Mr David Hetherington Messenger

# Ernvale House Care Centre

**Inspection report**

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## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| 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? | **Requires improvement** |

## Overall summary

We inspected this service on 2 and 3 September 2015. This was an unannounced inspection. Our last inspection took place on May 2013 where we found that the provider was meeting the Regulations that we inspected them against.

The service was registered to provide accommodation and personal care for up to 85 people. People who use the service tend to be over 65 years old and have physical and/or mental health diagnoses. There are five units at the service. These comprise of a residential unit for people with low level needs, a nursing unit, a unit for older people with mental health needs and two single gender units for people with behaviours that challenge. At the time of our inspection 76 people were using the service.

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

# Summary of findings

During this inspection we identified a number of Regulatory breaches. You can see what action we told the provider to take at the back of the full version of the report.

Preventable incidents had occurred because risks to people's health and wellbeing were not consistently identified or managed to promote their safety. We found there were not always enough staff available to deliver people's planned care or keep people safe.

People were not always protected from potential abuse because staff did not report incidents of alleged abuse in accordance with local safeguarding procedures. Effective systems were not in place to ensure medicines were administered in a consistent and safe manner.

People did not always get the support they needed to eat and drink and suitable quantities of food were not always available. This meant some people's meal preferences and nutritional needs were not met.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not always being identified and rectified by the registered manager and provider. People's feedback was not always acted upon to improve their care experiences.

People and their relatives were not always involved in planning their care. This meant staff did not always know people's care preferences. There was a risk that people would not receive end of life care in accordance with their preferences. This was because effective, personalised end of life care plans were not in place.

People were not always given the opportunity or supported to make choices about their care. Social and leisure based activities were not consistently promoted and people told us they were often bored.

There was a homely and relaxed atmosphere and people were treated with care and compassion. However, staff told us they needed more time to give people consistent positive care experiences.

People's health and wellbeing needs were monitored and advice was sought from health and social care professionals when required. However, a lack of resources meant that some people could not regularly or consistently experience the positive health effects of sitting out in a chair.

Staff sought people's consent before they provided care and support. When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Staff received training and support that provided them with the knowledge and skills required to work at the service. Training gaps had been identified and plans were in place to address these gaps.

People knew how to complain about their care and complaints were managed in accordance with the provider's complaints policy.

# Summary of findings

## 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. Risks to people's health and wellbeing were not consistently managed and reviewed to promote safety, and people were not protected from potential abuse.

There were insufficient numbers of staff available to meet people's individual needs and keep people safe. People's medicines were not always managed in a consistent or safe manner.

**Is the service effective?**

**Requires improvement**

The service was not consistently effective. People who were at risk of malnutrition did not always receive the support they needed to manage this risk effectively. Resources were not always available to enable professional advice to be followed.

People consented to their care and support, and staff knew how to support people to make decisions in their best interests if this was required. Staff received training to provide them with the skills needed to provide care and support.

**Is the service caring?**

**Requires improvement**

The service was not consistently caring. Improvements were needed to ensure effective and personal end of life care plans were in place. People were not always supported to make choices about their care.

Although we saw caring interactions between people and staff, these positive interactions were often limited to when people needed support with specific care tasks. Care was delivered with dignity and respect and privacy was promoted.

**Is the service responsive?**

**Requires improvement**

The service was not consistently responsive. People did not always receive care that reflected their individual preferences and needs. This was because people and their relatives were not always involved in the planning of care.

People knew how to complain about their care and complaints were managed in accordance with the provider's complaints policy

**Is the service well-led?**

**Requires improvement**

The service was not well-led. Effective systems were not in place to assess, monitor and improve the quality of care. This meant that some areas of poor care were not identified and rectified by the registered manager or provider.

People and relatives felt the service had a homely and relaxed atmosphere and staff felt supported and enjoyed working at the service.

# Ernvale House Care Centre

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 and 3 September 2015 and was unannounced. Our inspection team consisted of four inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. The provider had completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Through this process, we identified that the service provided end of life care. We therefore chose to add this specialist area to our inspection plan.

