The Gables (Northumberland) Ltd

The Gables Care Home

Inspection report

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Bedlington
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Gables is a residential care home providing personal care for up to 10 people with mental health issues, including both younger and older adults. At the time of the inspection there were 10 people using the service.

The home is a converted house in Bedlington Station. It has accommodation on the ground and first floor. There is no lift or stair lift to access the upper floor. There is a lounge area on the ground floor and a small dining room. People have access to shared bathroom and washing facilities and a shared laundry area. There is a secure courtyard area at the rear of the building which contains a small hut that people can use for smoking.

People's experience of using this service and what we found
People were not always supported in a safe environment. Risks related to people's care were not always well detailed or actions identified to mitigate risks. Infection control procedures were not robust and did not meet current recommendations. Staff recruitment processes were not robust and staffing levels were not regularly assessed or reviewed. Systems around supporting people to manage their finances required review. We have made a recommendation about this. People were supported to receive their medicines safely and appropriately.

People's needs had not always been fully assessed or reviewed. Staff training was being reviewed and updated the manager was over seeing this. People told us they enjoyed the meals at the home and were able to suggest changes to the menu. They were assisted to attend health appointments and maintain their well-being. People were supported to have considerable choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported practice.

People told us they were well cared for and they enjoyed good relationships with the staff. They told us that staff respected their privacy and dignity. There was some evidence people were involved in making decisions about their care, although this was not always well recorded.

Care plans were not always up to date and did not contain the most recent advice from professionals. Reviews of care were not always detailed. People were supported to maintain relationships with friends and family and were able to participate in activities. Staff reminded people about safety procedures when accessing the community during the pandemic. There had been no formal complaints in the last 12 months, but people said they could raise any concerns with the manager or the provider.

The manager at the home was not formally registered with the CQC. There was no evidence on CQC systems to show an application process had been started. People and staff told us the manager had made improvements to the service. Some quality checks and audits were in place, although they were not robust

and did not cover significant areas, such as infection control. There was no substantive oversight of the quality of care by the provider. Staff said they were well supported by the manager and were able to raise issues if they wished to.

We found breaches in regulation 9 (Person centred care); regulation 12 (Safe care and treatment); regulation 17 (Good governance) and regulation 18 (Staffing).

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

Rating at last inspection.
This service was registered with us on 1 August 2019 and this is the first inspection.
The last rating for the service under the previous provider was good (published on 27 May 2017.)

Why we inspected
We received concerns in relation to several areas of care at the home. We had also twice spoken to the manager whilst undertaking an Emergency Support Framework call (support call during the Covid-19 pandemic) and highlighted that the service required ongoing support. As a result, we undertook a comprehensive inspection to review all the key question areas.

The overall rating for the service is requires improvement. 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. The provider has taken some action to mitigate immediate risks at the home.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Gables Care Home 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 monitor the service and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 9 (Person centred care); regulation 12 (Safe care and treatment); regulation 17 (Good governance) and regulation 18 (Staffing). Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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?

Good

The service was caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

The Gables 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
The inspection was undertaken by one inspector.

Service and service type
The Gables Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection a person was managing the service but had not formally started the process to register with the CQC.

Notice of inspection
We gave a short period notice of the inspection to ascertain the situation at the with regard to Covid-19 infections and to allow the home to prepare for the inspection to be carried out safely, with minimal risk to people living at the home.

What we did before the inspection
We reviewed information we had received about the service since it first registered. We sought 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 we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with three members of staff including, the manager and two care workers.

We reviewed a range of records. This included three 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, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who regularly engage with the service and also the provider.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated; requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Risks were not always clearly acknowledged and actions to mitigate against risks were not always identified or detailed for staff to follow.
• Documents to identify risks to people living at the home were often tick box in nature, with minimal detail.
• Actions to mitigate or limit risk during the delivery of care were not always written in care plans, although staff were aware of the hazards. For example, care plans did not contain up to date information on people's mobility needs and systems had not been established to limit the fire risk when people smoked in their rooms.
• People had emergency plans on how they should be supported in the event of a fire, but these were often limited in detail and did not always identify the extra needs some people had. Plans for evacuating the building at night, when there were fewer staff on duty, were not explicit.

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.

Following the inspection, we alerted the local fire safety team to our findings and asked them to contact the manager to review emergency plans.

• The manager had instigated processes to check on a number of safety issues, including the checking of fire safety equipment and water temperatures around the home. A fire safety audit had recently been completed and actions from this audit were in the process of being dealt with.

