Care Quality Commission

WAYPOINTS (UPTON) LTD

Waypoints (Upton)

Inspection report

1 Dorchester Road
Upton
Poole
Dorset
BH16 5NJ

Tel: 01202620020
Website: www.waypoints-care.co.uk

Date of inspection visit:
17 September 2020
23 September 2020

Date of publication:
20 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Waypoints (Upton) is a purpose-built nursing home registered to provide care for up to 67 people. The home was divided into five separate living units. At the time of our inspection there were 38 people living there. This was due to a major refurbishment that was taking place. The people living in the home had complex care needs associated with their dementia.

People's experience of using this service and what we found
Governance and oversight of the service was not robust: shortfalls and concerns have been identified at this inspection which internal audits and assessments had failed to highlight. Where internal systems had identified issues that needed to be addressed, this had not been done in a timely manner, leaving known issues unresolved.

Since the last inspection, the ownership of the registered provider has changed. The transition between different policies, procedures and ways of working had left staff confused and uncertain.

Systems and management of areas such as the administration of medicines, infection prevention and control and matters relating to the safety of people and the environment were not satisfactory. Records did not show people received their medicines in the way that they had been prescribed, appropriate infection prevention measures were not always maintained and checks and tests of important areas such as fire prevention were not always completed.

Risks to people's health and wellbeing were not consistently managed. As well as living with dementia, many people lived with other conditions or specific needs. We could not be certain that people received the correct support to manage conditions such as diabetes or epilepsy or that areas such as moving and assisting people, preventing skin damage or dehydration were managed effectively.

Staff had not received the required training and competency checks to ensure they had the necessary skills to meet people's needs.

Staffng was provided in accordance with the provider's own policy and assessment tools. We identified times where, due to some people's needs, staff were not always be available for everyone in the home.

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

Rating at last inspection
The last rating for this service was good. (Published 28 August 2019)

Why we inspected
We received concerns in relation to people not receiving the care they needed, staffing and poor

management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control, medicines management, assessment of risk, consent, safe recruitment of staff and governance of the service.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Waypoints (Upton) on our website at www.cqc.org.uk.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not always well-led. Details are in our well led findings below.	**Requires Improvement**

Care Quality Commission

Waypoints (Upton)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by one inspector.

Service and service type
Waypoints (Upton) is a care home. People in care homes receive accommodation and nursing or personal care as a 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 had a manager registered with the Care Quality Commission, although they no longer worked at the service. They had submitted an application to de-register and an interim manager was in place. Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was no longer working at the service and had submitted an application to deregister.

Notice of inspection
This inspection was unannounced. We spoke with the registered manager from the car park to discuss the safety of people, staff and inspectors with reference to Covid-19.

Inspection activity started on 17 September 2020 and ended on 7 October 2020.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four relatives by telephone about their experience of the care provided. We spoke with 13 members of staff including a regional manager and consultant, the interim manager, nurses, senior care workers, care workers and housekeeping staff whilst we were on site. We 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 looked at a range of records. These included sections from eight people's care records and medication records, five additional medicines records and records relating to the management of the service.

Due to the pandemic, we reduced the time we spent in the home and continued the inspection remotely. This meant the registered provider sent us a variety of records relating to the management of the service, staff training and supervision, quality assurance and some policies and procedures, electronically.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We had discussions with the manager via email and the telephone and we contacted all the staff via email to seek their views of the service. Sixteen staff gave us their feedback about the service and we also received information from one professional.

Inadequate

Is the service safe?

Our findings

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

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

Preventing and controlling infection

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed.

● Not all staff had not received the required training in preventing and controlling infection. Fifteen staff were not included in the training records and records for three staff stated that they were on long term absence when all three were seen to be working in the home. We sought clarification from the service regarding this but did not receive a response.

● The provider was unable to assure us they were following guidance by restricting the movement of staff between care services to reduce the risks of infection. A member of agency staff told us that they had recently worked in another service. The manager told us that the agencies they used had been made aware of this requirement and they tried to book the same staff each time but this was not always possible.