We spoke with 16 people who used the service, eight relatives, four nurses, 12 members of care staff, the deputy manager and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met. The provider's operations manager and compliance manager were also present during the inspection.

We spent time observing care in communal areas and we observed how the staff interacted with people who used the service.

We looked at twelve people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, staff rotas and training records.

Inadequate

# Is the service safe?

## Our findings

Some people told us they didn't always feel safe. One person said, "When [person who used the service] has an 'off moment' it can be a little bit fraught, but most of the time I do feel safe". We saw that when risks to people's safety and wellbeing were identified, effective plans were not always in place to prevent further incidents from occurring. For example, staff told us and care records showed that one person had attempted to assault or had assaulted people and staff using their mobility aid on at least six occasions. The person's care plan recommended that, 'Staff may need to remove stick if [person who used the service] is being physically aggressive or showing signs of being physically aggressive'. However, staff told us it was not always possible to identify that the person was becoming aggressive as there were not always enough staff available to supervise the person to identify any changes in mood.

People who used and visited the service told us there were not always enough staff available to keep people safe. We saw that staff were moved from unit to unit in response to incidents and changes in people's behaviours. One person told us, "They don't always have enough staff, so when things go wrong they fetch more staff from other parts of the home". We found that this reactive approach to moving staff around units led to occasions where the provider's minimum safe staffing levels were not met. For example, the registered manager told us that three staff were needed during the day on one unit to keep people safe. The care records for one person who lived on this unit also confirmed this. However, staff and visitors told us that at times only two staff were working on the unit. A relative told us, "There should be three staff on this unit, but there are frequently times when there are only two as they move to the other units". A staff member confirmed this by saying, "I do get told to go to other units sometimes" and, "Yes, sometimes it only leaves two people here".

We saw that people did not always receive the support they required from staff to keep them safe. For example, staff told us and care records showed that one person required one to one support to keep them safe. However, over a five month period, we saw that this person did not receive this level of support. The care records for this person included statements such as, 'Cannot one to one [person who used the service] with only two staff on the unit' and, '[Person who used the service] requires one to one attention which staff are unable to give'. We saw that this person had suffered unwitnessed falls since staff had identified that one to one support was required. We also saw that this person had sustained injuries as a result of their falls. Their latest injury resulted in hospital intervention.

Staff told us and care records showed they had shared their concerns about this person's safety with the registered manager five months before our inspection. Despite this, no changes to staffing levels were made to reduce this person's risk of harm. When we asked the registered manager about this, they told us the person needed to be reassessed by the local authority in order to gain the funding required to increase the staffing levels. On the second day of our inspection an additional staff member was deployed to reduce this person's risk of harm. This meant there had been a five month delay in providing the extra staff needed to keep the person safe.

We found that avoidable incidents occurred because staff did not always follow the guidance contained in people's support plans. For example, staff confirmed that one person's care plan was changed in response to them falling on two occasions. Their care plan stated, 'Not to be left unsupervised when sitting in any chair'. However, care records showed and staff confirmed that this person had suffered a further unwitnessed fall from their chair. One staff member said, "We don't have enough staff to observe [person who used the service]". This showed the person's care plan had not been followed by the staff.

The above evidence demonstrates that appropriate action was not always taken to protect people from harm and sufficient numbers of staff were not always deployed to keep people safe. This was a breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of potential abuse. Staff told us what abuse was and how to report it. However, we found that incidents of potential or actual abuse or harm were not always reported to the local authority in accordance with local safeguarding procedures. For example, one person's care records showed they had assaulted other people who used the service on at least 18 occasions. None of these incidents

Inadequate

# Is the service safe?

had been reported to the local authority as required. Following our inspection, the registered manager told us they would share the unreported incidents with the local authority.

