Community Integrated Care

Eccleston Court Care Home

Inspection report

Holme Road
Eccleston
St Helens
Merseyside
WA10 5NW

Tel: 01744453655
Website: www.c-i-c.co.uk

Date of inspection visit:
06 June 2019
11 June 2019

Date of publication:
30 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Eccleston Court Care Home accommodates up to 54 people who require personal and nursing care. At the time of the inspection there were 36 people using the service. The service consists of two separate Units, one of which provides nursing support to people who primarily have a physical health need and another that provides nursing support to people living with dementia.

People's experience of using this service and what we found
Parts of the environment were unsafe putting the health and safety of people and others at risk. The safety of the environment was not monitored to ensure risks to people and others were identified and mitigated. Fire doors and communal areas were obstructed, and good practice was not always followed to minimise the spread of infection.

The deployment of staff was disorganised which led to people's needs not being met in a timely way. A number of permanent nurses had left the service over recent months and there was a high use of agency nurses which unsettled people and family members.

Assessments lacked information about people's needs and how they were to be met. Assessments and care plans were not personalised, they did not reflect people's choice and preferences. People and/or relevant others were not always involved in the development and receiving of care plans.

There was a lack of opportunity for people to maintain their interests and hobbies. On both days of the inspection staff on Eccleston Unit spent very little time engaging people in conversation or activities. Staff told us they were unable to socialise with people because they were so busy meeting people's physical care needs. People were given limited choice and flexibility with regards to some aspects of their personal care.

People and family members commented that the staff were kind and caring in their approach and we observed examples of this. However, people were not always treated with dignity and respect. People were left waiting for longs periods of time for assistance with personal care needs. Personal care records about people were not always stored securely. Personal belongings of people no longer living at the service were not treated with respect. There were limited opportunities for people to express their views and be involved in decisions about their care.

The number of complaints received about the service had increased since March 2019. Complaints received about the service were not always recorded and responded to and they were not always used as an opportunity to make improvements to the service.

The systems in place for monitoring the quality and safety of the service were ineffective. They failed to identify the areas of concern found during this inspection. There was a lack of oversight by senior managers and the provider to ensure that the systems for assessing and monitoring the quality and safety of the

service were implemented. People and family members commented on a lack of communication and visibility by the manager.

People told us they felt safe living at Eccleston Court. Overall, feedback received about the caring approach of staff was positive. However, our findings did not support this positive feedback.

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

The last rating for this service was requires improvement (published 12 June 2018)

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the relevant key question sections of this full report.

During and following the inspection the provider took action to mitigate the risks and this has been effective.

The overall rating for the service has changed from requires improvement to Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eccleston Court Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches at this inspection in relation to the five key questions we ask is the service; safe, effective, responsive, caring and well-led.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Eccleston Court 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Day one of the inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was carried out by one inspector and a dementia care specialist nurse advisor.

Eccleston Court 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Day one of this inspection was unannounced and day two was announced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. This included any statutory notifications sent to us by the provider about incidents and events that had occurred at the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and nine family members about their experiences of the care provided. We also spoke with a visiting professional, the manager, area manager, quality manager and twelve members of staff including nurses, care workers and ancillary staff.

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 a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures and audits were reviewed.

After the inspection
We looked at information the provider sent us following this inspection visit about the actions they had taken to mitigate risk to people and make improvements to the service based on our feedback following the inspection visits.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health, safety and welfare were not identified and mitigated because the safety of the environment was not monitored and managed.
- Obstructions across the service put people's safety at risk in the event of a fire and increased the risk of slips trips and falls. A fire exit and a fire extinguisher on Eccleston Unit were obstructed by items of furniture and a fire exit on Haydock Unit was obstructed by a dining table.
- Two corridors close to people's bedrooms on Eccleston Unit were obstructed with large hoists and access to the toilet and sink in a communal bathroom near to people's bedrooms was obstructed by items of equipment and plastic boxes.
- The activities room and a shower room on Haydock Unit were unlocked. Both rooms contained items which were potentially hazardous to people. People living with dementia who liked to keep themselves busy around the environment had access to these rooms without any supervision.
- Aspects of people's care was not adequately monitored to help identify and mitigate risk.

