We Care Residential Homes Ltd

The Kilkenny Residential Care Home

Inspection report

Kilkenny Residential Care Home
6 Third Avenue
Frinton On Sea
Essex
CO13 9EG

Tel: 01255672253

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16 April 2019
24 April 2019

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service: The Kilkenny Residential Home is a residential care home for older people situated in Frinton on sea. The accommodation is located over two floors. There were eight people living at the service on the day of inspection.

People's experience of using this service:

The service failed to manage and mitigate fire safety. We referred the service to the local fire authority

The service failed to have appropriate and detailed evacuation plans in place for staff to follow.

The provider failed to maintain the environment to ensure it was safe for people living in the service. We have recommended a maintenance schedule is implemented to address environmental improvements.

Staff and relatives told us there were insufficient staff in the service.

People's medicines were not managed safely

Mental capacity assessments were not always completed in line with law. We have recommended mental capacity assessments are reviewed.

Staff and relatives told us the service failed to provide adequate and meaningful activities for people

The service was not well led. The provider and management lacked oversight of the service.

Systems were in place to monitor the quality of the service; however, these were not effective and failed to highlight concerns raised during the inspection.

End of life care plans were not always in place for people. We have recommended end of life care planning for people is developed.

The service failed to encourage staff to maintain and develop their knowledge and skills.

Staff respected people's privacy and dignity but failed to interact with people in a caring and compassionate way.

Staff and relatives told us the service failed to provide adequate and meaningful activities for people
Rating at last inspection: Good (report published 20 October 2016.)

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: Action we told provider to take (refer to end of full report)

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvement.

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

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 effective? The service was not always effective . Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not Well-Led Details are in our Well-Led findings below	**Inadequate**

The Kilkenny Residential Care Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: This inspection took place on 16 and 24 April 2019 and was unannounced. The team consisted of two inspectors on day one and one inspector on day two.

Service and service type – The Kilkenny Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission (CQC). A person was in the process of making an application with CQC to become the registered manager. Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of inspection, the manager had applied to the commission to be registered.

What we did: Before the inspection, we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must let us know about, such as safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We sought feedback about the service from the local authority and other professionals involved with the service. The provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they

plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

●Fire safety arrangements placed people at potential risk. A fire risk assessment was in place, but records identified it had not been updated since 2013. An audit by the local fire and rescue in December 2017 found the service non-compliant. Some improvements had been made however we could not see all actions had been taken to mitigate risk. We raised this immediately with the provider and asked for immediate action to be taken. This was checked again when we returned to the service on 24 April 2019 and this had been updated. Due to our concerns about people's safety we referred our concerns to the local authority Fire Service on 16 April 2019.

● Risk assessments relating to the environment were not robust and did not mitigate risk. This included Personal Emergency Evacuation Plans (PEEP) for use in case of an emergency. Staff were not able to tell us what they would do in an emergency and how they would evacuate people. This was raised with the manager immediately. We checked again when we returned to the service on 24 April 2019. We found PEEPs had been updated and training had been arranged for staff.

● People's care plans contained limited assessments of potential risks, in relation to physical and verbal behaviours. Two people were identified by the provider as having behaviours that challenge. Records lacked detailed guidance for staff on how to mitigate these risks, in the least restrictive way.

● Staff did not always understand people's risks and support people to minimise these. We observed two people become agitated with each other, however staff did not intervene to reduce this. Inspectors intervened and asked staff to de-escalate the situation. Staff told us they did not always read care plans or risk assessments. One member of staff told us, "I have no time to read care plans and risk assessment. I don't even have time to get a break".

● Equipment was maintained included hoists, fire alarm systems and stair lift.

Using medicines safely

● People's medication was not managed well. People were not always supported to manage their 'as required' medicines. Where people exhibited behaviours that may challenge others and put people at risk of harm 'as required' medication was in place. However, staff did not always understand how and when to administer this. One person was prescribed medication to reduce anxiety. Both staff on shift did not know what this medication was. One staff member told us, "I don't have a clue what the medication is for and when to give it to (person)." We raised this with the provider and asked for a protocol to be put in place immediately. Before we left, this had been put into place.