● Equipment in the home did not promote safe hygiene practices. None of the waste bins around the home in either communal areas, shared lavatories and bathrooms were hands free to support no touching of possible contaminated surfaces. The manager reported that this had been identified in an audit completed in May 2020 and the service was "buying a few each week".

● In most ensuite facilities, there was no liquid soap in a suitable dispenser for staff use. There were no disposable towels or if there were, they were not in an enclosed dispenser and bins, where they had them, were not hands free.

● Each unit had a small kitchen to make drinks and snacks. Some fridges and microwaves required cleaning. There was no separate hand wash basin in these areas even though food preparation was taking place.

● The arrangements for monitoring cleanliness and recording of cleaning were not consistent. We were not assured that there was enhanced cleaning of frequently touched surfaces.

● Staff did not support people to clean their hands before their meals on the first day of inspection.

● The provider was not meeting social distancing guidance. Lounge furniture had not been arranged to promote this and we saw people sharing two seat sofas or sitting close to one another.

● The provider was not ensuring that Personal Protective Equipment (PPE) was used effectively and safely. A number of staff were observed not to be wearing face masks correctly. One member of nursing staff was wearing a re-usable face mask which is not in accordance with guidelines. A relative told us, "I have video calls with [person's name]. Staff don't always have PPE on during the calls."

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate infection prevention and control was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included the purchase of additional equipment and a review of staff training and compliance with procedures.

● The provider was reducing the risks of visitors catching and spreading infections. Arrangements had been made for outdoor visiting during the summer and a room was being converted during the inspection to enable safe visiting through the autumn and winter. A relative told us, "We have nothing but praise for the management response to this ongoing Covid emergency." Another told us, "I was happy with the measures in place to try to keep people safe and make visiting fair."
● The provider admitted people safely to the service. Arrangements were in place to support people moving into the service or returning from hospital to isolate in their bedrooms.
● The provider's infection prevention and control policy was up to date.
● The provider was accessing testing for people using the service and staff.
● People who were unable to consent to testing for Covid-19 had been tested without the necessary mental capacity assessments, to ensure this was in their best interests, being completed.

We found no evidence that people had been harmed. However, where people were unable to give consent, the requirements of the Mental Capacity Act 2005 and the associated code of practice had not been followed. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included a review of assessments and best interests decisions.

Assessing risk, safety monitoring and management
● Sixteen people had care plans detailing they required a form of restraint on occasions when care was being provided. These plans were not personalised and did not detail triggers for people's behaviours or alternative strategies to manage these
● The majority of staff had not received training to safely restrain people where this intervention was deemed necessary. This meant there was a risk of inappropriate or unsafe restraint.
● Business continuity and emergency plans were inadequate. The emergency plan had not been updated since June 2018. It contained out of date contact details and lacked important information such as how to contact the locations that had been identified as places that could accommodate people if the service needed to be evacuated.
● Fire safety was not appropriately managed. The fire risk assessment was not updated to reflect the building works underway. Actions identified from a fire safety audit in October 2019 had not been taken. We requested further information from the service about this, but it was not provided. Not all staff were aware of the actions to take in the event of a fire.
● Evidence that the required tests and checks of the fire alarm system, fire doors and automatic door releases, sprinkler system, emergency lighting and firefighting equipment had been completed in accordance with government requirements was not provided. The service did not provide evidence that the fixed electrical system had been checked within the last five years and was safe.
● Care plans for people who required support to change position using a hoist did not contain the required detail. Information such as hoist sling type and size was not included. A relative told us about their concerns for their loved one's decline in mobility and added, "I feel the carers are doing their best with limited resources."
● Pressure area care was not always provided appropriately. Some people had vulnerable skin and were

assessed as at risk of developing pressure sores. Repositioning charts and care plans did not always specify how frequently this support should be provided. Air mattresses were in use for some people. Staff were required to complete regular checks to ensure they were operating and set correctly. None of the records checked included what the mattress settings should be. This meant checks were not effective as staff would not know when a setting was incorrect.