There were gaps in the recording of fluid intake. Fluid intake was not always totalled at the end of the day to ensure that people's fluid intake was sufficient to minimise the risk of dehydration.

- Pressure mattress settings were not always checked to ensure they were set at the correct level to minimise the risk of people developing pressure ulcers.
- People with sensor mats in place next to their beds had no access to a nurse call bell because their sensor mat was plugged into the call bell socket. The use of an adapter to operate both had not been considered.

Preventing and controlling infection;

- Practices carried out at the service increased the risk of the spread of infection.
- On Eccleston Unit freshly laundered clothes were hung up in a bathroom and on rails in corridors outside people's bedrooms. Many items of clothing were trailing on floors.
- Used personal protective equipment (PPE) including aprons and gloves were disposed of in domestic waste bins in people's bedrooms.

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

The provider responded immediately during and after the inspection. They confirmed all actions were completed and suitable checks of the environment and equipment were in place.

Staffing and recruitment

● Staff were not always suitably deployed. Staffing levels were calculated based on the number of people using the service and their dependency level. On both days of inspection, the right amount of staff were on duty, however the deployment of staff was disorganised.

● There was little staff presence in the main lounge on Eccleston Unit throughout both days of inspection. When staff occupied the lounge, it was to offer task-based support.

● We observed two people left sat in their wheelchairs in the lounge on Eccleston unit for a long period of time because staff were in other parts of the service.

● People told us they had waited a long time for their call bells to be answered. One person told us they had waited over an hour on two occasions for staff to respond to their call bell. We observed a call bell ringing for over 20 minutes before staff answered it.

● Staff told us they felt under pressure and felt the staffing arrangements were disorganised. Their comments included; "We are all over the place," I think working in dedicated teams would be much better" and "I don't think staff are well organised."

● There was a high turnover of nursing staff at the service which led to a high usage of agency nurses. A family member commented; "Agency staff are not the answer, people with dementia need familiar faces and consistency. One person told us, "There's lots of different nurses which unsettles me."

Staffing arrangements were not effective in meeting people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed the deployment of staff had been addressed.

● Robust recruitment processes were followed. Applicants were subject to a range of pre-employment checks and attended interview to assess their suitability to work at the service.

● Nurses registrations were regularly checked to ensure they remained valid.

Using medicines safely

● Medicines were safely administered; however, some medicines were not safely stored.

● Prescribed food supplements which were no longer needed and waiting collection from the pharmacy were left in boxes outside the medication room on Eccleston Unit. A member of staff secured the items after we raised this with them.

● Trained nurses were responsible for the management and administration of medicines.

● Medication administration records (MARs) were completed to reflect prescribed medicines and when they were administered.

● Guidance was in place, and records maintained for the use of 'as required' medicines, creams and ointments.

Systems and processes to safeguard people from the risk of abuse

● A record of allegations of abuse raised with the local safeguarding authority was maintained. These showed the provider had responded appropriately.

● Staff had received safeguarding training and had access to information and guidance about how to keep people safe and how to report safeguarding concerns.

● Staff understood safeguarding and whistleblowing procedures and their responsibility for reporting concerns.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- An assessment of people's needs was completed, however assessment documentation lacked information about how people's needs were to be met and what the intended outcome was. Sections of some people's assessments were incomplete and other sections failed to describe the type and level of support people needed. For example, they included statements such as 'needs assistance' 'needs regular pressure relief' and 'requires support.'
- Guidance was not always followed for monitoring aspects of people's care. Monitoring records lacked information about the care and support people needed to meet their needs and they were not always completed to reflect the care given. This included charts in place for monitoring aspects of people's care such as food and fluid intake, positional changes, wound care and air flow mattress settings.

We found no evidence that people had been harmed however, a lack of robust record keeping placed people at risk of receiving ineffective care and support to meet their needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They confirmed action had been taken to update care records.

- People were provided with a choice of meals and drinks and food and drink was prepared to meet people's dietary needs and choices.
- People who needed support to eat and drink were given the assistance they needed.
- People were generally happy with the choice and quality of food and others were not. Comments included; "I've just had a lovely meal. You've got two choices basically, and I'm happy with that," The food's very good. I'm usually happy with one or the other of the choices offered and there's plenty" and "The food is rubbish."

