A.G.E. Nursing Homes Limited

Brockfield House

Inspection report

Inspection report
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on the 21 and 23 April 2015.

Brockfield House provides accommodation for people requiring nursing care. The service can accommodate up to 45 people. At the time of our inspection there were 41 people using the service. The service provides nursing care to people that are living with dementia and enduring mental health and physical conditions.

There was no registered manager in post. The provider had appointed an interim manager to manage the home, while they appointed a new registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Staff were not always deployed effectively to preserve people's health or safety. There was a lack of risk assessment and measures in place to mitigate risks to people's safety. Staff had an inconsistent level of knowledge to ensure safeguarding procedures were adhered to. Medicines were not always given as they were prescribed. There were safe recruitment practices in place to protect people from the risk of unsafe staffing.

People could not always be assured that consent had been obtained in line with legal requirements. There was a system of basic staff training but this did not equip staff to care for people. There were systems to monitor people at risk of not eating and drinking; however these were not applied consistently. The premises were not maintained to an acceptable standard. People did not always receive safe and effective support to access a range of health and welfare services.

The systems for communicating with people and their relative's needed further work to be effective. People were not always given choices about their care and the arrangements for people's privacy and dignity and supporting independence required improvement.

The systems for planning people's care needed developing to show how people and their relatives had been involved. There were some arrangements in place to support people to undertake a range of social activities and pastimes. The provider had a complaints system; however staff were unaware of the need to report complaints and concerns to the interim manager.

The management and monitoring of the service had been unstable and there was a lack of leadership. The systems in place for measuring the quality of the service needed to be re-established to become operational. The arrangements for supporting staff to understand whistle-blowing procedures needed further work.

The provider took a range of actions following our inspection and is working with an external management consultancy company to support the improvement in the home. They have also stopped admissions into the home while improvements are being made.

We identified a number of areas where the provider was in breach of Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end to this report the action we have asked them to take.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

The purpose of special measures is to:

· Ensure that providers found to be providing inadequate care significantly improve.

· Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

· Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staff were not deployed to ensure people's safety.

People did not receive safe care due to lack of risk assessment and management.

People were not safeguarded from the risk of abuse.

People's medicines were not managed appropriately.

There were safe recruitment systems in place.

Is the service effective?

Inadequate

The service was not effective

Procedures for obtaining consent were not adhered to.

Staff were not trained to meet people's needs.

People at risk of not eating and drinking received a lack of support

The premises was not always suitable or to a required standard of cleanliness.

People did not always have access to a range of health professionals involved in their care.

Is the service caring?

Requires improvement

The service was not always caring.

People did not always receive a choice about their care.

People did not always receive care that was respectful of their need for dignity and independence.

Is the service responsive?

Requires improvement

People and their relatives were not fully involved in care planning.

Staff did not always understand how to deal with people's complaints

Is the service well-led?

Inadequate

The service lacked operational management and monitoring to ensure safe care.

Risks to people's health and safety were not always identified and managed.

Staff were not always aware of whistle-blowing procedures to protect people living at the home.

Brockfield 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 unannounced inspection took place on the 21 and 23 of April 2015. The inspection on the 21 April 2015 was undertaken by two inspectors. The inspection on the 23 April 2015 was undertaken by three inspectors and an inspection manager. This was a responsive inspection as significant safeguarding concerns had been received about the service.

Before the inspection, we looked at information we held about the service including statutory notifications. A notification is important information about events which the provider is required to send us by law. We also spoke to health and social care professionals and service commissioners. They provided us with information about recent monitoring visits to the service including the outcomes of safeguarding investigations.

During this inspection we spoke to the provider, a senior manager who worked for the provider and the interim manager of the home. We spoke with eight care staff, a business administrator and two qualified members of staff. We also spoke with four people's relatives. We undertook general observations in communal areas and during mealtimes. 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 reviewed the care records of three people who used the service and six staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Inadequate

Is the service safe?