Preventing and controlling infection
• Systems to prevent and control the spread of infections were not always in place.
• Some areas of the home needed additional cleaning or repairs to improve the prevention of infection. Tiles and grouting in a shower area needed deep cleaning, flooring in the kitchen where a new sink had been fitted needed to be made good and the splashback and tiling in the kitchen needed to be updated. Two fridges in the kitchen needed cleaning and had areas of rust on the casing.
• There were limited prevention measures in response to the current Covid pandemic. The home's infection control policy had recently been updated but failed to note any additional measures for limiting the spread of Covid 19 infections. Staff were wearing face masks, but we witnessed they pulled these below their chin or unhooked them from one ear at time, rather than wearing them for full sessions before removing and replacing them.

• There were some bottles of hand sanitizer around the home, but none available in bathrooms and toilets. Toilet areas had cloth towels in use, which were used by multiple individuals at the home. No additional cleaning measures were in place for high risk areas, such as door handles and bannister rails.

The provider had failed to put in place effective measures to prevent or control the risk of infection at the home. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, we alerted the local infection control team to our findings and asked them to contact the manager to review infection control practices. The manager later told us they were reviewing the cleaning schedules at the home to improve the infection control practices.

Staffing and recruitment
• The manager told us the service had only recruited one new staff member recently. We looked at this file. There was no evidence in the file of an application form or current CV. There was no evidence in the file of two current references or a current Disclosure and Barring Service (DBS) check.
• We spoke with the manager about the recruitment of this individual. They told us this matter had been dealt with by the provider, but they understood all these issues had been addressed.
• We contacted the provider to ascertain the status of this person's employment. They sent us an email showing an up to date DBS certificate and later told us they had checked that a current DBS was in place using the online checking system. They told us they were only dealing with the DBS aspect of recruitment and the manager was dealing with all other aspects. This meant the recruitment process was not clear or robust.
• Duty rotas showed, and the manager confirmed there was only one member of staff on during the night shift. For two nights of the week the rota indicated this was a female staff member. One person's care record indicated female staff should avoid being alone with them due to their behaviour. There was no clear risk assessment or system in place to protect this lone female worker.
• Another person's care records stated they should be supported in the shower by two staff, due to mobility issues. This person was prone to occasional incontinence meaning they may require support with personal care at any time. Whilst there was an on-call system between the manager and the provider, there was no clear process to summon immediate assistance if problems arose during the night.

The provider had failed to robustly assess the risks relating to safe recruitment or have in place effective systems to ensure proper staffing levels were maintained. This was a breach of regulation 18 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• At the time of the inspection the service was under organisational safeguarding. Organisational safeguarding is a process put in place by the local authority where there are multiple concerns about a service.
• The service had a system to record and deal with any safeguarding issues that may arise.
• The manager had put in place a new system to help manage and monitor people's money and bank cards, which were retained in a locked cupboard. Whilst receipts for purchases were retained and regular audits were carried out, we were concerned all staff were able to access this cupboard.
• We were also concerned that where people could not get out to manage their own finances staff were accessing bank accounts on their behalf. Whilst there was no indication any issues had arisen from the system, we spoke to the manager about the potential for financial abuse to take place without improved arrangements.

We recommend the provider reviews the current arrangements with each person's care manager to ensure stringent systems and checks are in place to limit the potential for financial abuse.

Following the inspection, we raised our concerns with local safeguarding adults team and the practitioner leading the organisational safeguarding review.

Using medicines safely
• Systems were in place to manage medicines safely and effectively.
• Medicines were kept in a locked cupboard in the main office of the home. People had individual files regarding their medicines, including any creams and lotions they were using or homely remedies, such as over the counter pain relief.
• Where people had 'as and when required' medicines, that were only give occasionally, then there was a protocol on file dealing how theses medicines should be administered.
• Staff had received training around the safe administration of medicines and competency checks had been undertaken by the manager. A professional told us staff were very good at supporting people with their medicines and using 'as and when required' items appropriately.

Learning lessons when things go wrong
• During the early stages of the pandemic CQC had undertaken two calls with the manager about how the service was managing during the current crisis. The manager had acted on several the issues identified during these calls and put in place systems to improve the quality of audits and checks.
• The manager acknowledged there was still a great deal of work to be done to improve care and operating systems at the home but was trying to work through matters methodically. Following the inspection, the manager told us they had already started to address some of the issues raised.

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.

This is the first inspection for this newly registered service. This key question has been rated; 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
• People's needs were not always fully assessed and where needs had changed care plans had not been updated to reflect these changes.
• One person's care had been reviewed by a care manager. They had recommended the individual should not go out alone because they had previously fallen. The care plan relating to the person's mobility had not been updated to reflect this advice.
• Due to changes in mobility a person now required two people to support them in the shower. Their care plan did not reflect this change, although staff were aware of the issue.
• Some people were living with memory issues or could suffer periods of delusions or hallucinations. Information on how staff should support people during this period was limited. Staff were instructed to 'remain professional' without any clear guidance on what this meant.

