Holt Green Residential Homes Limited

Silver Birch Lodge

Inspection report

Bold Lane
Aughton
Ormskirk
Lancashire
L39 6SH

Tel: 01695424259

Date of inspection visit:
11 February 2019
12 February 2019
13 February 2019
15 February 2019

Date of publication:
05 April 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Silver Birch Lodge is based in Aughton, near Ormskirk and provides accommodation for up to 31 older people, who require help with personal or nursing care needs. At the time of the inspection there were 21 people who lived at the service.

People's experience of using this service:
The service had significantly deteriorated since the last inspection.

The provider failed to ensure individual risks for people who lived at the service had been assessed and this placed them at significant risk of avoidable harm.

Medicines were not managed safely and people did not always receive their medicines as prescribed.

People were not always risk assessed in relation to falls and weight loss this meant they were at risk of serious harm.

The provider had not ensured equipment such as bedrails were routinely checked for mechanical safety or that decisions made to use restrictive equipment were in line with people's wishes or best interests.

We found the provider had not acted upon actions specified in a fire safety inspection report and therefore placed people at risk of avoidable harm in the case of fire. The provider did not have a suitable emergency evacuation procedure in place.

Staff were not always safely recruited. The provider did not always make sure checks were done in relation to suitability to work with vulnerable adults.

The service did not always support people in a person-centred way.

We found shortfalls in relation to the assessment of a person's mental capacity before restrictive practices were considered. We also found a substantial lack of understanding from the registered manager and senior staff about the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

The provider did not ensure staff had up to date training to be able to provide safe and effective care.

The management and oversight of the service was poor. We found ineffective quality assurance systems and this meant that risks highlighted at this inspection had not already been identified by the provider.

The service was clean and people were protected by the prevention and control of infection.

Throughout the inspection we observed suitable numbers of staff deployed across the service and people who lived at the service and their representatives provided positive feedback about staff who supported them.

We observed staff interacted with people in a dignified and respectful way. People who lived at the service had access to meaningful activities and were encouraged to access the local community.

Rating at last inspection:
Our last inspection report for this service was published on 31 October 2018 and the rating was 'Requires Improvement' across all domains. There were three breaches of regulations 9,12,17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, safe care and treatment and good governance. The provider was also in breach of regulation 18 of the Health and Social Care Act 2008 Registration Regulations 2009, Notifications of other incidents.

Following the last inspection, we took enforcement action and issued the registered provider with warning notices in relation to medicines management, risk assessment and good governance. We also asked the registered provider to tell us what actions they would take to comply with these regulations.

At this inspection in February 2019, we found the provider had made some improvements in relation to the prevention and control of infection. However, we found continuing areas for improvement in relation to governance arrangements, risk assessment and medicines management. Our findings showed there were areas which had deteriorated further and areas that required further improvements and improvements made needed to be imbedded and sustained.

The service had deteriorated and was rated overall Inadequate.

Why we inspected:
This was a scheduled inspection based on the service's previous rating and to review action taken against served warning notices for regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement:
Please see the 'action we told the provider to take' section towards the end of this report.

Follow up:
The overall rating for this service is inadequate and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Silver Birch Lodge

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

At the last inspection on 07 & 09 August 2018 the provider failed to comply with regulatory requirements and was served warning notices for breach of regulations 12 and 17 of the Health and Social Care Act 2008. This inspection was undertaken to check if the provider had made improvements.

Inspection team:
The inspection team consisted of four adult social care inspectors, one adult social care inspection manager and a pharmacist inspector.

Service and service type:
Silver Birch Lodge is a care home. People in care homes receive accommodation and nursing or personal care. 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:
The first, second and fourth days of the inspection were unannounced, we informed the registered manager that we would attend on the third day.

What we did:

Prior to our inspection we looked at all of the information we held about the service. This included any safeguarding investigations, incidents and feedback about the service provided. We looked at any statutory notifications that the provider is required to send to us by law. We used a planning tool to collate all this evidence and information prior to visiting the service.

