Mrs Keshwaree Ramana

# Coralyn House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This was an unannounced inspection that took place on 10 and 11 February 2016.

Coralyn House provides residential care without nursing to five people with learning disabilities.

The service is owned by the registered provider, who is also registered as the manager of the home.

Risks had not always been managed to keep people as safe as possible. Risk assessment's had not always been completed or updated when necessary, including when people had fallen.

This meant that staff did not always have the information they required to ensure people received safe care.

We could not be confident that people were receiving their medication as prescribed. Not all staff who administered medicines had been trained and assessed as being competent. Current legislation was not being followed regarding the storage, disposal and recording of the administration of medicines. Audits of medicines were not being completed to identify any areas for improvement.

There were sufficient numbers of staff on duty to meet the needs of the people who lived there although records of changes to rotas were not kept.

The recruitment procedure had not always been followed, this meant that one person had been employed without a criminal records check taking place. Staff did not receive induction training when they commenced employment, and did not receive regular supervision or appraisal.

This meant that staff did not receive the appropriate support or professional development to enable them to carry out the duties they are required to perform effectively.

The manager did not undertake a review of the home using a quality assurance system. Areas in need of improvement and oversights were not identified or addressed. Records regarding the safety of the building were not always completed. The home did not have contingency plans in place to be implemented in the event of an emergency.

This meant that the provider did not do all that is practicable to mitigate risks associated with the premises.

The manager was not aware of what training or competency assessments staff needed to complete. Not all staff had received the training the required to meet peoples assessed needs. Staff were not able to recognise or respond to all forms of safeguarding concerns.

This placed people at risk of receiving care that was not safe.

The requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had not been complied with. This meant that where people were being restricted from leaving the home on their own to ensure their safety, this had not always been done in line with the legal requirements. The manager and staff did not have a good understanding of the principles of people being assessed as having capacity or making best interests decisions, particularly around choice, consent and managing people's finances.

People's dignity and respect was not always maintained. Consideration was not always given to how people should receive care that ensured their privacy was maintained.

People were happy with the food and drink that was provided, and were included in menu planning, however people were not involved in the purchase and preparation of food although they wanted to be. The home did not promote peoples independence or self-help skills.

Care plans did not contain all of the relevant information that staff required so that they knew how to meet people's needs. We could not be confident that people always received the care and support that they needed.

People living at the home were able to enjoy outings and holidays on occasions, however opportunities to partake in activities during evenings and most weekends were limited and centred around watching television or shopping in the locality.

The manager was not clear about who was responsible for the day to day running of the home. The manager was unable to answer many of our questions unless she spoke with her husband who was also employed by the home and who undertook the majority of management tasks at the home.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see details of the breaches and the action we have taken at the back of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Medicines were not managed safely.

Individual risks to people were not always identified to ensure people
remained safe at all times.

Staff and management did not understand how to recognise and respond to safeguarding concerns which meant people may not always be protected from abuse and improper treatment.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The manager and staff did not have a good understanding the Mental Capacity Act and their responsibilities regarding this.

Staff did not receive appropriate training and supervision to enable them to meet people's needs effectively.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People's dignity was not always maintained.

Staff knew people well and displayed kindness and warmth when supporting people.

People were happy living at the home

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care documentation had not been maintained to ensure that it was clear, up to date and person centred so that staff had clear guidance about how to meet people's needs.

People's choices were not always sought, and expressed preferences were not always taken into account.

## Is the service well-led?

**Inadequate**

The service was not well led.

The manager had not undertaken training to renew or refresh their own knowledge and competency
The manager did not have an understanding of their requirements and responsibilities as a registered manager.

There was no effective quality assurance system in place to identify improvements needed and ensure that they were carried out.

# Coralyn House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 10 and 11 February 2016 and was unannounced.  It was carried out by two inspectors.

Before we visited the service we reviewed the information we held about it. We reviewed the information we held about concerns or complaints and received feedback from the local authority's quality monitoring team and safeguarding team.

During the inspection we spoke to five people using the service, and three staff. We spoke with the provider who is also the manager for the home.

We reviewed records associated with the care of people, this included medicines records. We checked recruitment records for four staff and training records for the staff team. We also reviewed records associated with the safety, quality and management of the service.

We asked the provider for some additional information to be sent after the visit.

Requires Improvement

# Is the service safe?

## Our findings

People told us "We receive our medicines on time" however we found that peoples safety had not been maintained with regards to medicines.