The provider had failed to robustly assess people's needs and put in place effective systems that reflected and supported people's care needs. This was a breach of regulation 9 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff had received a range of training and support.
• Staff told us the provider had recently engaged with a new training provider and they were in the process of updating all their on-line training. The manager demonstrated the system and showed how they were able to monitor and review completion of training.
• One professional told us staff had the right skills to support people and were understanding and willing. Another felt staff tried hard, but sometimes lacked specific skills to support people with more complex issues.
• The manager had established supervision and annual appraisal meetings for all the staff at the home.

Supporting people to eat and drink enough to maintain a balanced diet;
• People's dietary needs were supported.
• They told us they enjoyed the meals at the home and had plenty to eat. They said they had access to fresh fruit whenever they wanted. Meeting records showed the manager had asked people what meals they wanted as part of a review of menus. This included a fortnightly takeaway night, which people said they really enjoyed.
• People were able to access the kitchen at any time and could get drinks when they wished.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with a range of agencies to support people's physical and mental health needs.
• There was evidence in people's care files that individuals had been supported to attend GP or hospital appointments or had been seen by health professionals at the home.
• Professionals told us staff worked closely with them and alerted them to any concerns. They told us staff were good at contacting health services where they had concerns.
• People told us, and records showed there was regular access to a range of health services. Support was given to allow people to visit health service or access support from mental health professionals.

Adapting service, design, decoration to meet people's needs
• Some improvements were being made to the home. The manager told us there was still work to complete, but they and the provider were working together to ensure improvements were made.
• People we spoke with told us the provider had told them directly that they were planning to refurbish people's individual rooms, the main lounge area and the dining area. They told us the provider was looking to involve them in choosing colours and designs for the refurbishment.

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. 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 manager monitored where people had their freedom restricted under a DoLS and was aware when such orders required to be renewed.
• Professionals told us best interest decisions had been made where people did not have the capacity to make informed decisions themselves.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were well supported by staff and that they understood their needs. Comments from people included, "The staff are great, I get on well with them. They try and get me anything I need" and "I like living here. We are all happy here. The staff are friendly and look after us alright."
• Staff understood people's daily support needs and were aware of their mental health issues. Staff were aware of people's rights under the equality act and supported people to take their place in the community.
• Professionals had mixed views about the care. One professional told us, "The home has had to put up with some really difficult behaviour over the years and staff have gone the extra mile to try and manage the situation." However, another professional stated, "It's a little bit chaotic but on the caring side they do their best."

Supporting people to express their views and be involved in making decisions about their care
• There was some evidence that people were able to participate in day to day decisions about their care. We observed staff supporting people during the inspection and assisting them with their daily needs.
• Care records suggested that people had been involved in reviews, but this was not always clearly stated or fully recorded. People told us staff spoke with them about their care needs.
• A number of 'residents' meetings' had taken place, where people had been encouraged to express their views about meal options and activities. People had been encouraged to speak about the pandemic and discuss how this affected them and what they could do.

Respecting and promoting people's privacy, dignity and independence
• People told us staff respected their privacy and helped maintain their dignity. One person told us, "You can keep yourself to yourself, if you want. But if you don't show your face for a while someone will come and check on you."
• Staff understood about supporting people to make daily decisions about their lives. They were aware that where people had capacity, they could often make different and apparently unwise decisions. Staff tried to support people to consider all aspects of the decisions they were making. One professional told us, "(Person) has long standing mental health issues, which can be challenging to manage. Overall I feel the care received by the service user has been very good."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated; requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were often limited and did not always reflect fully people's preferences of needs.
• It was not clear from care plans that a detailed assessment of people's needs had been undertaken or reviewed before determining people's care needs.
• There was partial evidence in people's records to show they had been involved in determining their care. People told us they could raise issues with the manager or any of the staff and they were responsive to their needs.
• Guidance for staff to follow in supporting people was often incomplete or limited. For example, details of how to support people during acute mental health episodes, including delusions or hallucinations often lacked detail. One person's plan highlighted they could be verbally abusive. The care plan stated that staff should, 'remind them of good manners.'
• Care plans reviews were undertaken monthly but varied in detail and often contained sections that had been cut and pasted from previous review documents.
• A safeguarding professional told us they had offered to support the manager with assessing risk and writing care plans but had not received any response to this offer. The manager confirmed they had been offered this support but had not had time to respond.

The provider had failed to robustly assess people's needs and put in place effective systems that reflected and supported people's care needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
• Information about the home and the local community was displayed around the building that met the communication style of people who used the service. There were posters and information reminding people about restriction under the current pandemic regulations and on the need to wear a face mask when out in the community.
• People told us if they were unsure about anything, they could approach any of the staff or the manager and they would assist them.