The above evidence demonstrates that people were not consistently protected from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us medicines were administered as prescribed. One person said, "I take lots of medicines and they never miss any of them out". We saw that systems were in place that ensured medicines were ordered, stored and administered to protect people from the risks associated with them. However, some improvements were required to ensure the records relating to medicines were accurate and contained enough guidance for staff to administer medicines consistently and safely. For example, one person was prescribed medicines to enable them to receive a comfortable and pain free death when they were approaching the end of their life. However, there was no guidance for staff to follow to show in which circumstances each medicine should be administered. We saw that one of these medicines had been given even. However, staff were unable to tell us why it had been given.

Requires improvement

# Is the service effective?

## Our findings

We found that people's meal time experiences varied from unit to unit. On the older person's mental health unit, we saw that some people did not always get enough food to satisfy their appetite. We saw one person ask for more food when they finished their meal, but no more was given. When we asked the staff why, they told us, "It's always the same, there isn't enough food" and, "I can't give people seconds as there isn't enough to go round". We also saw that on this unit there was not enough sauce to accompany the meal of the day, therefore some people were served their meals dry. A staff member said, "There wasn't enough sauce today. I asked the kitchen, but there was no more left".

We fed this back to the registered manager on the first day of our inspection. On the second day of the inspection the registered manager told us the concerns around food quantities had been discussed with the kitchen staff. However, we saw that sufficient quantities of main meals and dessert were still not readily available on this unit. The staff were able to gain some more main meal from the kitchen when this ran out, but one staff member told us if there was not enough dessert they would, "Cut the cake portions in half to make them go round". We could not see that people had lost weight as a result of reduced portion sizes, but there was a risk that people could lose weight if unsuitable quantities of food continued to be provided.

On the nursing unit, we saw that people didn't always receive the support they required to eat and drink in accordance with their care plans. For example, staff told us and care records confirmed that one person required full assistance to eat and drink. We saw this person sat in their room with their meal in front of them for a 15 minute period before a staff member supported them to eat. We later saw this person sitting with their dessert in front of them unsuccessfully attempting to eat it with no staff support. This person's care records showed they had recently lost weight. Staff on this unit told us that on occasions they found it difficult to support people with their care needs due to time limitations. One staff member said, "There is a lot more paperwork and less hands on care". Another staff member said, "There's not enough staff, some days we are able to give people individual time, then on other days we can't".

The above evidence demonstrates that people's dietary needs were not always met as planned. This was a breach of Regulations 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns we identified around mealtimes, people who could tell us about their care told us they enjoyed the food and the choices on offer. One person said, "The food is magnificent". Another person said, "I'm very fussy with food and there is always something I like on offer". We saw that some people received food that was not on the menu in response to their food preferences.

People's health and wellbeing were monitored. People and their relatives told us and we saw they were supported to access a variety of health and social care professionals if required. One relative said, "The chiropodist is coming out next week to see [person who used the service]". We saw that advice from health and social care professionals was usually followed. However, we found that the availability of suitable resources within the service sometimes meant that professional advice was not always followed. For example, care records showed that a visiting health care professional had recommended that one person sat out in a chair for short periods on a regular basis. The person's relative and the staff confirmed that this person was being nursed in bed because a suitable chair was not available to enable the person to sit out comfortably and safely. The registered manager told us they were awaiting input from other health care professionals to source a suitable chair. However, no written evidence was available to confirm the staff were actively pursuing this. A member of staff confirmed that the availability of suitable seating was also affecting other people who used the service. They said, "Not everyone is able to get out of their beds each day, because we have limited availability of specialist chairs, so they take it in turns". This meant people could not always benefit from the positive wellbeing effects of getting out of bed.

The majority of people and their relatives told us that the staff were suitably skilled to meet their needs. One relative said, "The staff really know how to look after [person who used the service]". Staff told us they had received training which included an induction to provide them with the skills they needed to meet people's needs. One staff member said, "The induction was good. It gave me a real understanding of who people were and how to care for them before I started to work here". Another staff member

Requires improvement

# Is the service effective?

said, “We do lots of training here. The best training I had was MAPA (Managing of Actual or Potential Aggression). I learned how to manage aggression the right way, so I don’t hurt anyone”.

