

Four Seasons (Evedale) Limited

Evedale Care Home

Inspection report

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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

Evedale Care Home provides nursing and residential care for up to 60 older people, including people living with dementia. At the time of our visit 54 people lived at the home. This included three people in short term discharge to assessment beds (D2A) which are used to support timely discharges from hospital. Most people had complex needs. Accommodation is provided in a purpose built building across two floors.

People's experience of using this service and what we found

There continued to be a lack of effective governance, management and provider level oversight at the service. Quality monitoring systems and checks designed to identify shortfalls, and to drive improvement had not been embedded and were ineffective. This demonstrated lessons had not been learnt since our last inspection. Despite our findings, people and relatives told us they were happy with the care provided and staff felt supported by the registered manager.

Risks associated with people's care were not always identified, assessed and well-managed. Staff had been recruited safely. People's quality of life was negatively affected by staffs limited availability. People's medicines were not consistently managed and administered safely in line the provider's procedure and best practice guidance.

People had access to health and social care professionals. However, the advice they gave was not always followed. People were not 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 support this practice.

People and relatives spoke highly of the staff who cared for them and despite our findings told us they felt safe. Most staff were caring in nature but did not have the time needed to provide person centred care. Staff understood the importance of promoting people's rights. However, some staff practices did not always reflect this.

People's care was not always provided in line with their planned needs and preferences because staff were busy. Staff understood the needs of people who lived at the home permanently but had limited information about people staying in a D2A bed. Care records did not consistently contain accurate and detailed information. People had opportunities to engage in meaningful activities. Complaints were managed in line with the provider's policy and procedure.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 21 February 2019).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to safe care and treatment, including risk and medicines management, person centred care, and how the service is managed at this inspection.

Follow up

We will request an action plan for the provider to understand what they will do to improve 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.

Special measures

The overall rating for this service is now 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

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

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 ●

Evedale 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team

The inspection was conducted by two inspectors, one assistant inspector and one nurse specialist.

Service and service type

Evedale 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 are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This comprehensive inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection, including feedback from relatives and the local authority safeguarding team. We sought feedback from a health care professional and the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During our inspection visit

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to

help us understand the experience of people who could not talk with us. We observed care and support being delivered in communal areas of the home.

We spoke with eight people who lived at the home and four relatives about their experiences of the care provided. We spoke with the regional manager, registered manager and 11 staff including, nurses, care and housekeeping staff and the cook.

We reviewed a range of records about people's care and how the service was managed. This included eight people's care records, 28 medicine records and a range of supplementary records to ensure they were reflective of people's needs. We looked at three staff personnel files to ensure staff had been recruited safely. We also sampled records relating to the management of the service including, falls, accidents, incidents, complaints, staff rotas, the provider's policies and procedures and quality assurance checks and audits.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people's safety was not well-managed. Three people had been admitted to the home the day before our visit. However, nurses had failed to ensure required risk assessments were completed in line with the provider's admission policy. Therefore, staff did not have all the information they needed to provide safe care. We shared this with the registered manager. In response they said, "I will be speaking to nurses sternly they know these should be completed."
- One person was lying on a partially deflated air-filled mattress. The mattress pump was making an extremely loud noise and the low-pressure alert light was illuminated. Whilst the person had not been harmed by this, staff had failed to notice the deflated mattress and act to investigate the noise. This was despite them going into person's bedroom. We immediately alerted the registered manager and the mattress was then replaced. Air filled mattresses are used for people who have or are at risk of developing sore skin.
- Known risks had not always been assessed. One person had epilepsy. A nurse confirmed a risk assessment had not been completed. They said, "Oh we should have one in place, I will do it," and the assessment was completed.
- Whilst staff understood their responsibility to manage risk their practice did not demonstrate some risks were well managed. Staff had placed one person's breakfast on their overbed table which was positioned too high. This resulted in the person spilling their drink over their nightdress and bedclothes because they could not lift their arm high enough to put the cup back onto the overbed table.
- The provider's emergency evacuation plan was not up to date. We saw two lists detailing people who lived at the home in the 'grab bag'. Both contained inaccurate information. Therefore, staff and the emergency services did not have the information they needed to keep people safe in the event of for example, a fire. This was addressed during our inspection. A grab bag contains essential equipment and information for use, by staff, if it is not safe for people to go back into the home, for example due to fire damage.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate risk associated with people's care was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- At our previous inspection, we found people's medicine were not always managed and administered safely. At this inspection these concerns remained.
- One person was prescribed medicine to thin their blood. We found physical stocks of this medicine did not

balance with those recorded as received and administered. This indicated the person had not received one dose of their medicine. Missing a dose of this medicine can increase the risk of stroke, heart attack, or other serious conditions.