● We were not assured that the risks of people choking were well managed. Risk assessments had identified that two people were at risk of choking. Whilst care plans included steps staff should take if a person did choke, the specialist equipment for managing choking which was available in the home was not referred to. The manager stated that only nurses would be expected to use the equipment. They told us that use of the equipment had been discussed during a meeting in 2019 but could not confirm which staff had attended this meeting.

● The provision of diabetes care was not managed safely. Care plans lacked information about the required frequency of testing blood sugars, the normal safe blood sugar ranges for each individual or the action that should be taken when blood sugars were outside of the normal ranges. There was also no information about possible complications such as hypo- or hyper-glycaemic attacks, timing of the administration of insulin or footcare. Diabetes UK advises that a general blood sugar range is between 4 and under 9 mmol/L. We found numerous records where test results were well above this but there was no evidence that any action had been taken in response.

● We were not assured that regular foot care was provided appropriately. Podiatrists for people with diabetes were classed as essential visitors but the service was unable to provide evidence that the required care was provided between lockdown in March 2020 and September 2020.

● We were not assured that epilepsy care was well managed. Two people had not experienced seizures for many months. One person had a care plan advising which medicine to administer if a seizure lasted more than a certain amount of time but there were no other instructions such as the type of seizure, possible triggers or symptoms before a seizure or when to call 999. There was no care plan for the second person. This was not in accordance with national good practice or the provider's own policy and procedure. One person was prescribed specialist medicines to be administered during or after a seizure took place. Staff were not clear about the procedures they should follow if these medicines were required.

● The provision of fluids to prevent dehydration was not always well managed. Some people had been assessed as at risk of dehydration and their fluid intake was being monitored. None of the records had identified a target amount of fluid for each person so it was not possible to be certain whether people were drinking enough. When total daily intake appeared low, there was no evidence that staff had taken any action.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate that risks to people were appropriately assessed, planned for and managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included a review of staff training and compliance with procedures.

Using medicines safely

● The management and administration of various medicines including anitibiotics, medicines to support people when they were distressed, pain relief, and "as and when required" (also known as PRN) medicines were not appropriately managed and overseen. Care plans were generic, did not always include information about the type/name of the medicine, strength, frequency of administration, maximum dose in 24 hours or for how long the course was for. There was also no information about potential side effects or

instructions to review whether the treatment had been successful.
● Arrangements to manage people's pain were not always effective. Some people were prescribed regular pain relief but gaps in medicines administration records showed they were not always given the amounts prescribed. There were no records to explain why this was the case and no pain assessments had been completed for people who were unable to communicate their level of pain.
● The administration of covert medicines and medicines which needed to be crushed to assist people to swallow them were not managed safely. Care plans lacked information and detail and relied on generic statements. Appropriate consultations and agreements with pharmacists to ensure this not have a negative effect on the medicine had not always been completed.
● The administration of medicinal patches was not managed safely. The manager confirmed that no records of the site of application of patches were kept. Manufacturers advise that careful rotation of application sites should take place to ensure that skin is not affected and there is no risk of overdose on the site of administration.
● Not all medicines were stored as required. One product should have been stored in a fridge and many did not have opening dates recorded so it was not possible to identify when they were no longer effective.
● Topical medicines were not stored securely. Prescription labels stated mostly stated "apply as directed". There was no evidence that this had been clarified to determine the area of application, amount to be applied and how often. Records for the administration of topical medicines were incomplete. All the records we checked contained gaps to indicate that medicines had not been administered and no explanation was available.
● We were not assured that staff had the skills to administer medicines safely. The manager was unable to confirm that two nurses had completed the required competency assessment. Care staff administered topical medicines such as creams and lotions. Not all staff had not received training in this area. Fifteen staff were not included in the training records and records for three staff stated that they were on long term absence when all three were seen to be working in the home. We sought clarification from the service regarding this but did not receive a response.
● The manager could not confirm that agency nurses were provided with suitable training or an assessment of their competency to ensure that they understood systems and procedures in the home and could safely administer medicines. There were occasions where an agency nurse was the only person on duty to administer medicines.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate that people received their medicines as prescribed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included a review of the systems in place for the management of medicines.