Our findings

There was a failure to accurately assess risk and implement measures to reduce the risk of unsafe care. For example we observed staff locked people's bedroom doors from the outside. Although the doors could be opened from the inside by activating the handle; many of the people were being cared for in bed at the time of this inspection would be unable to open the door from the inside. We observed that staff in charge of monitoring people's bedrooms did not always have a key to open people's doors. One staff told us that keys went "missing". Another staff said "I am unsure what to do if there was a fire and people were in a locked room". We also observed that there was a lack of accessible call bell system in place to enable people to call staff for assistance. We saw that people had communication difficulties and were unable to call for help; we observed other people called out for staff from their bedrooms. Staff told us that people relied on staffing checking them. The provider had no risk assessments in place which considered this situation or planned additional safety measures to reduce this risk in the event of events such as a fire or a medical emergency.

The team of staff were not deployed to respond to people's changing needs. For example we found several people in their beds who were in an unclean condition and required immediate staff intervention. We observed that staff appeared unaware that the people required attention and there was a lack of co-ordinated approach to deploying the staff. One qualified member of staff told us this was a frequent occurrence and relatives had complained that people had been left in an unclean condition. They said "I have also found people who need changing myself and have had to ask staff to check everyone". We found that the team of staff had been newly recruited and lacked experience in the allocation of care tasks and the monitoring of people's wellbeing. We also found there had been a lack of consistency of nursing staff due to staff shortages; the provider had allocated nursing staff from another home and from an agency; however they lacked insight into people's health conditions, medicines taken and lacked an understanding about the care arrangements to provide a well-co-ordinated and safe level of care.

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

People were not adequately safeguarded from the risk of abuse or from restrictive practices. For example we found several people in an unclean condition and staff confirmed this was a regular occurrence. There was no accessible call bell system and people were left to calling out or waiting for long periods for staff attention.

We found that staff had an inconsistent knowledge of how to safeguard adults; some were unsure about different types of abuse or safeguarding procedures. One qualified member of staff was unable to tell any information about different types of abuse and had no knowledge of external agencies involved in the safeguarding of adults. Another new member of staff said "I am unsure if I had safeguarding training and am unsure who to report my concerns to". Safeguarding records showed that some safeguarding concerns were identified and that recent safeguarding incidents and concerns had been appropriately reported by the service.

There had been a recent escalation of safeguarding concerns about care practices in the home and about staff conduct. These allegations were under investigation at the time of our inspection by relevant external agencies. The manager had responded appropriately to safeguarding alerts in relation to safeguarding staff and people involved and they had investigated allegations when they had been asked to do so by the Local Authority Safeguarding Leads. However, there was little evidence of how learning from previous safeguarding incidents or allegations had been used to improve practice or fed back to staff to enhance their knowledge and understanding of safeguarding.

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

The provider had systems in place to manage people's medicines; however these systems had become disjointed and ineffective to ensure people received their medicine as prescribed. For example, although systems were in place to store, obtain, administer and dispose of people's medicines; we found several examples of medicine errors and omissions. This included example's where people's medicines had been lost, where people had missed taking their medicine, recording errors such as missed staff signatures, inaccurate medicine administration records (MAR) and inaccurate recording of medicines required as and when needed (PRN). This situation was further

Inadequate

Is the service safe?

complicated by the inconsistencies in the nursing team and a reliance on using non-permanent and agency staff with little knowledge of people's medical histories or medication needs.

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

There were robust staff recruitment processes in place. This included obtaining references from previous employers and ensuring staff had a Disclosure and Barring Service check (DBS). This check helps employers make safe recruitment decisions and ensures that people who are of good character are employed to work with people.

Inadequate

Is the service effective?

Our findings

The interim manager was aware of their responsibilities under the Mental Capacity Act 2005 and in relation to the Deprivation of Liberty Safeguards (DoLS). However there was a lack of formal systems which showed how these matters were consistently implemented or considered in the planning and delivery of care. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. For example people living with a diagnosis of dementia did not have a mental capacity assessment to determine their decision making abilities about the staff locking their doors from the outside. The interim manager told us that some people's relatives had agreed to the locking of their door to protect people and their property from other people living at the home. However there was a lack of formal processes to show how this decision had been made in people's best interests. While DoLS applications had been made to the local authority; they included no information about the potentially restrictive practice of locking people's bedroom doors. We saw some people had received an assessment of their mental capacity; however these were not decision specific and 'blanket' decisions had been made reflecting the need for people to have all decisions made about their care.