Staff support: induction, training, skills and experience

- Staff had received formal supervision through meetings with their line manager. However, the frequency of them was not in line with the providers staff supervision policy. The manager told us they were addressing this to ensure all staff received the required level of supervision.
- New staff were inducted into their roles and received ongoing training for their role.

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

● On Eccleston Unit there were communal areas apart from the main lounge and dining room where people could sit, however they lacked focal interest and items of stimulation.
● Signage using pictures and words was used to help people identify areas such as the lounge, dining room and bathrooms. However, some people's bedroom doors lacked signage and items such as photographs and memorabilia which could be used to help them locate their rooms independently.
● Corridors on Haydock Unit displayed some items of interaction and stimulus such as pictures and items of favourite pastimes of people supported. Work to improve the environment further for people living with dementia was ongoing.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People received additional support from external healthcare professionals where this was needed.
● Staff were aware of the processes they should follow if a person required support from any health care professionals. A staff member told us; "All the staff have had oral health training and we can access the community dentist for individuals."
● People told us they received a good level of support with their healthcare needs. Their comments included: I've had trouble with my chest and the staff called the doctor out for that,"
"I see my doctor when I need to" and "They [staff] are very good at noticing if I'm not so good and do the right thing."

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People who needed the protection of a DoLS had one in place. Staff were aware of people's DoLS and the restrictions this may place upon the person.
● Staff had a good understanding of the MCA in relation to supporting people. They asked people's consent and gave them the opportunity and choice to make their own decisions about their care and support.

Inadequate

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence;

- People were not always supported and treated in a way that respected their dignity and privacy.
- One person told us on one occasion they had waited for over an hour to be assisted into to bed and on another occasion had waited an hour and a half to be assisted off the toilet.
- On the first day of inspection one person waited 20 minutes for staff to respond to their call bell. When we visited the person, they were anxious and upset because they had waited for such a long time for staff to respond to their call for assistance.
- After breakfast on the first day of inspection a person was transported in their wheelchair out of the dining room into the lounge. The staff member informed the person they needed to go and get help from another member of staff to assist with helping them into an easy chair. The staff member assured the person they would return shortly. The person was left sat in their wheelchair for over an hour before staff returned to provide them with the assistance they needed.
- People did not always get the appropriate care and support with their personal care. People expressed that they would like more baths and showers, however they considered that staff were too busy.
- Files containing personal care records about people were left on handrails outside their bedrooms making them easily accessible to none care staff and visitors to the service.
- Items of clothing and other personal effects were stored in carrier bags and boxes in a communal shower room. Staff confirmed that they were the belongings of two people who passed away several weeks ago. The staff were unsure whether family members had been contacted to collect their loved one's personal items.

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

- There were limited opportunities for people to express their views and make decisions about their care. Staff expressed their frustration about not having time to sit and talk to people.
- Care review meetings were not regular and when they did take place they were conducted without the persons involvement.

People were not always treated with dignity and respect. This was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our finding on this inspection people and family members commented positively about the caring attitude and approach of staff. Their comments included; "They are very nice and caring", "There are some

really good carers" and "There's a lot of respect and courtesy shown to my relative and to me. The staff are very caring."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care was not always planned in a personalised way. Sections of assessment and care plan documentation were incomplete and other sections were written as a series of tasks. They lacked information about people's choices and preferences with regards to how their needs were to be met and did not always direct staff as to the level of support the person required.
- Feedback from people and family members and records showed they were not involved in the assessment and care planning process. Care plan reviews did not always take place each month as required and where they did take place there was no evidence of people's involvement.
- There was a lack of care planning for some people's needs. Assessments identified people's disability or sensory loss but did not include how the identified need was to be met. For example, assessments identified that people had some hearing, sight and speech impairments, however there was no information recorded in assessment and care planning records about the support people needed.
- People were not always afforded choice and flexibility with regards to their care and support. For example, one person told us "I have my shower on a (given day), you have particular days. I doubt you could have more because they're so short of staff" and another person told us "You can only have one a week (shower); I'd like more but they haven't got time." A third person told us they often had to wait for long periods of time to be assisted onto the toilet and into bed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them This

- People were not given the opportunity to follow their interests and hobbies. Throughout both days of inspection people on Eccleston Unit either occupied their bedroom or were asleep or watching TV in the main lounge. People were not offered any form of stimulation through activities or meaningful conversations with staff.
- The manager advised that there were usually two activity co-ordinators with a job share arrangement in place. However, one had left in May 2019 and they were actively recruiting for the vacant post. No interim arrangements were put in place to cover the post.
- Care staff told us that they did not have time to facilitate activities or to sit and chat with people due to them being too busy meeting people's physical needs. A family member told us "There's no time for anyone to sit with my relative."