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 told us they were supported to participate in a number of activities, although opportunities had reduced due to the pandemic restrictions.
• They told us they could go out if they wished and those who needed assistance were regularly supported to access the community. Staff reminded people to stay safe when going out.
• People said staff had worked hard at trying offer activities and distractions during the pandemic. They spoke enthusiastically about the regular film night at the home. They also told us they could spend time alone if they wished.

Improving care quality in response to complaints or concerns
• There had been no formal complaints recorded at the home within the last 12 months.
• People said they had not raised any formal complaints recently and if they had any concerns they could speak with the manager or the provider, when they visited the home. There was also evidence people raised some issues as part of the 'residents' meetings.'

End of life care and support
• No one at the home was receiving end of life care. There was evidence in people's care files that they had been asked to consider their end of life wishes and make arrangements, if they wished to.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated; requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• The manager had been at the home for approximately seven months. No formal process to register with the CQC had been initiated. They told us they had received the DBS required and had started the registration process. We checked CQC records and saw no application documentation had been received.

• The manager told us there was significant work required to improve the service and they were trying to work through a range of issues. They had established regular monitoring for fire systems, medicines and people's individual finances. They stated they did not carry out any regular checks around the home and there were no consistent reviews of infection control and cleanliness to manage the threat posed by the pandemic.

• Reviews of care documentation had not identified that changes to people's needs had failed to be incorporated into care plans. We found several instances where information and documents had not been filed away in the appropriate areas.

• The manager said this was their first management post and so was unsure about what needed to be done or what were the required regulatory responses, although they were willing to be guided.

• There was some evidence that the manager had met with the provider to discuss changes and improvements, but these were not regular events and no clear action plans and time scales were evident. There was no indication of regular checks on the service by the provider to ensure quality and safety was being maintained.

• We spoke with the provider about what formal checks they carried out at the home. The told us that following the inspection they were now putting in place a formal process to monitor quality and safety, but until this point the system had been very much informal.

• Professionals told us that the manager was trying hard but felt they struggled because it was their first post. They said the manager was willing but would benefit for better support. They felt the provider needed to have better oversight of the service.

The provider had failed to establish robust management systems to ensure the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• There had been no instances where the provider was required to fulfil their legal responsibility under the

duty or candour, although the manager was aware of the requirement.
• There was no registered manager registered with the service. The previous registered manager had cancelled their registration in November 2019, meaning there had been no registered manager in post for 11 months.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and staff told us the manager had made improvements to the home and was very approachable. Staff told us, "(Manager) has done an excellent job since they have been here. There was loads of paperwork not up to date and they have sorted mountains of it" and "(Manager) has changed a lot of things. It's very different to how it used to be."
• People told us the manager was approachable. One person told us, "You can go and see (manager). They will always put things right, if they can." Staff said they felt better supported since the manager had arrived and could speak with them about anything. One staff member told us, "(Manager) is very understanding. If they can sort it, she will."
• Professionals told us the manager was trying hard to make improvements and was open to suggestions, although could be more proactive. One professional told us, "I feel (manager) has taken charge of the service and has tried to provide the necessary leadership."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us there were regular 'residents' meetings' and minutes from these meetings were available. We saw people were able to discuss a range of topics and make suggestion for improvements and changes. They told us they could also approach the provider, when they visited the home to make suggestions or discuss concerns.
• Staff told us there were staff meetings, but that the staff cohort was quite small, so communication was good. They said they could raise any issue with the manager or the provider at any time.

Continuous learning and improving care
• The manager was aware that there were considerable actions still required to improve the home and raise the quality of the service. They agreed they were happy to receive support and guidance, as this was their first post and they were not always sure about what should be a priority. One professional told us, "I feel they are very good; ask questions appropriately and engage well."
• Following the inspection, the manager told us they had already started to address some of the issue found during the visit, such as improving the cleaning regime to ensure high risk areas were cleaned on a more regular basis.

Working in partnership with others
• There was some evidence that the service worked in partnership with a range of services. Care records showed the service had worked alongside several organisations. One professional told us, "They will record and report things and are very good at working in partnership."

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 Systems were not in place to ensure people received up to date personalised care that met their needs or reflected their preferences. Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment were not provided in a way that kept people safe. Risks had not been fully assessed and action to mitigate risk had not been taken. Regulation 12.(1)(2)(a)(b)(d)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to effectively assess, monitor and improve the quality and safety of the service and ensure that risks were mitigated. Regulation 17.(1)(2)(a)(b)(c)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place to ensure there were sufficient number of suitable qualified and experienced staff to meet people's care needs. Regulation 18.(1).