Staff told us that they knew how to give medicines as they were supplied in a managed dosage system that was straight forward to use. They told us that they followed the instructions on the medication administrations record (MAR) and the monitored dosage system blister packs containing the medicines. However not all medicines had been supplied in the blister packs. For example, we saw that one person had been prescribed and supplied with a medicine by an out of hours GP, but this had not been entered on to the MAR and was being administered without a record being kept.

We asked staff what happened when people chose not to take their medication and if they had been given a process to follow in the event of this happening, such as contacting a senior member of staff or the persons GP. Staff told us that they were not aware of any process to follow if this happens and they had not contacted a GP for advice on occasions when this had occurred.

This meant that risks from when people did not take their medicines were not managed safely and staff did not know what to do when this occurred.

We found that medicines were not stored securely, the key to the medicines cabinet was left unattended in the lock on both days of our visit. Staff told us that this should not normally happen and had been an oversight. Staff told us that they key was usually left in an unlocked drawer when not in use. This meant that access to the medicines could be gained by people not authorised or safe to do so.

We asked the manager for a copy of the homes policy and procedure for the administration of medicines. The manager was unable to locate one during the visit. The provider sent us a policy after the inspection but this was a generic policy and had not been adapted for use in the home. The staff that we talked with during the inspection were not aware of the policy or where to find it.

The home did not have a protocol for the administration of 'as required' (PRN) medicines. One person had a strong pain relieving medicine to be taken as and when required for joint pain. This medicine could not be taken with their regular pain relieving medicine as it would have resulted in an over dose of one particular element of it. When we spoke to staff about how this was managed, they told us that they would not have given the stronger medicine.

This meant that the person would not have received their prescribed pain relief when they required it.

The manager could only provide training records for the administration of medicines for one member of staff. Staff told us that they had not undertaken recent training in the administration of medicines, but had been shown what to do by the manager. However the manager could not provide any evidence that they had completed their administration of medicines training or that they were qualified to train other staff. The

manager told us that she had not completed formal observations of staff administering medicines.

Stock levels of people's medicines were not recorded accurately. The records we reviewed showed one person living at the home as having a supply of medicine that could not be located in the medicines cupboard. It was not clear whether the medicine was missing, returned to the pharmacy or had been taken from stock and used. Medicines were not always disposed of safely and promptly. We found tablets that were not in their original packaging and could not be identified in the medicines cupboard. Staff told us that when people refused their medicine, they put the unused tablets in the kitchen bin. The manager told us that unused medicines are "never thrown away in the bin", but are returned to the pharmacy and recorded in the returns book. We looked at the returns book and found that there had not been any medicines recorded as being returned since 25 March 2013.

This meant that the right amount of peoples medicines were not always in place and people were at risk of not having the medicine they needed.

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

We found that the environment was not always safe for the people living there. Most of the internal fire doors were held open with wedges. We saw on the second day of our inspection that these had been removed. The home did not have contingency plans in place that could be used in the event of an emergency or loss of utilities. The manager told us that they had not considered what to do in this event.

Staff told us that laundry that needed to be sluiced before going into the washing machine was taken into the garden where they used a bucket and hosepipe to rinse away faeces. The home did not have an up to date policy or procedure in relation to good practice to reduce risks of cross infection. This practice meant that there was a risk to people's health and safety as infection control was not always managed appropriately.

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

Peoples risk assessments were not up to date and did not always reflect any changes in need. Staff were not aware of changes that had been made to peoples risk assessments because they did not regularly read peoples care plans. We saw that one person's risk assessment said that they were not at risk of any falls despite the person having had two recent falls, one of which took place shortly before the risk assessment was written. We saw that risks to people who may need to call for support during the night had not been fully considered. People's bedrooms did not have call bells installed, to call for help they needed to leave their bedroom and press a door bell that had been installed on the landing. People who were too unwell to leave their bed or had fallen in their bedroom would not have a way of alerting sleep in staff located on the floor above that they needed help.

We saw that one person had a pressure mat alarm by their bed, we were told that this was in place as it had been identified that it was likely that they were living with dementia. The manager had recognised that the accommodation no longer met this person's needs and there were plans for them to move elsewhere.

The manager told us that people who lived at the home did not display any behaviour that challenges, and that there had not been any event when people were abusive towards each other. We found entries in the daily notes that detailed a physical altercation between two people. One person had a risk assessment that

stated that they can become agitated quickly and could harm themselves or others however this was not mentioned in their care plan and there was no plan to support management of this behaviour in either the care plan or risk assessment. When we spoke with staff about how they would support this person to manage their behaviour, they told us they were not aware that this person needed this, but that they could use skills and experience gained previously.