We saw that training included; safeguarding adults, dementia awareness, moving and handling people and health and safety. Where there were gaps in the staffs’ training, additional training had been booked to address these gaps. For example, one staff member said, “I would like to have some dementia training”. The training records showed that this training had been arranged and made available for staff to attend. We saw that training had been effective and staff had the skills they needed to provide care and support. For example, we saw staff assisted people to move safely using specialist equipment.

People told us and we saw that staff sought people’s consent before they provided care and support. For example, we saw a staff member ask one person, “Is it okay if I put this apron over you?”. The staff member waited for the person to consent to this before putting their apron on. Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people’s best interests, when they lack sufficient capacity to be able to do this for themselves. Staff told us about the basic principles of the Act and we saw that mental capacity assessments were completed when required.

The staff were also aware of the current DoLS guidance and DoLS referrals had been made for people who had restrictions placed on them to promote their safety and wellbeing. At the time of our inspection, a number of people were being restricted under the DoLS. We saw that the correct requirements had been followed to ensure these people were restricted within the legal guidance.

Requires improvement

# Is the service caring?

## Our findings

We found there was a risk that people may not receive effective end of life care that reflected their preferences. Staff told us that one person who used the service was approaching the end of their life. There was no clear plan in place to guide staff on how to ensure this person remained pain free and comfortable and as a result of this, the person had received one of their pain medicines with no known reason or indication for its use. This person told us about some of the activities they missed participating in because of their declining health. Staff were not aware of the person's activity preferences and their care records contained no record of these preferences. No plans were in place to enable this person to access these activities to give them positive experiences during their end of life care. We shared this with the registered manager who told us they would look at addressing this person's unmet need.

We found that people were not always supported to make choices about their care. This varied from unit to unit. Some people told us they could make choices about their care. One person said, "I'm off outside now for a bit of fresh air" and, "I can please myself with what I do". We also saw some good examples of staff supporting and enabling people to make choices about their care. For example, on the residential unit we saw staff ask people what they would like for breakfast. When people chose cereal, staff then asked people if they wanted hot or cold milk with it. However, we saw that some people were not always given the same opportunities to make choices about their care. For example, on the male unit for people with behaviours that challenged, we saw that people were provided with drinks and biscuits without being offered any choice. We observed one staff member serve six people hot drinks without milk because no milk was available on the unit at the time. Other staff confirmed these people usually had milk in their hot drinks. We raised this immediately as a concern with a senior member of staff who replaced some of the hot drinks with lemonade, again without offering people the choice.

Staff told us they would like more time to enable them to give people more positive care experiences. We saw that the amount of time staff had to interact with people varied from unit to unit. For example, on the female unit for people with behaviours that challenged, we saw staff had the time to consistently engage people in meaningful conversation and activities. However, on the nursing unit staff told us and we saw that interactions with people was task led. This meant people only interacted with staff when they received assistance with person care or other hands on care tasks. Comments from staff on this unit included, "It would be nice if we could give people more time" and, "It would be lovely to have the time to sit with people and give them a bit of a pamper".

Relatives told us they could visit anytime. However they told us it was often difficult to find a member of staff to speak to about the care. One relative said, "Time for relatives to speak with the unit manager would be really useful, but we don't get dedicated time to do this". Another relative said, "The staff all work really hard, it's very hard to get time to talk to them".

People told us that they were treated with kindness and compassion. One person said, "The staff take good care of me, I like it here". Another person said, "The staff are always friendly and kind". We observed caring interactions between people and staff. For example, we saw one staff member gently stroke a person's head and tuck their hair behind their ear. The person responded positively by smiling. We saw another staff member showing a person a photo album. They said, "I've got a nice photo of you". They then showed the person a specific photo and said, "Can you remember last Christmas when this was taken". They sat and spoke about the story behind the photo and the person responded by laughing and smiling.