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

There was a system of staff training in place; however staff had not received training to meet people's dementia needs. We observed that staff failed to spot signs of people's increasing boredom, agitation and escalating behaviours. We also observed that staff practice did not focus upon reducing behaviours that challenged the service. For example, during the lunchtime meal one person was becoming bored and was observed filling their drink with their food. We saw staff assisting the mealtime did not notice this situation and when the person's behaviour became more challenging two staff proceeded to 'prise' the drink from the person's hands leading to a spillage across the table which disrupted other people eating at the table. We also observed two people becoming increasing agitated with one another and staff provided little support or care to resolve the situation. Staff confirmed that managing people's behaviours had been difficult due to a lack of staff training. One staff said "I have had no training about mental illness or dementia but I need some". Another staff said "quite often people get aggressive and shout at one another but we haven't been told why they do it and have not been shown how to manage people's behaviour".

Although we saw that staff had received training in how to assist people to move in a safe way. We observed some practice which put people at risk of a fall. For example, we saw one member of staff assist a person to move without any aids to assist the manoeuvre. We saw that the member of staff held the person by the upper arms and struggled to ensure the person retained balance. We also observed another member of staff grab at a person's clothing to assist them to maintain balance. While records showed that a system of staff training was in place; staff told us they required more training to meet people's needs. The interim manager confirmed that the new staff team were not up to speed with training requirements and had not yet received training about dignity in care, managing people's behaviours that challenge the service, mental health or dementia training. However, they confirmed their intentions to put these aspects of staff training in place immediately.

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

People did not receive enough support with eating and drinking. For example, relatives told us that they came at mealtimes to assist their family member's to eat due to lack of staff support at mealtimes. One relative said "I come along and help at meal times because I cannot be sure that staff will feed [person's name] and not make a mess". Another relative remarked that "often people are not encouraged to eat". At lunchtime we observed that people who were able to eat and drink independently or who needed a little staff support or encouragement received this assistance. However, we also observed that two people received very little staff support to eat or drink their meal. Both people were seated in arm chairs and were not encouraged to sit at the table to enjoy a social experience. They also received a lack of staff intervention, encouragement or one to one support to enable them to eat their meal. We saw one person was not served their meal until other people had finished eating and the other person had a delay in receiving staff support despite their

Is the service effective?

meal being served 20 minutes prior to this. In general, we observed that both people received a lack of staff assistance and support to eat their meals which resulted in both people eating very little food.

Staff identified people who were at risk of not eating and drinking enough; however they were not consistently monitored to check they had enough to eat or drink. For example we observed people on bed-rest at risk of not drinking enough. We saw that fluid monitoring charts were in place; however they showed that people had drunk little fluid, did not state how much fluid was needed and did not total the amount of drinks consumed to monitor hydration levels. This was a particular concern as there had been a recent safeguarding concern raised about adequacy of hydration for a person being cared of in bed. This was under investigation at the time of our inspection by the appropriate external agency.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Appropriate standards of hygiene in people's bedrooms were not being met. For example, we observed several people's bedrooms had unpleasant smells. We observed that one person spent considerable time in their bedroom and the environment smelt very unpleasant. The interim manager confirmed that some of the carpets in people's bedrooms needed removing and they were waiting for this to be improved. We also observed that some people's equipment such as a sensor mat and bed cover were inappropriately stained. We saw another person's bed was wet, stained, and had an unpleasant smell which permeated the room.

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

The arrangements for supporting people to maintain good health required improvement. For example we found that staff had not reported a potential health condition to a senior or qualified member of staff to ensure swift action was taken. We had to request that a GP was called promptly. While the person was found to be in good health; we found that the health condition had gone un-monitored by staff and there was a lack of understanding of the implications of the health condition such as risk of spread infection at the home. Although staff told us they received a good handover before the start of each shift; there were no recordings of this person's health status and qualified staff were unaware of this situation.

People's relatives had mixed views about access to health services. For example, one relative said "[person's name] has not seen a dentist recently and the staff lost their dentures". Another relative told us that "[person's name] has had new glasses since being here and sees a chiropodist and the nurse if needs be. They also had an eye infection and the doctor was called out".

Requires improvement

Is the service caring?