We spoke with seven people who lived at the service and four relatives. We also spoke with the registered manager and provider, two registered nurses, three senior support workers, the care manager and a domestic worker. We looked at a variety of records which included the care files for eight people who used the service and three staff recruitment files. We also reviewed a number of records related to the operation and monitoring of the service and medicines management.

Inadequate

Our findings

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

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

Using medicines safely

● The provider failed to ensure service users were protected from harm or serious risk of harm in relation to the safe management of medicines. We found examples were people who lived at the service had not received their prescribed medicines. For example, one person was not given eye drops for glaucoma for 21 consecutive days. Not having eye drops for glaucoma regularly reduces the effectiveness of the eye drop, potentially increasing the risk of the person developing glaucoma related blindness and exposing them to the risk of harm. Another person had not received their prescribed Parkinson's disease medicines at times specified by the consultant neurologist. Parkinson's disease symptoms such as slower movement, known as the 'off time' period occurs commonly just prior to taking the next dose of the treatment. Delaying the administration of this medication may increase the risk of an off period and the health and wellbeing of the individual.

● Medicines systems were not adequately audited and therefore failings had not been identified by the provider.

● Staff responsible for the administration of medicines had not received training or been checked for competency in relation to the safe administration of medicines.

● People's medicines were not always stored at a safe and correct temperature. This meant that medicine properties and potency could have changed and therefore not been safe to administer to people that lived at the service and could have been less effective.

The provider had failed to ensure that medicines were consistently managed safely. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People had been exposed to the risk of avoidable harm because the provider had not sufficiently identified and managed risks to individuals. For example, one person was found by the inspection team on day one of the inspection to be entrapped in a bedrail that did not have a safety bumper. The provider failed to act on the information shared to them about the individual until the same person was again identified by

the inspection team on day two of the inspection to be entrapped in the same bedrail. Subsequently the provider then transferred the individual into a different bedroom and provided different equipment without any formal risk assessment or care planning. The individual then had a fall in their bedroom and sustained bruising to their hand.

● We found people's risk assessments were not always updated after they had fallen. This meant the provider did not ensure risks to the individual had been considered and, where possible, reduced. Another person's care plan showed they required bedrail bumpers to prevent entrapment or injury when in bed. We found bedrail bumpers had not been provided. Another person had fallen from their wheelchair and the incident had not been recorded in their care plans or risk assessments to show how further risk of falling would be managed or reduced.

● The provider and staff lacked understanding and knowledge of how to effectively risk assess. During the inspection external health and social care professionals were asked by commissioners to provide support and guidance at the service to help reduce the risk of further avoidable harm. The provider agreed to engage with services offered.

● The provider failed to undertake robust maintenance checks of the environment including bedrail and fire safety. We looked at maintenance, equipment servicing and fire prevention records. Areas highlighted to require action by the fire safety officer in September 2018 had not been addressed. We found people who lived at the service were at risk of harm in the event of a fire. The provider's emergency continuation plan had not been updated since 2016 and did not provide up to date information to assist staff in the event of an emergency and need for evacuation. We informed Lancashire Fire and Rescue of our findings.

The provider had failed to adequately assess risk and monitor safety at the service. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider failed to ensure people who lived at the service were safeguarded from the risk of avoidable harm. One person had been reported to have frequent falls. The falls log for the individual showed they had 11 falls from 12 September 2018 to 17 September 2018. The provider had not informed the local safeguarding authority or consulted the safeguarding triage tool in line with their safeguarding processes.

● We found an individual had received unlawful treatment. We escalated this to the local safeguarding authority for investigation.

● The provider failed to ensure people were provided appropriate equipment to prevent them falling from bed. Bedrails were being used without full consideration of a person's needs or preferences. When used inappropriately bedrails can be a form of mechanical restraint and the provider failed to demonstrate comprehensive assessments to show why bedrails were routinely used for 19 out of 21 people who lived at the service.

