Ernehale Lodge Care Home Limited

Ernehale Lodge Care Home

Inspection report

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Date of inspection visit:
26 April 2019
29 April 2019

Date of publication:
03 June 2020

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: Ernehale Lodge Care Home is a care home that provides personal care for up to 30 people in one purpose-built building. It is registered to provide a service to people who may be living with dementia or physical disability. At the time of the inspection 20 people lived at the home.

People's experience of using this service: The service was not safe. People were placed at risk of harm as risks associated with their care and support and the environment were not managed safely. Opportunities to learn from accidents had been missed which meant people had been exposed to the risk of avoidable harm. People were not protected from the risk of infection. Although people told us they felt safe, action had not always been taken to protect people from improper treatment and abuse. Overall there were enough staff, however, there were concerns about night time staffing levels. Safe recruitment practices were followed.

People's rights under the Mental Capacity Act 2015 were not protected. Staff required more effective training and support to enable them to provide high quality care. We have made a recommendation about this. Mealtimes were positive experiences; however, more work was needed to ensure risks were managed safely. People had access to a range of health care professionals. Overall, the home was adapted to meet people's needs, but further work was needed to ensure the environment was well maintained.

People's right to privacy and to be treated with dignity were not always upheld. People told us that staff were kind and caring. However, care plans lacked information about people which meant staff did not always have enough information to provide person centred care. There was an inconsistent approach to involving people in decisions about their care and support.

People did not consistently receive personalised care that met their needs. People were not consistently provided with opportunity for meaningful activity. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Ernehale Lodge Care Home was not well led. There had been a failure to identify and address issues with the safety and quality of the service. Systems to monitor and improve the quality of the service were not effective. Where audits had identified areas for improvement action had not been taken to address issues. This failure to identify and address issues had a negative impact on the quality of the service and for people living there.

The service met the characteristics of Requires Improvement in three areas and Inadequate in two areas; more information is in the full report.

Rating at last inspection: Inadequate (report published on 8 January 2019). At the last inspection September 2018, we asked the provider to take action to make improvements in relation to promoting dignity and respect, risk management, staff recruitment and governance and leadership. At this inspection we found

action had been taken in some areas but not others. You can see what action we told the provider to take at the back of the full version of the report.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service therefore remains 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.

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**

Ernehale Lodge 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: This inspection was carried out by one inspector and an expert by experience who had personal experience of caring for someone who uses services that support older people.

Service and service type: Ernehale 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: This inspection was unannounced.

What we did: Before the inspection we reviewed any notifications we had received from the service and information from external agencies such as the local authority. We did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us to give key information about the service. We gave the provider and registered manager the opportunity to share this information during the inspection.

During our inspection we spoke with nine people who lived at the home and four visitors. We also spoke with four staff, a member of the catering team, a nurse, the clinical lead, the registered manager and nominated individual. The nominated individual is the person who the provider has nominated to communicate with CQC. We reviewed records related to the care of seven people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, three staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information from the provider. This was provided within the requested timeframe.

Inadequate

Is the service safe?

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.

Assessing risk, safety monitoring and management;
• At our September 2018 inspection we found that people were not protected from risks associated with their care and support or from the risk of infection. This was a breach of regulation 12 of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these issues remained.
• People were not protected from risks associated with their care and support. Risks such as falls, choking and pressure ulcers were not always effectively managed. For example, records showed one person had a pressure ulcer. We observed they were not provided with sufficient personal care to prevent the pressure ulcer from worsening. Another person was at high risk of choking, there was insufficient information in their care plan about this and staff did not know what to do if the person choked. This failure to assess and manage risks placed people at risk of harm.
• People were not protected from the risks posed by the behaviour of others. Records showed one person often behaved in a way that placed others at risk. There was insufficient information in their care plan about triggers to behaviour or how staff should support them. Furthermore, staff did not follow the small amount of guidance there was. For example, the care plan stated the person must be supervised at all times to reduce risk. However, we observed the person was not supervised as directed. This placed other people at risk of harm.
• Staff were at risk of harm. Behaviour records documented a person frequently threatened to hit or punch staff. Staff told us they did not have sufficient training in managing behaviour and we saw there were not always enough staff on shift to ensure safe practices were followed. This placed people at risk of harm.
• People were not protected from environmental risks. Dangerous storage areas were not kept locked and could have been accessed by people. For example, we accessed the lift shaft plant room containing dangerous equipment and a storage area containing hazardous items such as white spirit and tools. This placed people at risk of harm. The provider had fitted locks to these areas on the second day of our inspection.