● Medication Administration Records (MAR) were not always kept in line with national guidelines. Records showed multiple missing signatures. One person's medication had been hand written onto a MAR sheet without dosage information. Records showed that staff had not recorded the amount of medicines received in the home in line with the national guidelines. This meant staff would not always be able to easily check what medicines are there and if people had received these. Despite this, we completed a stock check of

medicines and found that stock levels held were correct.
● Policies and procedures were in place to manage medicines. However, these were generic and not specific for the service. We raised this with the provider and asked for this to be rectified.
● Staff told us they had received training and had been assessed as competent.

Staffing and recruitment
● Staff and relatives told us there were not enough staff to meet people's needs. One relative told us, "I have questioned the staffing levels in the home especially after (person) was involved in an incident with another person. Staff were somewhere else, so no one was there to deal with it." One staff member told us, "There are not enough staff. We are running around like headless chickens and can't spend time with residents especially when they are calling for you. I haven't got time to do see them. There has been a couple of times in the lounge when staff member is upstairs, and one is in the kitchen and a person has shouted for us to support and I have had to leave the kitchen with cooker on which is dangerous." Another told us, "I think there should be two awake staff. There has been a couple of falls where the asleep worker has had to be awake and then has to work the next day."
● The manager also raised concerns about staffing levels. They told us, "Staff have fixed hours so in theory all care hours are met. However, if someone goes sick or is on holiday, hours need to be covered but this is not understood by the provider. Staffing levels are only safe because I can come in or we have goodwill of staff, but this won't always last. I am not allowed to use agency staff."
● Rota's confirmed shifts were covered by staff and the manager. However, staffing levels had not been based on assessed on people dependency levels. The manager told us, "The staffing levels have always been like this, before I even started and have stayed like this. When I tell the provider we need more staff, I am told we have no vacancies, so I cannot get anymore." We discussed this with the provider who confirmed this was correct.
● Recruitment processes were not always safe to ensure staff were fit to carry out their role had been completed. Records of two staff found photographic identification or any proof of address had been requested to verify identity. This was raised with the provider who was not aware that this was a requirement.

This was a breach of Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Learning lessons when things go wrong
● Accidents and incidents were recorded but it was not always clear how these were monitored by the manager.

Systems and processes to safeguard people from the risk of abuse
● Staff knew how to recognise abuse and protect people from the risk of harm and abuse. The provider had reported abuse to the local authority and Care Quality Commission when it was identified.
● Staff told us they had not raised a safeguard but had received safeguarding training. Staff had a good understanding of what to do to make sure people were safe. One member of staff told us, "If I saw something I would straight to my line manager and do a report of what I had seen as evidence. If it involved the manager, I would go to the owner."

Preventing and controlling infection
● The environment was mostly clean and fresh. Relatives told us staff understood and followed infection control procedures. One person told us, "I do think the home is clean." Another told us, "The home is always clean. The cleaner is always in and out and is good with my (person) and knows them well as they don't like the noise of the vacuum so leaves it until (person) has gone."

● Staff told us they had received appropriate training in infection control and knew how to prevent the spread of healthcare related infections. One staff member told us, "I wear gloves, general Personal Protection Equipment (PPE) and have masks too if we want them. After every task, I generally wash my hands and if someone has flu, we isolate them to prevent it spreading."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

● Staff told us they had did not have the training they needed to support people's individual needs. One staff member told us, "There has been a times when we have had people with more mental health issues who have been violent, and we have not had training on how to deal with this. During an incident last year, I restrained a person because I just reacted to protect myself. I didn't know what to do. I now know I shouldn't have used restraint." Another staff member told us," I wouldn't mind more training on how to deal with challenging behaviour as I have not done any." Training records showed that staff had not completed this training.

● Three members of staff told us they had not received training on how to use the evacuation chair although this had been identified as required to evacuate specific people. One staff member told us, "We do have an evacuation chair in the home, but I have not had training on how to use." Another member of staff told us, "I have not had any training on how to use the evacuation chair." This was raised with the manager immediately. We checked again when we returned to the service on 24 April 2019. We found training had been arranged for staff.