- Where people were prescribed 'as required' medicines, information was not always available to inform staff why the medicine had been prescribed or when they should give it. This is important to ensure these medicines are administered as prescribed.
- Four people were prescribed medicine administered via a patch applied directly to their skin. Records did not confirm daily checks had been completed as required. These checks are important as patches can fall off or be accidentally removed by the person. Ensuring patches remain in place is important in ensuring, for example people do not experience unnecessary pain.
- One person was prescribed oxygen therapy. Records to show the required twice daily checks of the person's oxygen levels were incomplete. For example, no checks had been completed on 1, 2 and 3 February 2020. These checks are important because reduced oxygen levels can lead to very serious health complications.
- At our previous inspection, the use of poor-quality photocopied forms meant information recorded could not be easily read. At this inspection we found the same concern, including charts used to record blood sugar levels prior to administering insulin. Checking these levels is an important part of diabetes management to determine the amount of insulin needed. People could be put at risk of receiving incorrect doses of insulin because the records were illegible.

We found no evidence that people had been harmed however systems and processes were not sufficient to demonstrate people's medicines were managed and administered safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the registered manager began to address the concerns we identified.

- People told us they received their medicine when needed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Despite our findings people felt safe. One person commented, "Security is great."
- Staff received safeguarding training and knew how and when to report concerns. Whilst confident these would be addressed, staff understood how to escalate their concerns if they were not.
- The registered manager had shared information with the local authority safeguarding team to ensure allegations were investigated. However, learning from a recent safeguarding investigation, for example the need to improve record keeping, had not always been used to make improvements.
- Accidents, incidents, including falls and unexplained bruising were reported and analysed to identify patterns and trends. Where needed action had been taken to prevent reoccurrence. For example, the whole staff team had re-read the provider's falls procedure and protocol. Records confirmed these were being followed.

Staffing and recruitment

- People and relatives provided mixed feedback about staffing levels. Comments included, "They are short staffed. [Person's Name] waits a long time." And, "[Person's name] presses their button and they come quickly." And, "There are very few carers and they are rushed all the time."
- Staff felt more of them were needed because people who stayed in the D2A beds required high levels of care and support.
- The registered manager told us they believed there were enough staff. However, they described the effect

D2A beds had on staff availability. They said, "Sometimes these impact on permanent residents, they hardly see the nurse because they are focusing on the new people."

- A health care professional told us there appeared to be a need to increase staffing to 'improve patient care' because of people's complex needs. They added, "I genuinely do feel they [staff] do their best taking this into account."
- Staff were recruited safely in line with the provider's recruitment procedure.

Preventing and controlling infection

- There were systems in place to prevent and control the risk of infection.
- Staff had completed infection control training and practiced good infection control.
- Housekeeping staff followed cleaning schedules to ensure high standards of cleanliness were maintained throughout the home.

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 deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they moved into the home. However, information for people in D2A beds was not shared with staff in a timely way. This meant staff did not fully understand people's initial needs, associated risks and preferences.
- Staff had not always followed the provider's procedures and best practice guidance. For example, nurses had not taken measurements and photographs of wounds as required. One nurse told us this was because, "We haven't had a camera for some time."

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

- People had access to a range of health and social care professionals. One person explained a GP visited the home weekly which meant they could 'be seen quickly' when needed.
- Staff regularly consulted with healthcare professionals, such as GP's. However, health care professional's advice was not always followed, for example in relation to weight loss.
- A health care professional told us working closely with the management and staff team had resulted in positive outcomes for people.

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

- Monitoring of food and fluid intake for people assessed at risk of malnourishment was not always undertaken. This included one person who had lost weight and regularly refused their meals. When we raised this, one nurse told us, "I will put the charts into place now."
- We saw some people who were cared for in bed were unable to reach their drinks which could leave them dehydrated.
- People gave positive feedback about their food and one person described it as 'excellent'.
- Staff knew what people liked to eat and drink. People's dietary preferences were catered for.

Staff support: induction, training, skills and experience

- People and relatives were confident in the skills and knowledge of staff.
- Staff developed and refreshed their knowledge and skills through a best practice-based induction and programme of on-going training. One staff member said, "We have had some more falls training to help us keep people safe." Staff training was up to date. However, we saw staff did not always put their training into practice, for example to ensure people's rights were promoted and upheld.