Learning lessons when things go wrong;
• There had been a failure to learn from incidents. Although there were systems to review and incidents effective action was not always taken to prevent the same thing happening again. One person had sustained scalding as the result of dropping a hot drink on themselves. Their care plan had not been reviewed to incorporate learning, this posed a risk this may happen again. Furthermore, there was no evidence that this incident was investigated to identify and address any poor practice.
Preventing and controlling infection;
• People were exposed to the risk of infection. Hygienic practices were not always followed. Some equipment such as mobility and pressure relief equipment had not been effectively cleaned. This could have increased the risk of infection.

Using medicines safely;
• Medicines were not always administered safely as directed. One person required support to apply creams to prevent skin damage. However, there were no records this had been applied. We observed this person's skin was in poor condition. Records showed another person was known to try and cause harm to themselves with medicines. Despite this known risk, there were no procedures in place to ensure the person did not stockpile medicines. This placed people at risk of harm.

The provider failed to provide safe care and treatment, this was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other than the above issues, medicines were managed safely and records showed people received their medicines as prescribed.
During and after our inspection, the provider took action on our feedback to reduce risk in some areas. This included the installation of locks on unsafe areas and the implementation of new care plans.

Systems and processes to safeguard people from the risk of abuse
• Action had not always been taken to protect people from improper treatment and abuse.
• People were subject to potentially unsafe restrictive practices. Staff told us that it had been necessary to hold one person's arms down during personal care to prevent injury. This approach was not specified in their care plan and staff did not have training in physical intervention. Records showed this person had unexplained bruising on their forearms. This had not been investigated or referred to safeguarding for further investigation.
• Records showed another person who was resistive to personal care had also sustained an injury resulting from a struggle whilst being supported with personal care. This had not been investigated or referred to safeguarding. This posed a risk that action may not be taken to protect people from abuse and improper treatment.

The provider failed to provide safeguard people from improper treatment and abuse, this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite the above, most people told us they felt safe. One person told us, "'This is a safe place. I don't want to be anywhere else." Records showed the registered manager had made safeguarding referrals for incidents other than the above.

Staffing and recruitment
• Overall, there were enough staff to ensure people's safety. People's feedback about staffing levels was positive. One person told us, "I don't think they are short staffed. There are always plenty of staff around and they are really good." We identified concerns that there may not be enough staff on shift at night to respond to an emergency. We discussed this with the provider who told us that it was in line with their staffing dependency tool.
• At our last inspection we found staff were not recruited safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. Safe recruitment practices had been followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

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

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.

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. We checked whether the service was working within the principles of the MCA.
• At our September 2018 inspection people's rights under the MCA were not protected. This was a breach of the legal regulations. At this inspection, we found continued concerns in this area.
• Several people resided in shared bedrooms and some were unable to consent to this. Although capacity assessments had been implemented, there was no evidence that less restrictive options had been considered to ensure people's privacy. Furthermore, 'room sharing contracts' had been put in place, these had been signed 'on behalf of' people by relatives that did not had any legal decision-making powers such as power of attorney.
• One person's care plan directed staff to remove high sugar food from their room to prevent them from eating it. There was no assessment of their capacity to make this decision and no consideration of less restrictive or alternative options for snacks.
• 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The approach to DoLS was disorganised, it was unclear who had a DoLS authorised. Conditions were not met, one person had a condition related to medicines. This had not been complied with and did not respect their rights.

The provider failed to protect the rights of people who lacked capacity to consent. This was an ongoing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Although records showed staff had training in key areas this did not always ensure their competency. Most staff and managers were trained in safeguarding, but safeguarding referrals had not always been made as required. Staff had infection control training; however, hygienic practices were not always followed. Further work was needed to ensure staff competency.
• Staff told us that they had enough training but said they would benefit from training in behaviour management. During our inspection, we found poor staff practices in this area. This was also reflected in a relative's comments who told us, "I'm not sure they really have the training for dealing with somebody like

[my relative]."

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

• Staff did not always have regular supervision and support. This meant opportunities to manage performance and support staff development may have been missed. The registered manager had identified this and had started providing supervision to staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to them moving into Ernehale Lodge Care Home. Concerns were raised by external professionals that assessments were not always effective resulting in inappropriate placements. We discussed this with the provider who told us they would review their assessment process.
• Although nationally recognised tools were used to assess risk and manage care they were not used consistently or properly. For example, a nationally recognised tool was used to assess the risk of malnutrition, however, we saw this was not always completed accurately resulting in incorrect scores. Although this had not resulted in harm, there was risk care may not be safely managed as a result.