● Training was completed through e learning and included safeguarding and manual handling. Not all received face to face manual handling training in the use of equipment. One staff member told us, "I have not had training here, but I have prior experience on how to use the equipment." The manager told us that some staff carried over training from previous employment where it was in date. One staff members training had been completed at a domiciliary care agency. The person had not received any competency assessment to ensure the training was appropriate.

● Staff received an induction programme although feedback was mixed on its quality. The induction included policies and procedures and meeting people in the service One staff member told us, "When I started I had an induction, but it was only had one night because they were short staffed. It was with one of the seniors and showed me the ropes and one or two nights later, another person took me through fire safety. On my second shift, I learnt the policies and procedures, and someone pointed things out." Another told us, "I came in on a couple of shadows shifts and did some shadow of medication runs and see what they do."

Adapting service, design, decoration to meet people's needs

● Improvements had not been made to the environment since the last inspection. We found several issues that needed to be immediately addressed. This included exposed radiators and pipe work both in communal areas and people's bedrooms. We found radiator covers in people's bedrooms were not safely secured to walls. One person's bedroom window on the first floor did not have an appropriate window restrictor, exposing people to risk of falling. We immediately raised this with the provider and asked for this

to be rectified. This was checked again when we returned to the service on 24 April 2019. Some actions had been taken including the window restrictor. However, radiators and pipe work had not been covered. We asked for this to be addressed immediately to mitigate risk posed.

We recommend a planned maintenance schedule of works is developed for the service to improve the environment.

● People's rooms were personalised, accessible, comfortable and decorated with personal items. One relative told us, "(Person) friends went in and took some pictures and has a few things they wanted. (Person) told me they like the furniture in their room."

Staff working with other agencies to provide consistent, effective, timely care
● Staff did not always communicate effectively with other staff. Inspectors were told that an incident had occurred at the weekend involving people living at the service. Two staff were asked about this incident and both confirmed they were unaware of the incidents. We raised this with the manager immediately and asked for this to be discussed immediately

Supporting people to live healthier lives, access healthcare services and support
● Relatives told us people were supported with their healthcare. One relative told us, "Staff are good at getting someone out straight away, no hesitation." However, one person had lost significant weight over a five-month period. An assessment highlighted this however no referral was made to appropriate healthcare services. We raised this immediately with the manager who told us, "I agree, this should have been referred to the dieticians." A referral was made immediately before the end of the inspection.
● People had detailed notes in their health folders so that staff and or visiting health care professionals could access information they might wish to know about the person's needs.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met

●Staff told us they had received training in MCA and DoLs. One staff member told us, "I did do some training in mental capacity." However, on speaking to staff, we found they did not have a full understanding of fluctuating capacity. One staff member told us, "For some areas, one person does have capacity and some areas not, but I am not too sure which ones." We spoke to the manager who confirmed that the person had fluctuating capacity.
● People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice. Related assessments and decisions had not always been completed properly. One person's capacity assessment had not been fully completed in line with legislation. We raised this with the provider who said they had completed these but were not fully aware of what they needed to do.

We recommend the provider review mental capacity assessments to ensure they are compliant with MCA 2005.

● Continuous supervision and control, combined with lack of freedom to leave, indicated a deprivation of liberty, and the provider had applied for this to be authorised under DoLS.
● Staff understood the importance of gaining consent before providing support. Observations of staff and people showed this. One staff member told us, "I always ask a person if they are happy for me to do something and if they refuse I won't do it. If someone refuses, I accept their choice, write it down and hand it over."
● The manager understood their responsibility to apply for DoLs as needed and their responsibility to inform the commission.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before admission to service. However, there were inconsistencies with the level of information recorded for people. Some people had not been appropriately assessed.
● Care plans had been developed from these assessments. However, the care plans were incomplete and lacked detail.
● Some people had not had their choices and preferences regarding care recorded. It was unclear if this was because they had not been assessed or because there was a recording error.

