Countrywide Healthcare Ltd

Headingley Court Care Home

Inspection report

Headingley Way
Edlington
Doncaster
DN12 1SB

Tel: 01709866610

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Headingley Court is a care home providing personal and nursing care for younger adults with a physical disability. It can accommodate up to 25 people. There were 23 people using the service at the time of the inspection.

People's experience of using this service and what we found
We found systems and processes used to ensure the service was running safely were not effective. They had not identified required improvements, therefore they were not effective to ensure the service was running safely. We observed lack of leadership, direction and oversight. Staff told us they did not feel listened to.

Risks associated with people's care were not always identified or managed in a way that kept people safe. Incidents and accidents were not effectively reviewed to ensure lessons were learnt to drive improvements. We identified some shortfalls in the way people's medicines were managed. We were not fully assured people were protected by the risk and spread of infection, although this was addressed by the registered manager.

Staff were not always deployed effectively to ensure people's needs were met. We observed people who were meant to be supported on a one to one basis with no support. We observed staff were not present in communal areas, we observed people waiting for assistance and staff not having time to talk to people. Staff had not consistently received specific training to meet people's needs. Staff did not receive effective competency checks on their performance and abilities to ensure they carried out their roles and responsibilities safely. There were systems in place to safeguard people from abuse. However, we referred a safeguarding concern to the Local Authority, which we identified at inspection.

Staff told us they did not always get opportunity to spend time with people, they were rushed and often short staffed. Therefore, staff did not always support people appropriately. Care and support we observed was task orientated and not person-centred. Staff did not always show concern for people's well-being. For example, we observed people left with no interaction or stimulation for long periods of time.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. There was lack of evidence to show that people were involved in decisions about their care, support and treatment. Relatives we spoke with told us there was lack of communication during the pandemic.

We identified a closed culture, people did not have their human rights upheld, protected characteristics were not recognised or respected and equality was not promoted.

We saw people were referred to health care professionals and advice obtained. However, from

documentation it was not always clear if the advice was followed. Therefore, it was not clear if people's needs were being met. Care plans did not always detail people's current needs, were difficult to follow, were contradictory, inconsistent and not person centred.

The service was purpose built and the adaptation and design could meet people's needs. Complaints were recorded in line with the provider's policy.

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

Rating at last inspection
The last rating for this service was good (published 4 February 2020)

Why we inspected
The inspection was prompted due to concerns received from the local authority commissioners and safeguarding referrals. These were regarding, risks not being managed and allegations of abuse. We completed a site visit to look at the safe, effective and well led key questions. Following the concerns, we identified at this visit, we included the key questions of caring and responsive, therefore we have looked at all key questions.

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

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

We have found evidence that the provider needs to make improvement. Please see all sections of this full report.

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

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

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

We have identified breaches in relation to safe care and treatment, consent to care and treatment, person centred care, staffing and governancet at this inspection.

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.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 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?

Inadequate

The service was not 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.

Headingley 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.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Headingley 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 21 January 2021 and ended on 2 February 2021. We visited the home on 21 January 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information 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 five people who used the service and eight relatives via the telephone about their experience of the care provided. We spoke with twelve members of staff including the provider, registered manager, deputy manager, 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 four people's care records, medication records and weight records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The provider and registered manager have also submitted an action plan following our feedback.