People's relatives told us staff promoted dignity by ensuring people were clean and smartly dressed. One relative said, "[Person who used the service] is always clean and presentable. The staff work hard on that". We saw that people were supported to change their clothing if required after mealtimes and people received personal care and support in private areas of the service.

Requires improvement

# Is the service responsive?

## Our findings

People told us they were bored and we saw that the promotion of social and leisure based activities varied from unit to unit. One person said, "I'd love to go on a day trip but we don't go on them any more". Another person said, "There's nothing to do I just watch TV". We saw excellent and consistent promotion of activities to meet people's individual preferences on the female unit for people with behaviours that challenged. For example, we saw staff engaged people in meaningful conversation and they facilitated pamper, crafts and food preparation sessions for people. We saw that people responded positively to these activities which reduced the incidents of behaviours that challenged. However, we saw limited or no evidence of the promotion of social and leisure based activities on the other units. Staff told us the activities coordinator was on leave, and they had no capacity to promote activities in their absence. One staff member said, "We don't have the time but we would like to".

We found that staff did not always know people's care preferences. For example, we asked two staff what the activity preferences were of one person who used the service. The information the staff told us did not match the information the person's relative told us. We found that no record of the person's care preferences, such as their likes, dislikes and hobbies were recorded in their care records. This meant staff could not always provide care in accordance with people's preferences as care preferences had not always been sought and recorded.

Some people who used the service were unable to be involved in the planning of their care due to their medical conditions. In these circumstances, we found that the involvement of relatives in the planning of care varied from unit to unit. Relatives on the units for people with behaviours that challenged told us they were involved in the planning of care. However, some relatives told us they had not been encouraged to be involved in the planning of their relations care. One relative said, "I would like to be more involved, I'm not always told about changes". Another relative said, "I'd like to be involved in care planning and have a say. I've not been involved or seen the care plan". People's records did not always show evidence of involvement by people or when appropriate, their relatives.

People did not always receive their preferred care at their preferred time because staff were not always available to facilitate this. One person asked staff to help them move away from the dining room when they had finished their meal. The staff member replied, "In a minute, we have to wait for everyone else to finish". We saw this person had to wait ten minutes before staff were available to assist them to move to another area on the unit.

People and their relatives knew how to complain and they told us they would inform the staff and registered manager if they were unhappy with their care. One person said, "I can go to any of the staff with a problem, they always resolve it". A relative said, "I would go to any of the nurses to complain, but I have never needed to". People and their relatives also told us that when they had complained, improvements to care had been made. One relative said, "I have made complaints and the issues have been addressed". The complaints process was clearly displayed and we saw that complaints had been managed in accordance with the provider's policy.

Requires improvement

# Is the service well-led?

## Our findings

Effective systems were not in place to enable the provider to consistently improve the service. We saw that some quality checks were being completed, but when concerns with quality were identified, action was not always taken to make the required improvements. For example, a quality check on the residential unit in June 2015 showed that evening menus were not being displayed. No action plan was in place to address this issue and we saw that no action had been taken as an evening menu was still not being displayed.

We also saw that prompt action was not taken to address safety concerns. For example, two quality checks over two months showed that the registered manager had identified that the lock on the external door on one of the units was not working. No action plan was in place to show what action needed to be taken and when any action should be completed. This meant the same concerns were identified for a period of two months before action was taken to address the safety concern.

We saw that provider visited the service to assess and monitor quality. However, we could not be assured that these visits were effective. Areas of concern that we had identified such as, the lack of identification of safeguarding incidents and the inconsistent management of risks to people's health and wellbeing had not been identified by the provider.

When areas of concern had been identified by the provider, evidence was not always available to show that action had been taken to address the concerns. For example, in May 2015 the provider had identified that high numbers of people on the nursing unit spent their time in bed. The provider's report showed they had spoken to staff to identify why people remained in bed. Their report recorded that staff had told the provider, 'They are in bed as we don't have enough suitable chairs'. We saw that this was still a concern as staff told us people had to take it in turns to sit out due to a lack of suitable seating. No action plan was in place to show how this concern was going to be addressed.

