manager failed to ensure that people received safe care and treatment that was based on their assessed needs. These matters constituted a continued breach of Regulation 12(1)(2)(a)(b)(g), Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Resident's questionnaires had been completed in 2016. Four of these identified that people thought there were not enough staff in the service. The registered manager told us that they had not analysed the responses. Staff told us that they were not sure staffing levels were correct. One member of staff said, "It is hard. We are trying to pull together to support each other. It is better than last time you came." Another member of staff told us, "It could be better. We try and cover. In the last two weeks there has been only three when there should have been four sometimes." One staff member commented, "Sometimes when we are in the middle of something the buzzer goes off. We cannot leave the person. We have to finish so the other person has to wait." Another staff member said, "Three is not enough in the afternoons as one is outside [in the flats]."

During our inspection there were six people living in The Gables Residential Home. One person was in hospital meaning that there were less people for the staff to support then would normally be present. Three people required one staff to assist them with walking. One person sometimes needed one member of staff and at other times needed two. On the day of our inspection they needed two each time they were supported to move. Another person was being cared for in bed and needed support from two staff. Four staff were on duty from 7:30am until 10am and then 5pm -9pm on weekdays. Three staff were on duty from

10am – 5pm. On the day of our inspection from 10am one member of staff was supporting people in their own homes. This left two members of staff on duty in The Gables. The staff told us they could radio the other member of staff if needed. One person who was being cared for in bed attempted to get out of bed twice during the day and setting off their sensor mat. Staff were required to stop what they were doing and immediately attend to this person. We observed that people who lived in The Gables were living with dementia and required reassurance and support on a frequent basis. We saw that staff were able to respond to these requests during our visit. There were times when people were left unattended in the lounge however these were only for short periods of time during our visit.

There were eight people who were receiving support in their own home. The registered manager told us that only four of these people were supported by staff. However, a member of staff said, "We clean all the flats including where people do not have other support." Three people needed support from two staff for moving. The other person sometimes needed one staff and at other times needed two. A member of staff was allocated to provide support to people in their own flats. When people needed two staff to support them the additional staff member was called from the staff who were on duty in the residential home. This left only one member of staff on duty at The Gables Residential Home. We reviewed the daily notes for all four people who received care in their own home for June 2017. There were 43 times during the times when only three staff were on duty that two staff provided support to people in their own homes. This left only one member of staff to support all seven people living at The Gables, and the three other people who lived in their own homes. The time periods that only one member of staff was available ranged from 5 minutes to 40 minutes. We also found that there were times when two staff should have been supporting people in their own homes for tasks and only one staff member was recorded as being present. This is a risk to people as the staff may not be able to safely support them on their own and left some people vulnerable and without adequate support.

There was another additional person who was present throughout the day of inspection and the registered manager advised this person was receiving day care. They did not have any allocated staffing but were assisted to walk to the toilet when they were unsteady. This was seen to happen on the day of the inspection. The needs of people at The Gables meant that there were times when both members of staff were supporting someone and there was no other member of staff available to see that another person needed support.

The registered manager told us they had completed a dependency tool to identify the levels of staffing required to meet people's needs safely. However, when we looked at this we saw that the numbers of staff identified as needing to support people had not been recorded correctly. For example, one person needed either one or two staff to support them at all times. They were recorded as being independent. As people had not had their needs assessed despite significant change the registered manager could not identify how much support each person needed through the day effectively. This was despite the commission being told all people had been reassessed following our last inspection in March 2017. Staffing levels were not appropriate to meet the needs of people who used the service.