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
- Risk associated with people's care were not suitably assessed or managed. For example, People at risk of choking did not receive care and support in line with their care plan to ensure the risk was managed.
- People's records did not always reflect their current needs. For example, one person had deteriorated since they returned from hospital, their care plan had not been reviewed or updated to detail the care and support required. We observed staff did not provide support to meet the person needs.
- We identified food and fluid charts were not always properly completed and did not accurately reflect what people had eaten or drunk. Therefore, the risk was not effectively managed. For example, one person was at risk of weight loss and their care plan stated they should have four high calorie shots each day and fortified meals to continue to build weight gain. The staff had recorded on the charts they had given one shot each day, we also saw that no snacks had been recorded. The charts were not always completed, monitored or reviewed.
- Accidents and incidents were not effectively analysed; therefore, any themes or trends were not identified to mitigate risk and ensure lessons were learned.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Medication systems were in place to ensure safe management of medicines. However, these systems were not always followed. Medication was not always recorded appropriately. Therefore, it was not possible to effectively audit to ensure medicines were appropriately and safely administered.
- Medication prescribed on an as required basis, (PRN) was not always recorded appropriately when it was administered. Therefore, it was not clear if PRN medicines were being given as prescribed. We saw some PRN protocols did not detail adequate information for staff to determine when to administer these medicines. We saw some people were regularly given medication for anxiety and agitation. Staff recorded 'agitated' but it was not clear how the person presented when they required the medicine and staff had not recorded if it had been effective when administered.
- Topical creams were not always given as prescribed. For one person, staff had recorded they had refused, although staff should respect people's choices, this person lacked capacity to understand the implications of refusal. This had not been reviewed to determine any alternate arrangements to ensure the persons needs were met.

The provider had failed to ensure the proper and safe management of medicines which is a breach of

regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The environment was predominantly clean. However, we identified some areas were not clean. For example, the shower chair and shower table were not clean and high-level shelves and behind the washers in the laundry were very dusty and a store room was malodourous.

● We found some areas of the home were not well maintained so could not be effectively cleaned. For example, cupboard units were damaged in the laundry, areas of untreated wood near sink unit. The fire exit was cluttered, and items were blocking the exit, store rooms were cluttered so the doors were not able to close.

● Staff were seen following the guidance regarding personal protective equipment (PPE) in relation to the Covid-19 pandemic. However, we were not fully assured by infection control practices. For example, on occasions we saw staff not washing their hands as frequently as required and not offering to wash people's hands frequently.

These areas were addressed immediately by the registered manager and the provider; however, they had failed to ensure the policies and procedures were followed, which is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was a dependency tool to help determine how staffing hours were calculated. However, it was not clear if the staffing hours were calculated correctly. We observed people who were meant to be supported on a one to one basis with no support, we observed staff were not present in communal areas, we observed people waiting for assistance and staff not having time to talk to people. Staff we spoke with told us they regularly worked short staffed and one to one support for people was not always provided because of this.

● Staff told us they did not have time to listen to people, as they were busy and, on many occasions, did not have enough staff to provide the appropriate support.

The provider had failed to ensure there were staff deployed to meet 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 had a staff recruitment system in place. Pre-employment checks were obtained prior to staff commencing employment. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes in place to safeguard people from abuse.

● Staff told if they had concerns that a person was being abused, they would report it to their line manager. However, we identified a safeguarding incident during our inspection and have made a referral to the local authority.

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance. Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
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.

● The provider was not always working within the principles of the MCA. We saw where conditions were attached to authorised DoLS these were not being met. The registered manager informed us that there was only one person living at the home with conditions attached to their DoLS. However, the local authority informed us there is another person with conditions and that their conditions are also not being met. Staff we spoke with were not aware of people who had conditions.
● Where decisions had been made on behalf of people, they had not always been completed in the person's best interests. We saw a best interest decision was made with no consideration to any alternate arrangements to facilitate the persons choice.
● People's wishes were not considered. People were deprived of their liberty. For example, some people were isolated in their bedrooms with no clear reason why.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not always working within the principles of the MCA

● People's physical, mental and social needs were assessed, however, their care, treatment and support was not delivered in line with legislation, standards and evidence-based guidance, to achieve effective outcomes.
● People's care plans we looked at did not include people's preferences and choices.

Staff support: induction, training, skills and experience

● Staff did not receive effective training. The training records we were sent by the registered manger showed staff training was not up to date. The providers told us this had been addressed and training had been completed or was booked. However, what we observed did not evidence training was effective. For example, staff had received training on how to support people in a person-centred way, yet we observed care was task orientated and staff did not provide care and support that was person centred.

● Staff received supervision and induction. However, staff told us this was not effective they did not feel listened to or supported by the management to ensure they fulfilled their roles and responsibilities and kept their professional practice and knowledge updated. Staff told us the induction felt rushed and if they had previous training, that was accepted even though it was a completely different client group with complex care and support needs.