● Not all staff had completed safeguarding training. However, they were able to tell us how they would respond to any concerns.

The provider had failed to ensure people were safeguarded from the risk of harm and abuse. This was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider failed to implement systems to ensure lessons were learnt when things go wrong. Accidents

and incidents had been documented, however they were not analysed and the provider had not provided adequate oversight on the incidents and any lessons learnt.
● The provider told us communication between the staff team had deteriorated because of issues before the inspection with high use of agency nursing staff. At the time of the inspection registered nurses had been recruited and were undertaking the probationary period of their employment.
● The provider failed to ensure policies and procedures were available to guide staff in relation to best practice and review of national guidance when things went wrong.

Staffing and recruitment
● The provider failed to consistently undertake safety checks when they recruited staff. We asked to look at five staff files. However, the provider told us staff recruitment files were held off site and we were only provided with three of the five requested staff files. We found four people who worked at the service or had access to service user or staff confidential data had not undertaken criminal record checks as part of the Disclosure and Barring Service (DBS) process. These checks are to ensure people who work with vulnerable adults are of good character.

The provider had failed to ensure that staff were of good character and suitable for their role and responsibilities. This was a breach of regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People who lived at the service told us they felt safe and supported by staff night and day.
● We checked staffing rota's and found sufficient numbers of staff were deployed. There had previously been a high use of agency nurses however, this had significantly reduced in January 2019 when nurses had been recruited.

Preventing and controlling infection
● Infection control systems at the service had improved. We observed staff followed safe procedures and they had access to and wore protective clothing.
● The service was clean and the provider told us there had been no outbreaks of infectious disease.

Requires Improvement

Our findings

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

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

Staff support: Induction, training, skills and experience

- The registered provider had failed to provide care staff and nurses with adequate induction, training and development to ensure they could effectively undertake their roles.
- We found significant gaps in training and competence checks in areas that the provider had deemed mandatory for the roles. For example, subjects such as moving and handling, safeguarding, nutrition, skin care, medicines administration and fire awareness. The lack of training had contributed to the failures we found in the safe management of medicines, the unsafe fire safety practices, the shortfalls in falls prevention and bedrail safety. We asked the registered provider to take immediate action to prioritise training in these key areas and they started to take action during our inspection.
- Supervisions and appraisals were not held on a regular basis and the provider's policy and procedure in relation to staff support was not accessible. Some staff were not able to recall when they last had supervision.

There was a failure to ensure that all staff had received such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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. The application procedures for this in care homes and hospitals are 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 were being met.

● The registered manager and staff members lacked understanding of the MCA and DoLS. The registered manager had applied for DoLS authorisation from the local authority. However, they had applied to deprive people of their liberties even when they were able to consent to their own care and were not restricted.
● Mental capacity assessments were generic and not decision-specific.
● Three people had their consent forms signed by family members; however, there was no evidence whether the people lacked mental capacity to make those decisions and there was no evidence the correct lasting power of attorney was in place to allow family members to sign consent.

The provider had failed to ensure they were working within the principles of the MCA and the correct DoLS were in place and is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care
● The systems in place for referrals to external services, such as GPs, were not always effective. We had to ask the registered manager to seek specialist support for people who lived at the service during our inspection. This included people who were at risk of falls and unintentional weight loss.
● Guidance from healthcare professionals was not always sought or followed, as discussed in the 'safe' section of this report.
● The registered manager had not sought support from external agencies to effectively manage people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● While care and support had been planned, people's care was not always delivered and monitored in line with current evidence-based guidance, legislation, standards and best practice.
● Assessments had been carried out and some obtained from other health and social care professionals and used to develop care plans, however this was not always consistently followed.
● Staff were unable to apply learning in line with best practice. This does not promote good outcomes for people or support a good quality of life.