Our findings

People's relatives told us it was difficult to establish good relationships with staff due to poor communication skills. One relative said "Some staff have little communication skills and there is very little communication from agency staff who do not always wear their name badges." Another relative said "No one told us what had happened when [person's name] had a fall; we were really worried and did not know why it had happened". We observed that while some staff communicated well with people living with dementia; other staff needed to develop further skill in their caring approach. For example we observed that some people frequently cried out when they were agitated or distressed. However, we saw that members of staff frequently ignored this behaviour and lacked a caring approach based upon interaction and re-assurance. We observed another member of staff forcibly pulled their clothing from a person's hand when they were trying to hold onto them for stability. During the lunch time meal we also observed some staff lacked the ability to interact and engage with people to make the meal time a more sociable experience.

We observed some good examples of staff communication with people. For example one member of staff was observed assisting a person to eat their meal and we saw they made conversation and maintained good eye to eye contact while they supported them to eat. Other staff adopted a more caring approach when they periodically spent time talking and interacting with people. Some relative's reflected more positively about the staff's caring approach. One relative said "The staff are alright and come across as caring". Another relative said "The staff's approach is calm and gentle and they treat [person's name] as an individual and sit and chat and have time".

People did not always receive care that was respectful or mindful of their need for dignity. For example, people's independence was not promoted by the home's routine practice of locking their rooms so that they could not easily enter whenever the wanted. We also found that people's independence was not promoted because they did not have access to a call bell system and could not easily call or summon staff to help them when in their rooms. We observed that some people had to frequently call out for staff assistance. We also observed that staff frequently 'banged' the doors in the corridors to people's bedrooms and this caused one person receiving care in their bedroom to respond by saying "shut up".

The service did not always support people to express their views or make decisions about their care. For example, one person informed us that they would like to spend time out of their bedroom environment. However, there had been no plans or discussion with the person about this situation with view to assisting them to spend more time in the main living area. We also found that there was a lack of available evidence to show how people had been consulted about or chosen to have their doors locked from the outside. Staff reflected the difficulty in giving people choices about their daily care due to a structured approach to delivering care. One staff said "They tell you who needs a shower and we don't do it daily, it's every other day". They also said "We were told that all doors had to be locked to stop people going into other people's rooms". People's relatives were more positive about the availability of choices at the service. One relative said "[person's name] is given lots of choice and there are plenty of choices of foods, snack, cups of tea and cold drinks". Staff also told us that giving people choices was an important part of the care.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service responsive?

Our findings

People's relatives told us there was a lack of involvement in the care planning process. One relative told us, "I have not been informed about the care arrangements and have not spoken to anybody in a formal manner about the care plans". They also said "I don't know who [person's name] GP is and nobody has spoken to me about the care plan". Another relative said "I have not been invited to any review of care, although my relative has lived here for over two years and I come along to the home very frequently". People's relatives also reflected that they had not been asked for information about people's personal histories to support with the care for people living with dementia. We found that staff did not always fully understand people's need for care to be responsive to a range of needs. For example, one member of staff reflected that they were unaware of the "triggers" that caused behaviours that challenge or caused people to be distressed. We looked at people's care planning records and saw that they confirmed a lack of personal information about people. For example we found some people had no information about their personal life story, and their care plans contained little information about potential triggers for behaviour or preferences for care. Care plans did contain some information about people's physical and mental health; however these had lacked a comprehensive review to demonstrate that plans still meet people's needs.

People were encouraged to undertake social activities; however this did not support all people to engage fully with social opportunities. For example, we observed people receiving care in their bedrooms received little social activity or interaction from the staff. We also observed the main living area for a significant period of time and saw that people were routinely positioned about the room and had a lack of social stimulation. Many people were observed sleeping for long periods of time. While we saw that an activities programme was in place; this appeared to be reserved for individuals who were able to go out into the community.

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

The provider had a system for managing people's complaints; however staff were unclear about the procedure for managing complaints about people's care. For example one member of staff told us "The family complained that [person's name] pad had not been changed. A carer was sent to immediately resolve this situation". They also told us that another family had complained that their relative was wet and smelt of urine. However, they told us these complaints had not been raised with the manager of the service and we saw that they were not captured in the complaints recording systems. However, we looked at records that showed that complaints had been managed and responded to in a suitable and appropriate timescale. We saw evidence that complaints had been used to inform the quality of the service and that improvements, such as a review of medication for one person had been initiated and improvements to the outside seating area had been made as a result of another complaint.

Inadequate

Is the service well-led?