Supporting people to eat and drink enough to maintain a balanced diet
● Relatives told us people received choice with food and drink. One relative told us, "We had a party at the home recently and there was lots of choice of food and drink for people." The manager told us, "The menu is a three-week rolling menu and the choice is there for anyone. (Person) will only eat certain foods and is offered choice, but we tailor to whatever they want. Afternoon staff will come in and generally sit with people and talk about what we've got for dinner and see what they want." Fluids were available in the lounge area for people to access. People accessed the kitchen whenever they wanted or asked staff for drinks as needed.
● The service promoted healthy eating. One staff member told us, "We have one person who lives here who will follow the newest diet that they have read in the newspaper. We have some bizarre requests from them but will always make whatever they want. (Person) always tells us this how they have lived so long" One relative told us, "I think (person) has put on weight since being in the home."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always well-supported, cared for or treated with dignity and respect.

At the last inspection this domain was rated good.

Ensuring people are well treated and supported; equality and diversity

- Staff did not have the skills and time to give people support. Staff told us they recognised when people needed support. However, they did not always have time to give it.
- During observations, people did not receive meaningful contact from staff. One person was observed to be sat in the lounge for significant time without any interaction. Relatives told us there was a lack of stimulation in the service. One relative told us, "(Person) has always been active but I knew that the home didn't have much activities. I raised this with the provider who agreed to change key worker so (person) could get out more. This only lasted a few weeks and stopped."
- People did not have detailed personal profiles recorded giving a life history to staff. Relatives told us staff knew people well and but did not always this information to support people. One relative told us, "I had already done a life folder for (person) when they moved in, but this is in ha draw and I don't think staff use it." The manager was aware this was not in place and told us, "I want to introduce life books. I have been speaking to other care homes about how they have done this. We are looking at pulling photos from when they can remember and work out how best to put them together for people."

Respecting and promoting people's privacy, dignity and independence

- A relative told us staff did not always promote people dignity. One relative told us, "Sometimes I go in and (person) hasn't always washed or shaved and I find it depends on what staff are on shift. I think this happens because there aren't enough staff on. On one occasion (person) came home for a visit and was unwashed, unshaved and had stains on their clothes. This caused emotional distress to the family because (person) was always so well dressed and looked after when they lived at home."
- We observed staff promoting people's dignity. This included knocking on bedroom doors before entering.
- The service followed data protection law. The information we saw about people was either kept in lockable cabinets in locked offices or on password protected computers.

Supporting people to express their views and be involved in making decisions about their care

- Relatives told us they were involved in people's care. Where appropriate, an independent advocate was involved to ensure that the person's best interests were central to any decision making.
- Resident meetings were held regularly. Minutes from these meetings showed people had discussed activities they wanted as well as any other issues.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Relatives and staff told us people weren't always able to follow a variety of interests and activities. An activities rota was displayed in the service. However, no meaningful activities took place during the inspection. A relative told us, "There's not much going on in the home really, they don't really have much going on and I don't think they get (person) out as much as they could."
One member of staff told us, "It would be good to have another member of staff in morning or afternoon so that we can do activities with people. We do have a list of activities, sometimes we have time do this."
Another member of staff told us, "Management say there are things going on for people, but they don't happen. The television just goes on as we don't have time for people. We have a games cupboard, but they don't get used much, only if we have time in afternoon, but people are sleepy. People go out when we can, but this depends on staff."
● People's needs had been assessed before they moved into the service. However, a detailed care plan had not always been developed to ensure these needs were met. The manager and staff told us that this was because staff know people but do not always write it down.
● People's care plans were not always detailed and had clear information about specific needs, personal preferences, routines and how staff should best support them. One care plan lacked information about likes, dislikes, behavioural triggers. Care plans had been regularly reviewed however they had no always been updated to reflect people's changing needs. However, this had not impacted on the care provided as staff knew people.

End of life care and support
● At the time of inspection, no-one was receiving end of life care. However, the manager knew how to access support from other healthcare professionals.
● Staff told us they had not received end of life training One staff member told us, "I don't think I have done training in End of Life. I feel I would like this to help me." Another member of staff told us, "I have not had any training in end of life. We had someone die and it was the worst experience of my life. I had to do things I had not had training in."
● Documents to record the arrangements, choice and wishes people may have for the end of their life were not always in in place to ensure peoples final wishes were met. One person's care plan had no information about their wishes or preferences, nor had it been explored. A relative told us, "The home hasn't spoken to us about (person) end of life plan."
We spoke to the manager who told us that following the inspection, this would be implemented into care plans

We recommend the manager develops, explores and implements end of life Care plans for people

Improving care quality in response to complaints or concerns

● A complaints process and system were in place and displayed in the service for people and relatives to follow.