Supporting people to eat and drink enough with choice in a balanced diet
● All the people we spoke with, told us they got a choice of what they wanted to eat every day. We observed people being supported and there was plenty to eat.
● People were given plenty of time to eat their meals and staff provided appropriate support to those who needed it. People had a choice of what they wanted to eat.
● People had access to fresh fruit and unlimited drinks. Care records contained assessments for nutritional needs.

Adapting service, design, decoration to meet people's need
● Signage was available to promote people's independence, for example to locate bathrooms and their bedrooms.

● We saw people had personalised their bedrooms with their own items of furniture and ornaments.
● As mentioned in the 'safe' section of this report there was a lack of timely response to shortfalls around the maintenance of the environment to ensure the safety of people. This included the provision of adequate lighting in the corridors and maintenance of fire safety doors.
● Technology was not widely used within the service.

Requires Improvement

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Supporting people to express their views and be involved in making decisions about their care
● People were not always involved in making decisions about their care. Not all the people we spoke with believed they were involved in decisions about their care and support. Comments we received included, "No one has spoken to me about my care." And, "If they come to me we can discuss my care; however no one has come to me."
● Care records we looked at did not always show whether people had been involved in the development or reviewing of their support needs.
● Information about people's background, history, favourite past times and life experiences had been captured in care records.
● Most people felt that information was given to them in a way they could understand. However, during the inspection we found staff and the registered manager were not always able to provide people with explanations about any changes to practices related to people's care and or safety. We asked the registered manager to ensure they communicate changes to people's care with all people in the home to ensure people were kept informed and to reduce anxiety.
● There was information about advocacy and how to access the service. Some people used their relatives to ensure their views were heard. The role of an advocate in health and social care is to support a vulnerable or disadvantaged person and ensure that their rights are being upheld in a healthcare context.

Respecting and promoting people's privacy, dignity and independence
● People told us their right to privacy and confidentiality was respected. However, we noted personal care records were in the registered manager's office which was left unlocked when unattended. We discussed this with the registered manager as records should be kept safely and securely who gave assurance that records would be stored safely.
● People who used the service were treated with dignity and respect. We saw staff knocked on doors before entering bedrooms and bathrooms. However, care staff had not received up to date training in relation to equality and diversity and human rights to increase their awareness of people's rights.
● We noted people were not always supported to manage their health conditions by ensuring they had their

medicines.
● Staff promoted people's independence and encouraged them to do things for themselves. We saw the registered manager encouraged some people to help with chores in the home. People also told us they were encouraged to go out in the community with their families if they wanted to.

Ensuring people are well treated and supported; respecting equality and diversity
● People told us, "Staff are kind. They are approachable." And, "They show concern and will ask how I am."
● We observed positive interactions with staff during our inspection. Staff presented as kind and caring. However, some of our findings did not demonstrate that the home was caring. For example, we found concerns that people were not given their medicines when they needed them which may cause a deterioration to their conditions.
● Staff understood how best to communicate with people.
● Visitors to the service were made to feel welcome and were offered refreshments. Visitors including family members, friends and health and social care professionals told us staff were always welcoming, polite and courteous.

Requires Improvement

Our findings

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

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● The provider failed to ensure people who lived at the service consistently received person-centred care. We found people's individual needs and associated risks were not always identified or considered. For example, failings around individuals' care in relation to inaccurate medicines management, falls and inappropriate use of bedrails as outlined in the 'safe' section of this report.
● We saw care plans did not always reflect people's choices, wishes and preferences and things that were important to them.

The provider had failed to ensure people received consistent person-centred care. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Throughout the inspection we observed staff approached people in a kind and respectful way. During discussion with staff they appeared to understand people's backgrounds and life stories.
● We received positive feedback from people in relation to how they were supported. People told us, "Staff know me well." And "The staff know I like to make my own choices and they respect that."