The provider was failing to provide safe staffing levels to meet all people's needs living in the home and their own flats. These matters constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

The provider had not consistently followed safe recruitment procedures as outlined in Schedule 3 of the Health and Social Care Act. This schedule gives providers of health and social care clear guidance on the safe recruitment of staff. We looked at the files of two staff members including the only member of staff who had been employed since our last inspection. The required pre-employment checks had not been

completed. The member of staff had started work before their Disclosure and Barring Service (DBS) check had been received. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who used care services. At previous inspections we had discussed with the provider the importance of completing checks before staff started work as reported on at their last inspection. The member of staff had been allowed to work at the service, without a risk assessment before the DBS check had been received. Pre-employment checks include seeking evidence of good conduct from previous employers. The provider did have two references. Neither were from the most recent job in the care field. One referee identified the person had last worked for them more than one year ago, raised concerns about their practice and suggested contacting a more relevant and up to date employer. This was not done. The registered manager told us that the person had started work while they were on holiday and they could not make any changes.

The registered manager had failed to ensure that any new staff employed were of good character and able to work at their service. These matters constituted a breach of Regulation 19 (2)(a)(b)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper person's employed.

People told us that they felt safe while receiving care and support from the staff. One person said, "I feel safe. I like the staff." Staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. They were aware of the signs to look out for that might mean a person was at risk. Staff knew the procedure to follow if they identified any concerns, or if information of concern was disclosed to them. One member of staff told us, "I would go to the senior or manager. I am sure they would listen." Staff confirmed that they had received training to support their knowledge and understanding on how to keep people safe and recognise abuse. However, training records identified that 11 staff had not completed this training in the last three years. There had been important changes to the legislation in this time. Staff would not have up to date knowledge in this area. Policies and procedures in relation to the safeguarding of adults were in place and the actions staff described were in line with the policy.

Where people required the use of specialist equipment to support them, for example, a hoist, assessments were in place regarding the safe use and maintenance of this. Checks were carried out on equipment to make sure that it was safe to use. There were emergency plans in place to keep people safe should there be an emergency such as a fire. These plans detailed the support each person would require to help them to leave the building should it be necessary. These had not been updated for people who received support in their own home when their needs had changed. If there was an emergency staff, and emergency responders did not have the correct information about how to support people to evacuate their properties safely. The provider had identified alternative accommodation to be used in an emergency.

Checks were carried out on the environment and equipment to minimise risks to people's health and well-being. Records showed that fire drills had taken place and that people had been involved so they knew what to do in case of an emergency.

Inadequate

Is the service well-led?

Our findings

At our last inspection carried out on 28 February and 2 March 2017 we found a breach of regulations. Regulation 17 Good governance, the systems and processes in place did not enable people to receive a quality service and resulted in a number of concerns. We required the provider to make improvements and requested they submit an action plan setting out what they were going to do. We also took enforcement action following the inspection and placed a condition on their registration. The provider failed to submit an action plan and also did not respond to two requests for further information when we requested it.

At this inspection we found that the provider had not made all the required improvements in the home and flats and we continued to identify a number of areas where improvements had not been made in the flats.

Audits that had been introduced at the service to ensure that risks to people were identified and reduced, however, these were not effective. For example, an audit on accidents and incidents completed in June 2017 identified that no incidents had happened. Accident records showed that there had been four including two falls resulting in serious injuries and one un-witnessed accident resulting in a serious fracture. The audits were therefore not being completed as they should and did not take into account the accidents that had taken place in the home.

Audits had not been completed on the care records or the quality of the information that was in them. For example, where there were inconsistencies in the information between care plan and assessment. The records were either incomplete or had not been updated as they should when peoples needs changed. Audits had not been completed for people living in their own homes who were supported with medicines. We identified areas of concern with medicines practices at our last inspection In March 2017. The registered manager told us they would start audits for people living in their own homes to address this. The provider had not completed any audits on the service that had been provided to ensure that it was meeting the regulations. They failed to keep people safe and ensure that the service people received improved.

At our previous inspections on 10 December 2015 and 13 September 2016 we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. This was because suitable staff had not been deployed to meet the needs of people who used the service. At our last inspection on 28 February and 2 March 2017 we found that there were enough staff deployed. However, this was because the home was not full. There were four vacancies in the residential service and two in the flats where people received support in their own homes. At this inspection the provider had completed a dependency tool to identify how many staff were needed to safely meet the needs of people. This had been completed incorrectly and accurate information was not used about peoples needs to influence the tool and ensure it recorded the staffing required. People did not have assessments of their needs to determine what support they required. The staffing levels were not appropriate to meet the needs of people using the service.