Although staff told us they felt the registered manager was approachable and supportive, we saw that concerns raised by staff were not always acted upon in a timely manner. For example, staff had shared concerns about one person's safety five months before our inspection. The registered manager had put no suitable systems in place to manage the safety concerns shared by the staff. As a result of this the person fell on seven occasions, with their last fall requiring hospital intervention.

At the end of the first day of our inspection, we fed back the immediate concerns that we had identified to the registered manager and provider representatives. Although the registered manager and provider acted upon some of the concerns immediately, we saw that some of the action taken was not effective. For example, the registered manager told us they had spoken to the kitchen staff about the food quantities on the older persons' mental health unit, yet food quantities were still inadequate on the second day of our inspection.

Relatives told us there were occasional meetings at the service where their feedback was sought. However, they said they did not see any changes to care as a result of the meetings. Improvements were needed to ensure people's feedback was acted upon. For example, the minutes of a meeting held earlier in the year showed that relatives had requested that provider representatives should be more polite and introduce themselves when they visited the service. We saw this continued to be an issue as one relative told us, "It would be nice if the owner and the people who work for him introduce themselves when they come and visit". Staff also told us that the provider and their representatives could be friendlier. One staff member said, "I see that the senior managers' visit, but they never speak".

Some relatives told us they had completed a satisfaction survey, but they had not seen the outcome of this. One relative said, "I have filled in the satisfaction survey, but I've never seen a report about what they are doing in response to what I have told them". We asked the registered manager about this and they said, "I have asked for them, but the surveys all go to the provider, we don't get to see them". This meant people's feedback was not being shared with the registered manager so that improvements to care could be made.

The above evidence shows that the service was not well-led. Effective systems were not in place to consistently assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

# Is the service well-led?

Despite the identified shortfalls of the service, people and their relatives were positive about the overall atmosphere at the service. One relative said, “It’s a nice atmosphere here, the staff are friendly and it’s so relaxed. I chose this home because it didn’t feel clinical, it’s got a nice homely feel”. Another relative said, “The staff all work so hard under challenging circumstances, I think they are absolutely excellent”.

Staff told us they received regular supervision and support from unit managers, the deputy manager and the registered manager. Staff also told us that despite the challenges they enjoyed working at the service. One staff member said, “I feel satisfied when I leave because I’ve been able to help people. It’s the first job I’ve had where I don’t mind coming to work. Another staff member said, “I love my job and I love the residents”.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>**People's dietary needs were not always met as planned. Regulation 14 (4) (a) and (d).** |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Appropriate action was not always taken to protect people from harm. Regulation 12 (1) and 12 (2) (a) and (b) |

**The enforcement action we took:**
We have served the registered manager and provider with a warning notice. This notice informs the registered manager and provider that immediate improvements to care are required by 30 October 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>People were not consistently protected from potential abuse. Regulation 13 (1), (2) and (3) |

**The enforcement action we took:**
We have served the registered manager and provider with a warning notice. This notice informs the registered manager and provider that immediate improvements to care are required by 30 October 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Effective systems were not in place to consistently assess, monitor and improve quality and manage risks to people's health and wellbeing. Regulation 17 (1), (2) (a), (b) and (e) |

**The enforcement action we took:**
We have served the registered manager and provider with a warning notice. This notice informs the registered manager and provider that immediate improvements to care are required by 30 October 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

This section is primarily information for the provider

# Enforcement actions

Diagnostic and screening procedures

Treatment of disease, disorder or injury

There were not always enough staff deployed to meet people's needs and keep people safe. Regulation 18 (1)

**The enforcement action we took:**
We have served the registered manager and provider with a warning notice. This notice informs the registered manager and provider that immediate improvements to care are required by 30 October 2015.