Improving care quality in response to complaints or concerns
● The provider told us there had not been any complaints since the last inspection.
● People who lived at the service and visitors had access to the complaints procedure and this was wall mounted at the entrance to the service.
● We received positive comments from people about the registered manager and senior staff at Silver Birch Lodge. Comments included, "I feel confident to raise my concerns with the owner." And "There is always someone to talk to if I have anything to complain about."
● The provider did not carry out regular resident and relative meetings. We looked at the most recent service user survey and results which were collated in April 2018. Survey results showed positive comments from people who used the service.

End of life care and support

● There were systems to support people at the end of their life. We looked at people's end of life care plans and found some examples where people had been engaged in conversations about end of life care and their preferences.

● The provider told us two senior support workers had been enrolled onto a nutrition at end of life course facilitated by a local hospice.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The service was not well-led. The registered manager lacked knowledge around the regulations, legislation and best practice guidance to ensure the service improved.
- The service had continued to fail since the last inspection. This showed there were inadequate management systems at the service.
- Leadership within the service was poor. Staff were not led by best practice.
- There was a significant lack of understanding around risk management.
- Those people with complex needs were at risk of receiving inappropriate or inadequate care and support.

The provider failed to assess, monitor and mitigate the risks relating to the health and welfare of people using the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider failed to ensure they promoted consistent person-centred, high quality care and support for people who lived at the service. We found people were not always assessed in a person-centred way in relation to individual risk and this meant that they were at risk of avoidable harm, as highlighted in the 'safe' section of this report. People did not always receive their medicines as prescribed and risk associated with inappropriate use of bedrail entrapment had not been addressed in a person-centred way.
- Care records did not always reflect people's needs.
- The provider did not always act on their duty of candour responsibilities in relation to escalation of people's change in health needs and reporting of incidents. For example, one person who lived at the

service had not received their eye treatment for 21 consecutive days which meant they were at risk of becoming blind. Two people had not received their anti-coagulant medication as prescribed and this placed them at serious risk of avoidable harm. Instances of medicine omission had not been escalated to the person's GP for review of their health and well-being.

The provider failed to maintain an accurate record in respect of each person using the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

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

- The provider did not routinely involve people who used the service, public or staff.
- The service did not hold regular meetings with people who used the service or their representatives.
- The provider told us that informal staff meetings were held on a regular basis during shift handover. However, formal meetings were not scheduled to give all staff members the opportunity to feedback on the service in a structured way.
- The provider issued a service user survey in April 2018 and results of the survey showed positive comments. Relative, staff and visitor surveys had not been issued.
- Throughout the inspection we found the provider did not effectively engage staff to understand the risks identified such as medicine management, fire safety and medicine management. We found their communication with staff was not effective.

Continuous learning and improving care and working in partnership with others

- Quality assurance processes were not effective and did not identify the issues we found during this inspection.
- The service had not adopted a learning culture.
- Local authority and health commissioners told us the provider previously failed to engage in resourceful initiatives such as training programmes and best practice committee places offered to them.

The provider failed to assess, monitor and improve the service and was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection the provider agreed to engage in the support offered from the local authority and health commissioners this included medicines optimisation and falls prevention to assist in risk reduction at Silver Birch Lodge.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure people received care and support in a person-centred way. Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) (f) (g) (h) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to ensure people were consistently cared for in line with principles of the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Equipment was not always used in a safe way. Medicines were not always managed safely.

	Risk assessments were not always carried out to protect people from avoidable harm and the registered provider had not done all that was reasonably practicable to minimise the risk of avoidable harm. Regulation 12 (1) (2) (a) (b) (c) (h) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to ensure people who lived at the service were always safeguarded against avoidable harm and abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to implement robust quality assurance systems. The Provider failed to maintain contemporaneous and complete records for people at the service. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure staff had received suitable training to be able to provide safe and effective care for people who lived at the service. Regulation 18 (1) (2)