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

The home did not have an up to date safeguarding policy or contact details for the local safeguarding team. Not all staff or the manager had completed safeguarding training. Staff could not tell us the correct procedures to follow or who to contact if they suspected that somebody had been harmed. The manager was not aware of the correct procedures to follow when dealing with an allegation of abuse.

Staff did not have an understanding of the different forms of abuse that people should be safeguarded from. This meant we could not be confident that people were always protected from avoidable harm or abuse as staff did not know how to report or recognise all forms of abuse.

We saw that when staff were recruited appropriate references and checks were made for most staff although one member of staff who worked at the service as a support worker and maintenance person, had not had a criminal records check (DBS). When we discussed this with them they stated that they only "helped out" but we saw that they were included on the rota for sleep in's and day shifts. This meant that we could not be confident that the service always followed safe recruitment practices.

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

During our visit we spoke to people who use the service one person told us "Staff make us feel safe". Another person told us if they were worried about anything, then they would talk to the manager.

We saw that there were suitable levels of staffing to meet the needs of the people who lived at the home. Staffing levels were planned so that there were more staff on duty in the evening and at weekends which enabled people to participate in activities if they chose too, including using community resources with appropriate supervision and support.

The manager was unable to provide us with accurate records of when staff actually worked and when she was present in the home. Changes to staff shifts, sleep ins and when the manager was on duty were not recorded. For example, on arrival in the home the rota showed that the manager should be in the home. However the staff member did not know when the manager would be arriving.

Requires Improvement

# Is the service effective?

## Our findings

The manager stated that the home's policy was to complete refresher training in safeguarding of vulnerable adults, basic first aid and the administration of medicines on a yearly basis. However we found that this had not been done. We found that out of the four staff employed, one had not completed training since 2013 that was relevant to their role, this included safeguarding of vulnerable adults, basic first aid, administration of medicines and risk assessments, and two staff had not completed any training at all. The manager told us that she had not undertaken updates to her previous training since 2013. The home did not have a system of planning for when staff training would need to take place or identifying what training was required.

A member of staff who had recently been recruited told us that they had not yet received any training and had not yet been given the time to read all the care plans. The same member of staff also told us that they had not been shown any policies or procedures for the home.

This meant that staff did not have all the appropriate skills required in order to undertake their role to support people competently.

The manager told us that they regularly supervised the staff team. However the records showed that that only one member of staff had a supervision record and this was for one occasion in 2015. Staff told us that they could and did speak to the manager when they needed to.

The manager told us that there was no induction programme in place and that induction was informal so did not make a record of this. We saw that one person who worked at the home did not have an induction or training period when they started and were placed to work on the rota on the first day they were employed. During this time there was another more experienced member of staff on duty, however there was a risk to the people living at the service, because they were being supported by a person who did not have the information they required to support them effectively.

The home did not have a system in place for staff appraisal, and observations of staff competencies were not undertaken. We saw that one member of staff had completed a self-appraisal in 2014, but there was no evidence to show that this had been discussed and objectives for the coming year had not been set.

This meant that staff were not adequately trained, skilled or supervised in order to deliver safe care and treatment of people who live at the service.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Two out of the four staff working at the service had not undertaken recent training in relation to the MCA. One member of staff had undertaken training with a previous employer. They were able demonstrate to us that they had a good understanding of the MCA by describing its principals and how they applied them when supporting people.

All the people who live at the home had their medications managed for them, care plans did not detail why people needed this to be done on their behalf.
The manager told us that all the people who lived at the home had full capacity to make their own decisions. However when we looked at peoples care plans, we found that one person had an appointee to manage their finances. The appointee was employed by the home. Another person's care plan stated that they were "unable to understand what is required of her in a particular situation" and required the support of staff to interpret for her. Mental capacity assessments and best interests' decisions in relation to this had not been completed for either person.

Staff gave us conflicting information about which people living at the home were able to go out on their own. Staff told us that one person living at the home was not allowed to leave on her own. There were not any records relating to why this person could not leave the home and a best interest decision had not been made. When we spoke to the manager about this, she told us that she thought that, "Capacity decisions were the responsibility of the social workers."

This meant that the manager was not clear of the needs of the people living at the home, or her responsibilities in relation to the MCA. This also meant that people were potentially being deprived of their liberty without the protection of the law.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that people were supported to access healthcare services when required, hospital passports were available for all people who lived at the service and these were used by visiting health professionals to record information in.