Care was not planned and delivered in a person-centred way. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People were provided with information about how to complain and they were confident about speaking up about any concerns they had.

● Since March 2019 there had been an increase in the number of complaints made to the service about the care.

● A complaints log was maintained, however there was no evidence to show a response was made to a written complaint received. A family member advised us of a verbal complaint they had made about the care of their relative, no record of the complaint could be found.

● There was a lack of evidence to show complaints were used as an opportunity to make improvements. People continued to raise the same concerns.

Complaints were not always responded to and improvements were not always made in response to complaints. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At the time of the inspection, no person using the service was receiving end of life care. However anticipatory medicines were in place for people who required them.

● Nurses and care staff were trained in end of life care and they understood the importance of working with other professionals to ensure that people experienced a comfortable, dignified and pain free death.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service did not have a manager registered with the Care quality Commission (CQC). The previous registered manager left the service in February 2019. A new manager took up post in March 2019 but is not yet registered with CQC. The manager told us they were in the process of applying to become the registered manager.
- The manager was not always able to provide information we asked for due to their limited knowledge about people.
- People and family members commented that since February 2019 there had been a lot of inconsistencies in the management of the service and that they had noticed a decline in the quality of the service.
- People and family members told us the manager lacked visibility across the service and did not communicate well with them. Their comments included; "Different managers have different ideas. The last one mingled with people; this manager never stops to chat," "The first time I met the manager was at yesterday's meeting," "The home is not what it was, it's gone down," "I don't know who the manager is at the moment because they've had a few," and "We have never met the new manager."
- The manager had not formally introduced themselves to people and family members since commencing work at the service in March 2019. They held their first 'residents and relatives' meeting at the service in June 2019. Apart from this meeting there had been minimal introductions and contact with people including those who were unable to attend the June meeting.
- Risks to people's health, safety and wellbeing was not always identified and mitigated effectively through on-going monitoring of the service. The system in place for checking on the quality and safety of the service was ineffective. It failed to identify the concerns highlighted on this inspection such as safety of the environment, staffing, poor record keeping, and regulatory responsibility.
- The registered provider did not always submit notifications to CQC in a timely way. Several allegations of abuse had been raised with the Local Authority safeguarding team, however there was a delay in the service notifying CQC as required about these.
- Complaints were not always responded to and used to make improvements to the service. People and family members reported that concerns they raised were not addressed.
- Records were not stored securely, maintained and kept up to date. Care records were not always securely stored and there were many examples were assessment, care planning and monitoring records were incomplete, lacked information about people's needs and not signed and dated.
- There was a lack of scrutiny by the registered provider to ensure that their systems for assessing and monitoring the quality and safety of the service were implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and others such as family members were not fully engaged or involved, and people's needs were not always considered and planned for.

● Opportunities for people to put forward their views and opinions about the service and the care provided were limited. Assessment and care planning records did not evidence the involvement of people and others. Care review meetings had not always taken place monthly in line with the providers requirements.

● There was no evidence that people's views and opinions had been obtained within the last year by surveys.

● The service worked with external health and social care teams where this was required for people.

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

● The provider or manager did not plan, promote and ensure people received person centred and high-quality care. We received positive feedback about how staff delivered care and support, however outcomes for people were not person centred.

● Staff described the morale amongst the team on Eccleston Unit as being low. Staff understood what person-centred care meant and described how frustrated they were at not always being able to provide care and support to people in this way.

● Staff felt better organisation of staff teams across the service would improve things, but they did not feel empowered to share their views with the manager.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) 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 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 Care was not planned and delivered in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users was not assessed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received were not always responded to and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements did not meet service users needs.

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 Systems for checking on the quality and safety of the service were ineffective.

The enforcement action we took:

Warning notice to be issued.