Staffing and recruitment
● Staff recruitment records were requested but were not provided. This means we cannot be assured that the required criminal record checks and references were obtained to demonstrate that new staff were of good character and had the necessary qualifications, competence, skills and experience to perform their role.

We found no evidence that people had been harmed. However, the information which must be kept and made available in relation to the recruitment of staff was not provided. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included a review of staff recruitment records.

- Staff induction records were requested but not provided. This means that there was no evidence that staff received suitable training and assessment before working with people.
- Systems to record and monitor staff training and competency were not effective, and we could not be sure that staff had received the required mandatory training in areas including moving and assisting people, first aid, the actions to take in the event of a fire or emergency, safeguarding people and diabetes care. Records were not up to date. Fifteen staff were not included in the training records and records for three staff stated that they were on long term absence when all three were seen to be working in the home
- We were not assured that nursing staff had current training in specialist areas of care including venepuncture, catheterisation, wound care and verification of death. Evidence of their training was requested and not provided.
- Agency staff did not receive appropriate formal induction. There were no records to demonstrate that agency staff received an induction that included safety information such as what to do in a fire. Staffing rotas showed that on some night shifts, the person in charge of the home was an agency member of staff.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate that risks to people were appropriately assessed, planned for and managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included a review of staff training and compliance with procedures.

- Staff told us there were frequent situations where people required three or four members of staff to support them and that this then meant there were no staff available on the unit to oversee the other people living there. They also highlighted that many people required two staff to support them, such as with getting up, going to bed, for personal care or for repositioning. They were concerned that, given the night staffing levels, there were times when no staff were available to oversee the other people living in the units. A relative told us, "The care of the residents has deteriorated… There have been occasions when staffing levels have been concerning and dangerous, resulting in residents being left alone in their rooms for long periods of time."
- Prior to the inspection we received concerns that the level of staffing provided meant there were days where there were not enough staff to be able to get everyone out of bed every day. Two staff confirmed this during the inspection. During the first day of the inspection we saw that fifty percent of the people on one unit were still in bed, 20 minutes before lunch was served. Staff said there was only one hoist available which caused delays. We fed this back to the manager who immediately made arrangements to purchase an additional hoist.
- Staffing levels were in accordance with the provider's staff calculation tool, which was used to assess the number of care hours required. Rotas showed that staffing was scheduled in accordance with the hours the tool indicated. Exceptions were due to last minute absence that management had been unable to cover.
- The manager advised that both she and other management staff were all available to provide care whenever they were needed including mealtimes. They said that staff had been told to ask for help but this had not happened.

Systems and processes to safeguard people from the risk of abuse
● Relatives told us they thought people were kept safe in the home, but some reported that, due to the pandemic, it was not always possible to obtain clear information and reassurances.
● The manager had a good knowledge of safeguarding and understood how to raise concerns with the local authority if this became necessary. The local authority safeguarding team told us the service worked well with them.
● Suitable and clear safeguarding policies and procedures were in place and available to staff, people and visitors.