People who lived at the home told us that they were happy there. One person told us "It's nice living here, you get lots of food". Another person told us "We choose what's on the menu". People told us that they were happy with the food they ate at the home and that they worked with the manager to plan menus. Staff told us that the people living at the service were very clear what they did and did not like to eat, for example staff made some spicy Asian meals for people to try, but having tried these, wished to remain with a more traditional menu. The food that was served was well presented and looked appetising.

We saw in one person's care plan that they had been advised to follow a low sugar diet due to suspected diabetes. We observed this person eating a cake, we discussed this with the manager and she advised us that the person's tests had been completed and shown that she did not have diabetes, so no longer needed to follow a low sugar diet. However this information had not been updated in the persons care plan. We saw that one person had previously been assessed at high risk of choking and their care plan stated that they

should only eat soft foods. When we asked why that person's daily notes said that they had eaten a sandwich that day, the manager told us that the person no longer required a soft diet, and could now manage to eat a normal diet. There was not a risk assessment to manage this change in support or guidance for staff to follow. There was no evidence that a speech and language therapist had been involved in this persons care or assessed their needs.

This meant that peoples identified needs for nutrition and hydration were not always monitored and managed effectively.

Requires Improvement

# Is the service caring?

## Our findings

We saw that interactions between staff and people who live at the home were warm and respectful, and that people appeared relaxed and at ease when talking to staff. Staff told us how they treated people with dignity and respect and how they met people's needs. Staff told us that they ensured people were offered choices, for example when choosing what to wear, or when being offered a drink. Staff knew how people made choices, such as pointing at an object if they were not able to verbalise.

During our visit people were very keen to show us their bedrooms. They had been decorated to their preference and personal items were on display including family pictures and pieces of their own artwork. We saw that staff always knocked on people's doors and waited for a response before entering.

We saw one person have their eye drop medication applied at the dinner table while people were still eating their evening meal. The person was not asked if they would like to have their eye drops administered in a communal area or whilst eating their meal. The other people living at the home were also sitting around the table eating their evening meal, and could see this taking place whilst they were eating.

This meant that people's dignity and respect were not maintained at all times.

People were not always routinely involved in making decisions around their care, treatment and support. People were able to contribute as part of a group to meetings to discuss menus and activities, but there was not a mechanism to discuss their own individual needs. Information kept about people was not always accurate, and the manager did not ensure this information was updated although they knew this to be the case.

People living at the service were not included in creating or updating their care plan. People told us that they had not seen their care plans, but would like to. Care plans were locked in a filing cabinet in the office, this meant that they were not accessible unless the manager was at the service to open it. We heard the manager tell people that if they wanted to see their care plan, then they would arrange for this to happen.

Requires Improvement

# Is the service responsive?

## Our findings

We found that care plans were not always accurate or contained the information required to provide sufficient guidance to staff to enable them to support people in a person centred way.

When changes in people's needs occurred, care plans were not always updated to reflect this. For example we saw that one person's care plan did not contain information about their continence management needs and risks were not identified or managed.

One member of staff who had recently been recruited told us that they had not yet had the chance to read peoples care plans, she told us she used prior knowledge from working in care to support people.

Other staff we spoke to had worked at the home for some time and had a good understanding of peoples support needs. Their knowledge was up to date regarding changes in needs for people using the service and was more detailed than that contained in the care plans. Staff did not refer to care plans whilst supporting people, however we could see that experienced staff had shared information about people with newer staff.

Care plans did not contain information that detailed people's likes and interests, or what activities people spent their time doing during the week. All of the people who lived at the home used day centres during the week, however there were options offered that people could choose from on a regular basis during evenings and weekends. People mainly chose to watch television or visit the local shops. People told us that they always went on an annual holiday arranged by the home that was very much enjoyed, this included visits to other counties. They also told us that occasionally trips out to places further away were organised.

Two people told us that they would like to help with the cooking but were not allowed in the kitchen other than to access other rooms as they may fall. When we asked whether they could use a chair, they told us "[staff member] would not like that". The persons care plan and risk assessments did not make any references to people not being allowed in the kitchen area or being at risk of falls. During our visit we saw that people living at the home did not enter the kitchen area.

One person told us that they would like to have a lie in at weekends, but were not allowed. The manager told us that as far as they were aware, people wanted to get up at the same time every day. We asked the manager whether people had been asked about what time they would like to get up, or if people would be able to change their minds from day to day. The manager told us that people had not been asked about this but they would do so now. This meant that people were not always able to be actively involved in making decisions about their care and support.