Our findings

There had been a lack of management stability and management oversight of the service. For example, there was no registered manager in place and there had been several interim manager's in post over the last few months. People's relatives told us that they were unsure who the manager of the home was and staff also reflected on the instability of this situation. One staff said "The managers change a lot and then leave". Another staff said "It is a supportive team but I'm not sure who leads the service and it's a bit of a concern. Someone is supposed to take the job on". The provider had recently appointed an interim manager from one of their other homes and they had been in position for little more than a week.

There was a lack of management oversight of the day to day clinical care. We saw that senior staff and nursing staff were responsible for the monitoring of people's care. However, this was not always effective as people receiving bed rest were found in a dirty condition and there was a lack of completed monitoring records to show that people had access to sufficient fluids. Staff reflected on the difficultly of situation and we found that staff roles and responsibilities had become blurred leading to a lack of clinical leadership and monitoring of people's health. For example, a qualified member of staff told us that although they were responsible for monitoring people's wellbeing; they did not refer at people's monitoring charts as an indicator of their health status.

Areas of poor practice had not been identified, assessed or acted upon to reduce risks around unsafe care. For example we observed that staff routinely locked people's doors from the outside; where there was no assessed need. The lack of an accessible call bell system had not been promptly identified as a risk and there was a lack of overall risk management or contingency planning around these situations and with particular regards to the risk it posed to people's health and safety.

There were systems in place to oversee the quality of the service although these needed to be re-established. For example, the service had recently initiated a review of care planning; however this had not been fully completed to establish areas of improvement. There were systems in place to oversee incidents, complaints and safeguarding concerns and notifications for serious incidents and safeguarding concerns known to the service were reported to agencies such as the Local Authority and the Care Quality Commission as required by regulation.

The acting manager and the provider had a clear vision about the quality and philosophy of care that should be provided; however this had not translated into practice. We found that the staff team was newly appointed and staff had not consistently received induction training to help them develop the skills to care for people. While staff told us they thought the service provided good care; staff were unaware of the values or vision of the service and some staff had a lack of experience to understand what good care looked like. One staff said "I am not sure whether there is a good standard of care here as I have not worked in a nursing home before and have nothing to compare it with". Other staff reflected on a good "team spirit", "care for people", and "support for one another" as important values at the service.

Staff told us there was an open culture at the service and understood the need to raise concerns with the manager. However they were not always sure of procedures for reporting concerns to a manager and there was an inconsistent knowledge about whistle-blowing procedures. One staff said "I would report anything untoward but I'm not sure who to report it to". Another member of staff was unaware that they could contact the Care Quality Commission with any concerns about the service. We saw there was a system of team meetings in place to keep staff informed and to discuss any concerns about the service; however we were informed that not all staff had been able to attend these meetings due to staff shift working patterns. Staff reflected the need to be more involved with further decision making about care arrangements and that more two-way communication with senior managers would be welcomed.

People using the service, their family members and staff were asked to provide their feedback on the quality of care and service improvement via bi-annual surveys. However some feedback indicated the infrequency of this and some relatives were unaware of the need to feedback their experiences. One relative said "I have not been asked to feedback or complete a questionnaire and I'm not aware of any residents meetings. The interim manager confirmed that the results of surveys were analysed and used to help develop the service and progress was reported back at

Inadequate

Is the service well-led?

residents and staff meetings. They confirmed that the last survey reflected people's concerns about the inconsistencies in staffing and that they intended to repeat this survey shortly.

This is 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 legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive a service where relevant persons were enabled to participate in decision makingThe provider did not design care or treatment with a view to achieving service users' preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not ensure that service users were treated with dignity and respect and did not always support the autonomy and independence of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not assess risks to the health and safety of the service user and do all that was reasonable practicable to mitigate such risks. They did not ensure

This section is primarily information for the provider

Action we have told the provider to take

the premises or equipment was safe for use by service users. People's medicines were not managed safely and the provider did not ensure that staff had the skill and experience to care for people safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not protect people from abuse and improper treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not meet the nutritional and hydration needs of the service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have systems in place to assess, monitor and improve the quality of the service. They did not assess, monitor and mitigate the risks relating to the health, safety and welfare of the service user who may be at risk from the carrying on of the regulated activity.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way. There was a lack of robust risk assessment in place to reduce the risk of unsafe care. People's medicines were not always managed safely. Staff were not suitably experienced or skilled to care for people.

The enforcement action we took:
We issued the provider with a warning notice to ensure people receive safe and proper treatment.