The provider had failed to ensure there were skilled and experienced staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● We looked at care records in relation to dietary requirements. We found people were offered a healthy balanced diet which met their needs. However, although people had not lost weight, it was not always clear from documentation if their nutritional needs were always met. Where people were assessed as requiring fortified meals the records were not completed fully, reviewed or monitored.

● People we spoke with told us the food was nice. We observed choices were given. However, the meal experience was very task orientated and there was a lack of interaction between staff and people to improve the experience for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff did seek support from health care services. However, we found advice given was not always followed.

● People were left for long periods alone with no interaction or support from staff. This did not promote their well-being.

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

● The service was purpose built, the environment was appropriate and meet the best practice guidance in supporting people with a physical disability. However, some bedrooms could be improved, we found a couple were malodourous, curtains falling off the track and some required decoration. This had been identified and was on the providers environmental action plan.

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

- We spent time observing staff interacting with people. We saw staff did not always engage with people when providing care and support and were task orientated. When staff did engage, people responded positively and enjoyed the conversation. However, we observed staff did not have time to spend with people. Staff we spoke with wanted to be able to engage with people in a meaningful way, but told us they did not always have the time.
- People did not receive the care and support required. People who were assessed as requiring one to one support did not always receive this.
- People were not supported in a meaningful way to enable them to express their views. We saw staff sat completing paper work in the dining room and not interacting with people. People were left in the lounge with only the television on. We observed for over two hours and saw no positive interaction or engagement between staff and people who used the service. There was no visual stimulation and best practice was not adhered to such as appropriate use of communication.
- Peoples choices and wishes were detailed in some plans of care. However, these were not always followed. For example, one person asked for a coffee and was refused it and a person had to wait to be taken for a cigarette, yet they were supported one to one. The person's care plan identified reasons why and detailed how staff should support them to understand this. However, we observed staff did not explain to the person why they could not have their choice and did not follow their care plan in order to alleviate their anxiety. We also observed people's preferences were not always considered as part of their care and support, we found people in bed with curtains closed, when we asked one person if they wanted them closed as it was daytime, they said no they wanted them open.
- People's independence was not always promoted. For example, staff did not support or encourage people to do things for themselves. One person used to be independent in their wheelchair, staff told us they were now not safe doing this so were in a lounge chair in their bedroom. Staff could not tell us why they were not in a communal area so they could engage with people and maintain some independence with support.
- Relatives we spoke with told us arrangements had not been put in place to see their relatives during the pandemic. There had been a pod provided, but relatives told us they struggled to hear, and it was not private as it was in the dining room. They told us there had been no formal arrangements during the summer when they could have met outside. Although the registered manager told us they facilitated visits, there was no documented evidence to support this. One relative said, "We have used the pod once it is not brilliant and garden visits were not even facilitated in the summer."

This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which met their needs.

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

- During our observations we saw people were not involved in decisions about their care. Staff did not always explain the tasks they carried out.
- Care plan documentation did not reflect that people had been involved in creating and updating them.

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. 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

- People did not always receive person-centred care which met their needs and preferences.
- Care records we saw did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences. Care records did not reflect people's care and support required. They were not updated, reviewed or evaluated effectively to ensure people's needs were met safely. For example, one person's needs had changed on discharge from hospital and the care plan had not been updated. Another person's care plans contained contradictory information, so it was not clear how to meet their needs.
- People were not always supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. There was an activity room and the provider employed dedicated activity co-ordinators, however, there were only two people engaged in any activity during the morning of our visit. These people were enjoying the activity and there was positive and inclusive engagement between the activity worker and the people taking part. However, there was limited consideration given to people nursed in their bedrooms or people who lacked verbal communication. Alternative activities had not been considered during the COVID- 19 pandemic when access to the community had been stopped. One staff member said, "We [Staff] are not allowed to take people out of the grounds due to Covid-19." Staff felt this had impacted on people's well-being.
- Staff told us there was lack of activities and social stimulation for people. One staff member said, "There are no activities at the weekend, people can't go out, it's so boring for people. We [care staff] don't have time to spend with them socially."
- The support provided was not in line with people's choices, needs or preferences. We observed staff interacting with people and saw they were task focused. For example, people were bought into the dining room and left unattended. Some people were nursed in bed with no clear reason why and others were bought into the lounge and left sat in front of the television with no choices given. Staff told us they did not have time to sit with people, and staff providing one to one support were often required to assist others.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which met their needs and considered their preferences.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●We found these standards were not always followed. Staff did not communicate effectively with people and there was lack of information in a format that people could understand. During our observations we found staff did not use accessible information to enable people to communicate effectively. We observed staff did not engage with people.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure.