● People and relatives told us they were able to raise complaints or concerns but had no reason to complain. One relative said that they felt able to speak to the manager at any time. They told us "I have not had to make a complaint but if I did, I would go to the manager first to sort it out"

● The service had received compliments since the last inspection. One compliment to the service said "(person) was in a home that gave not only good care but love and kindness which was a great comfort for me."

Inadequate

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Staff told us that the service was not well led. One staff member told us, "The service is not well led because we do not get enough support from the management." Another member of staff told us, "It's not well led because staff are not listened to by the manager."
● Quality assurance processes were ineffective. The lack of robust quality assurance meant people were at risk of receiving poor care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively. The manager completed audits monthly and quarterly audit including medication and environment, however issues identified on inspection had not been picked up on. The provider visited weekly however had no formal oversight of the service. The manager told us, "I see the provider weekly. When the provider is here, most of their time is spent doing the shopping. They do not complete any provider visits but spend the day coming in and out of service"
●The service did not have a manager registered with the Care Quality Commission (CQC). A person was in the process of making an application with CQC to become the registered manager. Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of inspection, the manager had applied to the commission to be registered.
● The manager lacked oversight of what was happening in the service. The manager undertook care hours as well as their management role. This had impacted their role as manager. They said, "If a member of staff goes sick during the day, I would have to cover the day shift. If I was already covering the night shift I would have t get a couple of hours sleep then cover it. This has happened before. The biggest impact of this has been on the paperwork such as care plans not being completed or updated."

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

Continuous learning and improving care
● Incidents did not prompt learning to improve care. For example, records showed an accident involving a member of staff on 11 April 2019. The cause of this was poor lighting on a landing area. It was highlighted during inspection that lighting was still poor and posed a potential risk to people and staff. We highlighted this with the provider who was not aware of the incident. Following the inspection, we were told action was taken to rectify this. We discussed with the provider concerns relating to the environment. The provider told us, "I was aware that the radiators needed to be done but it was just one of those jobs we never got around to."

● Staff told us they were not supported to develop internally in the home. One staff member told us, "There is no encouragement for staff to progress and I have asked but they don't encourage this at all."
● Where audits were not effectively in place in the service, issues were not being identified so improvements could not be made.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● Relatives and staff gave us mixed feedback on the on the manager. One relative told us, "The manager is ok and is visible from what I have seen when I have visited." Another relative told us, "My chats with the manager are never hurried and they have time for me and is very informal." A member of staff told us, "If I don't hang on every word the manager says and agree with them, then he doesn't want to know and will ignore me."
● The ratings from the previous inspection were on display within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they received supervision of their performance and had team meetings. However, staff told us suggestions for improvement which were considered and acted upon by the management team. One staff member told us, "When you ask for something, we are told it will be looked at it, but never happens." Another staff member told us, "When provider is not in the home, the manager won't support us. I have asked, and the response is always I'm busy."
● Relatives had completed a survey of their views. Feedback was collated, and an overview produced by the manager but was not shared with relatives.
● The manager and staff team knew people and their families well which enabled positive relationships. However, staff did not have time to develop these
● Relatives told us they were involved about peoples care in a meaningful way. One relative told us, "If there are any changes in (person) life, staff will always let me know. Whenever I call up, I will always ask how (person) is doing and staff will always tell me in detail." Another relative told us, "Staff and the manager always tell me what is happening."

Working in partnership with others
● The service was connected to the local authority's training programmes. The service had recently become involved in the PROSPER project. Prosper is an initiative aimed at improving safety and reducing the risk of harm to vulnerable people.
● The service was part of the 'Red bag scheme.' This is a collaboration between care homes and the NHS to share vital information about people's health and to improve the transition process between services.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(2) The registered person was failing to ensure people's safety from the risk of fire, unsafe medicine practice and unsafe staffing levels.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (a) (b) The registered person's quality assurance systems were ineffective