Learning lessons when things go wrong
● Accidents and incidents were recorded. However, analysis had not always taken place. This meant the home may not always be learning from accidents and incidents within the home.
● There was no oversight of events such as people displaying agitation or aggression, the use of safe holding or the administration of calming medicines. This meant that opportunities to identify possible ways to improve support to people, reduce incidents or review staff actions had been missed.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Governance processes were in place but had not always been effective. Audits had not identified all the risks and concerns that have been highlighted at this inspection.
● Where audit processes had identified risks or shortfalls, the response to this had not always been timely, which meant the service continued to operate with known problems rather than taking immediate action.
● Staff were not working in accordance with the provider's policies and procedures. For example, staff did not always work in a person-centred way and were not supported by person-centred, individual care plans to lead them to work in this way.
● There was no oversight of the staff and training. Training records were requested and queried during the inspection. The final documents provided included five staff who were no longer employed at the home and three staff who were noted to be on long term absence and therefore not available for training. All three of these staff were working in the home during this inspection. In addition to this, there were 15 staff who were working and shown on current rotas who were not on the training matrix.
● Record keeping was not always up to date and lacked important detail. Staff were not always certain where they should record information as there were two different systems operating at the service.
● Due to the pandemic, we agreed with the registered provider and manager that they would send us electronically the required records relating to the management of the service, staff training and supervision, quality assurance and some policies and procedures. A detailed list was provided. Some documents were repeatedly requested between 24 September and 5 October and were not provided.

We found no evidence that people had been harmed. However, the provider had failed to ensure governance systems operated effectively to ensure risks were managed, people were protected from harm and improvements were made when required. This placed people at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included the creation of an action plan to ensure that all areas of concern were addressed.

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

outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care
● Since the last inspection, the ownership of the registered provider and the service had changed. The new owners had embarked on a major refurbishment of the building and had plans to alter the model of care that was going to be provided in future. The introduction of new systems and processes had not been well managed; it was not always clear whether staff were expected to operate under the new policies and procedures or were still expected to use the old ones. Two computer systems were running, and staff were not clear what should be recorded on which system.
● The change in ownership had coincided with changes in the existing management of the home and a number of experienced staff had left. This meant the manager and all the provider's representatives supporting the home were new, did not yet fully know the people and staff and were trying to implement changes in almost all areas of care, support and day to day management. The manager acknowledged that this had affected staff and agreed staff morale was low.
● We received differing views from the relatives we contacted. Some were positive about management of the service and comments included, "We have never had any occasion over the years to doubt that [person's name] is being cared for in a sympathetic, properly managed fashion", "If there have ever been any queries or concerns, they have always been dealt with professionally and promptly", "Sadly, due to the restrictions, it has not been possible to build/maintain a rapport with staff", and "I really feel powerless. I don't feel like I have a say in anything that happens to him".
● The registered provider and manager disagreed that staffing levels were lower than those provided previously but recognised that the many changes that had taken place could have led staff to believe this was the case. It was acknowledged the usage of agency staff was higher than they would have liked, and that agency staff were not always as efficient as they did not know people or the home.
● Feedback from relatives was that staff were kind and caring. However, as well as seeing good interactions, many of the interactions we witnessed during the inspection were task-focussed rather than centred on the individual and their needs. Care plans were generic, lacked personal information about people's past lives, things that were important to them, their choices and preferences. This made it harder for staff to know and understand people and contributed to the culture of ensuring tasks were completed above caring for the "whole person".
● The manager advised that none of the people currently living in the home would be able to complete a survey to gauge their views about the service and how it was performing. They stated that a survey of relatives and visitors was underway but, due to the restrictions on visiting, so far, very few responses had been received.

Working in partnership with others
● The manager stated that they received good support from local GPs, other health services including dieticians and speech and language therapists and social care staff. They acknowledged that the impact of the pandemic had made this harder and new ways of working together were being developed.
● The registered provider and manager were responsive to the issues we raised during the inspection and very open to working with other agencies involved such as safeguarding teams and the local fire and rescue service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were unable to give consent, the requirements of the Mental Capacity Act 2005 and the associated code of practice had not been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems operated effectively to ensure risks were managed, people were protected from harm and improvements were made when required. Also, to ensure oversight of the staff, their training and skills.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to provide evidence that staff were recruited and inducted safely means we cannot be certain that people have not been placed at risk of harm.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place, or robust enough, to demonstrate infection prevention and control was effectively managed, medicines were managed safely and that risks to people were appropriately assessed, planned for, and managed. This placed people at risk of harm.

The enforcement action we took:

A Warning Notice has been served and must be complied with by 31 December 2020.