This meant that people were not actively involved in the planning of their care, and their preferences were not always sought and included.

We saw that one person had a pressure mat in place to alert sleep in staff should they get out of bed. We were told that the pressure mat had been put into place as it was thought that the person had begun the

onset of dementia as they were walking around at night time. The persons care plan had not been updated to reflect this change, and staff had not received training in supporting people living with dementia. The home had not reassessed the needs of the person to see if additional support is required at night time as the service does not have waking night staff.

This meant that people did not always have their individual needs regularly assessed and met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who live at the home had regular meetings with the manager of the home, where they could discuss day to day issues such as preferences for mealtimes and outings.

There was a complaints procedure in place. The manager stated that there had not been any complaints received. The procedure was not in a format that was suitable for the needs of the people using the home, however they were aware of who they could speak to if they were not happy. Staff knew what to do if a complaint was received.

The manager did not have a system in place such as a survey to see if people living at the home were satisfied, however during our visit people told us that they were happy and were having their needs met.

Inadequate

# Is the service well-led?

## Our findings

During our visit it was not clear who was managing the home on a day to day basis. Although the registered provider was also the manager she was unable to answer most of our questions unless she spoke with her husband who was also employed by the home. The manager stated that she thought her husband undertook the registered manager duties. Most systems that were in place for the running of the home, such as staff meetings, meetings with people living at the home and staff rotas were undertaken by the manager's husband. During our discussions with both they were unclear as to who had the day to day responsibility of the running of the home.

There was a lack of effective quality assurance systems being used to drive improvement. For example, care plans had not been audited which meant that the inaccurate information we found during this inspection had not been identified. The medication audit consisted of counting the amount of medication that was in stock. However we found that this was not accurate. There was no system for auditing of the storage, administration or recording of medication.

There was no system in place monitoring that the safety of the service being provided. For example, that regular fire safety checks were completed or that risk assessments had been completed and reflected people's changing needs.

The manager was not aware of what training and competency assessments staff were required to complete or had completed, for example staff had not completed a formal induction qualification but the manager thought they had. The managers own training had lapsed but she continued to show staff how to administer medication even though there was no evidence to show that she was  competent to do so.

There was no system in place which clearly indicated what training the provider expected staff to complete, if they had completed it and if a refresher course would need to be undertaken. The manager could not recollect when they had last undertaken any training themselves and was not aware of the Health and Social Care Act and the associated regulations, guidance and best practice information that was available. Policies and procedures were not available to staff and were out of date and inaccurate. The polices used were generic and had not been adapted to the home. The manager could not find several of the policies requested during the inspection.

The manager told us that staff had undertaken training, supervision and induction, but when asked to provide records relating to this, gave us conflicting and inaccurate information so we asked for written information to be sent to us.  The information sent to us showed that at the time of our visit, staff had not undertaken the training or induction required in order to meet the needs of the people living at the home, and the supervision of staff had not taken place in accordance with the homes  own policy.

Records about the safety of the premises were incomplete, the weekly checks of fire detection and safety equipment between April and September 2015 had not taken place and this had not been identified through a quality assurance system.  The manager was unable to provide us with any evidence that quality

assurance systems were used at the home.

The home did not have emergency or contingency plans in place. Staff could not tell us what they would do in the event of a situation that meant the home could not operate, other than to dial 999.

The manager was not transparent or clear when responding to our questions. The manager told us that people living at the home all had capacity to make decisions and that nobody living there required support to manage their behaviour. However when we looked at peoples care plans, we saw that that some people living at the service had appointees in place to manage their finances, one person's appointee was a member of staff working at the home

The home did not have an up to date whistleblowing policy, staff had not completed training in whistleblowing and were not aware that they could do this if they had concerns relating to the home.

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

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 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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered person did not have suitable arrangements in place to ensure people received person centred care to meet their needs and reflect their preferences. Regulation 9 (1) (c) & 3 (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not protected from the risks associated with not having proper safe management of medicines, infection control and risk assessment. Regulation 12 (2) (a), (d), (g) & (h). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 13 HSCA RA Regulations 2014 |

| | |
|---|---|
| personal care | Safeguarding service users from abuse and improper treatment<br><br>People were not protected from abuse and improper treatment because systems and processes were not established or operated effectively for the safe recruitment and training of staff or what procedures to follow when dealing with an allegation of abuse. Regulation 13 (1) & (2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a). |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b) (c) |

**The enforcement action we took:**

We have taken enforcement action to secure improvements we will report on this when this is complete.