People's needs had not been assessed when they changed. This was raised with the provider during our inspection in December 2105, September 2016 and March 2017. We asked that four people were assessed

due to changes in their needs. Assessments had been completed by a social care professional for two people. However, the provider had not completed their own assessment to ensure that they could meet people's needs. The provider and registered manager were failing to ensure that good governance practices were being followed or that they reflected on their previous inspection reports to make the necessary changes needed to make the service safe for people.

Records were not being kept securely. A member of staff has been asked to update care plans. They were doing this on their own lap top at home. There was no risk assessment to ensure that confidential and personal information about people was stored safely on the personal computer kept at the member of staff's home.

Recruitment procedures were not always robust. This was raised at all three of our previous inspections. We found that a member of staff employed since our last inspection did not have pre-employment checks completed on them before they started work.

Systems and processes in place were not being completed effectively. Where they were being completed they were failing to assess, monitor and improve the quality of the service. The provider has also failed to seek and act on feedback from relevant persons and other persons on the services provided, for the purpose of continually evaluating and improving such services.

These matters are a continued breach of Regulation17(1)(2)(a)(b)(c)(d)(e)(3)(a)(b) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014: Good Governance.

The registered manager had carried out checks on the service to monitor the service that people were receiving. These included checks on people having drinks available in their rooms, that people were wearing clean clothes and socks and that they could reach their call bells. The checks were important as they considered areas of dignity that are important to people.

Staff told us they usually felt supported in their role and that they could approach the registered manager. One staff member said, "[Registered manager] is approachable. You can generally talk to her. A lot of what we say in staff meetings doesn't get done. " The registered manager told us they stepped in to support staff if it was needed when they were short staffed. However, they were trying to focus on updating and completing paperwork. Team meetings had taken place. The frequency of these was variable. Minutes from the meetings showed that areas such as training, good practice and feedback from visits had been discussed. Staff had been supported in line with the provider's policy about staff supervision. They confirmed supervision meetings with the registered manager had taken place. Staff had access to the provider's policies and procedures for guidance and to support them in understanding their role.

The registered manager told us they had been allocated a member of staff one day a week to assist them in the office to update the care plans and records within the service. This had been a recent development that had been agreed by the provider. The provider did visit the service on a weekly basis. They did not carry out audits of the service to ensure that the regulations were being met.

The registered manager had notified CQC of most events they were required to. It is a requirement that providers tell CQC when certain events happen within the service. This includes allegations of abuse, events that affect the service and when an application to deprive someone of their liberty is approved. We found that most of the relevant notifications had been made. However, we found that two people had sustained injuries that we had not been notified of. The registered manager sent these notifications following the inspection. During our inspection we saw that the ratings poster from the previous inspection had been

displayed in the office and on their website. The display of the poster is required by us to ensure the provider is open and transparent with people who use the services, their relatives and people who use the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b)(g), Safe care and treatment Assessments relating to the health safety and welfare of people had not been completed or reviewed. The provider was not doing all that was possible to mitigate risks to people. Medicines were not managed safely.

The enforcement action we took:

The provider closed the location before we could take action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c)(d)(e)(3)(a)(b) Good Governance. Systems and processes were not established and operated effectively. The quality of the service that was provided was not assessed, monitored, or improved effectively. Risks relating to the health, safety and welfare of service users were not assessed, monitored and mitigated. Feedback from relevant persons was not acted upon.

The enforcement action we took:

The provider closed the location before we could take action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (2)(a)(b)(3) Fit and proper person's employed. The provider did not operate robust procedures to determine if an applicant was of good character.

The enforcement action we took:

The provider closed the location before we could take action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) Staffing There were not sufficient numbers of suitably qualified, competence skilled and experienced staff deployed to meet people's care and treatment needs. The approach to determine the correct number of staff required was not systematic.

The enforcement action we took:

The provider closed the location before we could take action.