- Staff received support and guidance through individual and group meetings and observations of their practice.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 registered manager worked within the requirements of the MCA. They had submitted DoLS applications where needed to keep people safe.
- Staff completed MCA training and worked within the principles of the Act by gaining people's consent before they provided care.
- Some people's care plans identified if they had capacity to make specific decisions and included details of representatives who had the legal authority to make decisions on their behalf.

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

- People had personalised their rooms with treasured items.
- People had access to a range of communal areas and quiet spaces, including a sensory room designed to meet the needs of people living with dementia.
- Directional signs assisted people to move around their home and wide corridor and doorways ensured people who used mobility aids could access all indoor and outdoor spaces.

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always upheld. One person told us a staff member had informed them they did not need to use the toilet because they were wearing a continence pad. The person said they did not understand this because they used the toilet, with assistance, prior to moving into the home the previous day. We alerted the registered manager to this poor practice. They confirmed the person had received an apology and the assistance they needed.
- People's independence was not always promoted. At the start of our inspection we heard a person calling out, "Is there anyone about, can you please come?" No staff were nearby so we went into the person's bedroom. The person was in bed trying to turn their television on using their remote control. However, they could not do this as the plug socket was switched off at the wall. They told us, "I have told them (staff) not to switch it off, but they keep doing it."
- We saw staff supported people to make daily decisions such as, where to spend their time. However, one person told us, despite feeling hungry, they would have to wait for their breakfast until it was served by staff an hour later. When we asked a kitchen assistant to provide breakfast in line with the person's wishes. They replied, "Ok, but people don't have breakfast until 9 o'clock."
- People said their privacy was respected. One person described how staff closed the door and curtains before providing assistance with personal care.
- People's confidential information was securely stored in line with legislative requirements.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People and relatives spoke highly of staff. Comments included, "I get treated as a human being. Not an old lady who needs looking after," and "They become friends, not carers or nurses."
- Staff enjoyed their jobs. One said, "We are a big family."
- Records showed most people and relatives were involved in planning and reviewing their care. One relative told us, "I have seen [person's name] care plan and they talk to me about their care so they get it right for them." The relative said this reassured them their family member received good care.
- Records for people who lived at the home permanently contained information about their life style choices, so staff knew what was important to them. Staff had completed equality and diversity training.
- Most staff supported people in a kind and respectful manner and demonstrate a caring attitude. However, they did not always provide timely personalised care because they were busy which meant they were task focused. Whilst, the registered manager acknowledged this approach commenting, "Staff complete tasks but don't always put people first. I need to do a massive job to teach staff how to care for people." They

failed to recognise how current staffing levels limited the time available to staff to provide person centred care.

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 deteriorated to requires improvement. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People did not always receive personalised and responsive care. We heard one person repeatedly shouting out 'carer'. No staff were nearby to hear the person's calls for assistance, so we activated their call bell. The person told us their toe was sore and their foot was rubbing on the bed bumper. The nurse who responded provided the person with pain relief medicine but did not assist the person to move their foot to stop it from rubbing until we prompted them to do so.
- Another person was also heard calling out for help because they did not have access to their call bell. They told us, "I need that call bell. I have been in a pickle." When we alerted staff, they did respond to the person's request for assistance.
- We saw a third person in bed wearing a hospital gown and hospital identification bracelet. Their personal belongings were on the bedroom floor in green plastic bags. Staff told us the person had been admitted to the home at 5.30pm the day before our visit and they had not yet had time to assist the person to change their clothing or put their belongings away. The registered manager told us they would address this poor practice with staff.
- People did not always have their preferences respected. One person liked to have a shower. This was reflected in their care plan and confirmed by their relative. However, completed records showed the person been provided with 'bed baths' but they had not had a shower for over a month. Staff were unable to explain the reason for this.
- At our previous inspection, people's care plans were personalised, detailed and up to date. This standard had not been maintained. For example, no care plan had been written for one person known to have sore skin. Another person's plan had not been updated to reflect recommendations made by a health care professional. Therefore, staff were not monitoring the person's weight at the agreed intervals to ensure action was taken if weight loss was noted. The person had lost weight. Action was taken to address this.
- Supplementary records, including bed rail checks, food and fluid intake, monthly welfare and continence and repositioning charts had not been consistently and accurately completed. For example, one person's care record showed they had been assisted to clean their teeth on the morning of our inspection. This conflicted with our observations because we saw the person's toothbrush was dry. When we asked a staff member about this they replied, "I don't have an explanation." Poor record keeping meant we could not be sure people were receiving their care as planned and in line with their wishes.