● We saw the registered manager kept a record of complaints that showed action had been taken.

● Some people and their relatives we spoke with told us they didn't feel listened to. They also commented there had been very limited communication during the pandemic.

End of life care and support

● People had end of life care plans, but they did not always identify people's preferences and choices.

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 good. 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.

Continuous learning and improving care

● Systems in place to monitor the service were not effective. There were quality monitoring systems in place that had been completed. However, these had not always identified issues. For example, the lack of person-centred care, care plans that did not reflect people's needs and contradictory information within care plans.

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

● Relatives we spoke with told us the communication had been poor during the pandemic. They felt they were not always kept informed or involved in the care and support of their loved ones. Due to the current Covid-19 pandemic there were restrictions on visiting yet no other methods of communication had been put in place.

● People had been consulted on who they wanted staff to contact during the pandemic and how often. The information sent to us by the registered manager as part of the inspection showed all people had documented in their care plans who they wanted to be contacted and how often. However, this was not supported by the documented evidence. There was no evidence to support this was carried out.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service had a registered manager who was registered at two locations. There was a deputy manager who was also responsible for the management of the service. There was lack of leadership, direction and oversight. The lack of leadership was impacting on the care people received. Care was not person centred and people were not always cared for in a safe way. Leaders in the home did not intervene or guide staff so that people received more appropriate care which met their personal needs.

● The staff were not clear about their roles and responsibilities and did not understand the regulatory requirements. We observed a lack of leadership, direction and deployment of staff. Staff told us they did not always feel supported and felt the registered manager was not at the service much. All staff we spoke with told us they felt the registered manager was at the other location most of the time. Staff also told us they did not feel listened to or confident in raising any issues.

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

outcomes for people

● The registered manager did not ensure that people received person centred care. Support we observed was task focused and institutionalised. For example, staff did not engage with people or respect their preferences or choices.

● Outcomes for people were not always met. For example, people's mental health needs were not met. We observed care workers just sat with no communication or interaction with people and lack of social stimulation.

● Staff did not work together as a team. This meant staff were not deployed effectively to meet people's needs, therefore, not achieving good outcomes for people.

● People did not feel listened to. The provider did not always promote a positive, open and inclusive culture. Staff told us they did not feel involved or able to share their opinions and relatives also told us there had been poor communication and felt their views were not acknowledged.

●Through our observations and from speaking with staff, people and their relatives, we could evidence that a closed culture had developed within the service. This meant people were not always able to speak up for themselves, restrictive practices were being used, and management and staff make choices for people which are not always in their best interest.

Working in partnership with others

● The registered manager and provider engaged and worked in partnership with others. They had acted appropriately in response to concerns and safeguarding. However, there was not always documented evidence to support this.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider were knowledgeable and understood the requirements of the regulations. For example, the need to show honesty and transparency from all levels of staff and leadership. However, this was not always evidenced in our findings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person-centred care that met their needs. Regulation 9 (1)(a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was only provided with the consent of the relevant person and act in accordance with the 2005 Act. Regulation 11 (1) (2) (3) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's risks were identified and managed to ensure their safety. Medicines were not effectively managed and infection control procedures did not ensure people were protected from the risk of infection. Regulation 12 (1) (a) (g) (h)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed effectively to meet people's needs.

Regulation 18 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that there were systems and processes established and operated to assess and improve the quality and safety of the service provided. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We have served a warning notice.