We found no evidence that people had been harmed however the care and treatment people received was not personalised to reflective their preferences and needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager assured us action would be taken to address the concerns we identified.

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.

- People had access to some information in different formats including, pictorial and large print.
- People's communication needs had been assessed and staff used people's preferred methods of communication to ensure communication was effective.

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 enjoyed the activities provided. One person told us they loved spending time with the different animals who were brought to the home. Another person told us they enjoyed quizzes.
- We saw people and staff smiling and laughing as they sang and danced together. One relative who was also dancing said, "[Person's name] loves music, staff get them up to dance, they just love it."
- People and staff were supported to practice their religious beliefs and people's friends and families were welcome to visit at any time.

Improving care quality in response to complaints or concerns

- People and their relatives knew how to make a complaint and felt able to do so.
- Staff understood their responsibility to support people or relatives to raise concerns.
- Records confirmed complaints had been managed in line with the providers complaints procedure.
- The home had received numerous 'thank you' cards and one relative had written a poem to thank staff for the care provided to their relative.

End of life care and support

- Staff had received training to support people as they neared the end of their lives.
- A health care professional told us they had received positive feedback from patients and relatives about the end of life care provided by the staff.
- Care plans contained some information about people's end of life wishes if they had chosen to share this information.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- At our last inspection in January 2019, the service was rated requires improvement for the fourth consecutive time. The provider has a history of failing to meet required standards and maintaining regulatory requirements.
- At this inspection the provider had failed to maintain compliance with regulations. We found the provider was in breach of three regulations.
- The provider had failed to ensure action was taken to address the concerns we identified at the last inspection to ensure people received good quality, safe care.
- The provider continued to fail to maintain sufficient and accurate oversight of the service which meant previously demonstrated good standards had not been maintained, including care records.
- The provider's systems and processes failed to effectively monitor the quality and safety of the service provided. For example, a medicine audit dated January 2020 and a care plan audit dated November 2019 had not identified the issues we found.
- The registered manager lacked oversight of the service provided. They had failed to identify people had not received personalised care because staff were not available at the times people needed them. This meant person centred care was not promoted.
- The registered manager had failed to identify risk management was ineffective. Therefore, people were not in receipt of safe care.

We found no evidence that people had been harmed. However, the above issues demonstrate a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had met the legal requirements to display their latest CQC rating.
- Since our last inspection the deputy manager had been appointed as the registered manager. They were supported by a team of nurses and senior care staff. The registered manager described their role as 'challenging'. They said, "I haven't physically got time to do everything."
- The registered manager recognised their need to develop their management skills and knowledge of regulations. They told us, "Once I get my deputy. I am hoping to do an NVQ 5." A deputy manager had been appointed.
- Staff described the registered manager as approachable and supportive. One said, "I think [registered

manager] she is doing a good job...she does ask us our opinions, so she does listen to us."

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

- Despite our findings people and relatives were satisfied with the service provided and the way the home was managed. One person said, "I love it here." A relative described being 'very happy with everything', adding, "The manager is lovely."
- The provider invited people and relatives to give feedback about the service through quality questionnaires. The most recent feedback showed good levels of satisfaction.
- The registered manager and staff team worked in partnership with other professionals and were supportive of community projects. The home had hosted a coffee morning to raise funds for a national charity and plans were in place to further develop community links, including a local bowling club.

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 understood their responsibility to be open and honest when things had gone wrong. Throughout our inspection the registered manager was open and honest and welcomed our inspection and feedback. They said, "I would rate us as requiring improvement, but we are working hard, and the cleanliness has improved." They added, "I know we can do it, we just need a bit more time."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not taken all reasonably practicable steps to ensure people received person-centred care that met their needs and reflected their preferences.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care and treatment was consistently provided in a safe way. The provider had not ensured risks associated with people's care was identified and assessed and well-managed. The provider had not ensured timely action was taken and risk reduction measures introduced to minimise known risk. The provider had not ensured medicines were managed and administered in line with their policy and procedures and best practice guidance.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury

The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided.

The provider had not ensured they had effective system and process to identify and assess risk to the health and safety and welfare of people who used the service.

The provider had not ensured records relating to the care and treatment of each person using the service were accurate, detailed and up to date.

The provider had not ensured, timely, improvements to the service provided had been made and sustained.

The enforcement action we took:

NOP