Supporting people to eat and drink enough to maintain a balanced diet
• People had enough to eat and drink. People told us they liked the food. One person said, "The food is nice. I look forward to my meals."
• Overall, mealtimes were positive occasions. Staff provided timely assistance to people when needed. People were offered choices and dietary preferences were catered for.
• Further work was needed to ensure risks associated with eating and drinking were managed safely. We have reported on this further in the 'Is this service safe' section of the report.
• When people were at risk of losing weight, staff monitored their weight regularly and made referrals to specialist health professionals as needed.

Adapting service design and decoration to meet people's needs
• The home was adapted to meet people's needs. Some improvements had been made to the environment since our last inspection However, it was not well maintained in some areas. The provider informed us they had an ongoing programme of modernisation.
• There was a garden; however, this was being used to store some disused furniture. People commented they did not get use the garden as much as they wished.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People told us they were supported with their health needs and people's relatives said they were kept informed about any changes to people's needs.
• Care plans did not contain clear, personalised information about people's health conditions. This meant there was a risk people may not receive the support they required to maintain their health.
• Records showed staff sought advice from external professionals when people's health needs changed. There was evidence that advice had been sought from external health professionals, such as speech and language therapy.
• Systems were in place to ensure information was shared across services when people moved between them. This helped ensure people received person centred support when they moved between services.

Requires Improvement

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

People were not always treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People were not always treated with dignity. Throughout our inspection staff addressed people in an inappropriate manner, routinely using potentially condescending terms such as "lad", "boy" and "kid." This language was not respectful. We discussed this with the provider who told us they would address this.
• As far as possible, people's right to privacy was respected by staff. People felt staff helped maintain their privacy, for example, by closing the bedroom door whilst they were helping them to get dressed. At our previous inspections we identified concerns about how staff promoted dignity for people who shared bedrooms. This issue remained at this inspection.
• The registered manager told us people were supported to be as independent as possible. However, care plans contained little information about how to promote each person's independence. This placed people at risk of inconsistent support in this area.

Ensuring people are well treated and supported; equality and diversity
• Overall, people were positive about the atmosphere of the home and the caring attitude of the staff. One person told us, "They are lovely, all of them. They help me to get dressed and they are gentle." A relative said, "The staff here are good. I think they try their best and visitors are made welcome." People told us they were treated fairly and were free from discrimination.
• People told us staff knew them well. We observed this throughout our inspection, for example, one person was becoming upset and a member of staff sat and sang to them which helped relieve their distress. However, care plans lacked information about what was important to people such as their likes, dislikes and background. This placed people at risk of inconsistent support.

Supporting people to express their views and be involved in making decisions about their care
• None of the people we spoke with told us they had been involved in agreeing their care plans or had discussed their choices and preferences or support needs. We observed that care plans contain very little information about people's choices and preferences. This meant there was a risk people's needs may not be met.
• Most people told us staff consulted with them about their day to day care and said they felt listened to. One person said, "I tell them exactly what I want or don't want." However, some people commented that they were not offered choices. One person told us, "They bring me in (the lounge) in the morning and sit me in this chair. Nobody asks us where we want to sit. They just put you in a chair."
• People's relatives felt involved in the care of their family members. A relative told us, staff always called them to let them know about changes in their relations care.
• There was a risk people may not receive the support they required to communicate effectively. Information in care plans about communication was very limited and we did not see any alternative forms of

communication being used with people who struggled to communicate verbally. This placed people at risk of receiving inconsistent support.
• People had access to an advocate if they required one to help them express their views and there was information about advocacy displayed in the service. No one was using an advocate at the time of our inspection.

Requires Improvement

Is the service responsive?

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
• People did not always receive consistent support that met their needs. Care plan review records showed one person had a pressure ulcer; however, their care plan had not been updated to reflect this information and consequently there was no guidance for staff about how to provide care in this area. This placed them at risk of receiving unsafe support that did not meet their needs.
• Care records did not contain sufficient information to ensure people's needs were met. Care plans lack detailed information about people's health needs and the impact upon them. For example, one person's care plan documented they had several complex health conditions. There was no information about what these conditions were or the impact upon the person. This placed them at risk of inconsistent support that did not meet their needs.
• People's needs were not always met. Some people told us staff were sometimes too busy to assist them to have a bath or shower when they wished. We observed staff did not provide the support a person required with their continence and consequently they were left in an undignified state for over an hour. Staff did go to them, but the support they provided did not demonstrate effective communication, distraction or diversion techniques. Consequently, this was unsuccessful which resulted in their needs not being met.
• People were not consistently provided with opportunities for appropriate activity and occupation. Some people commented that staff were too busy, "One person said, "I'd like to get out for some fresh air. I'd like to get out if I can but they're always busy.'' The registered manager told us there was no activities coordinator at the time of our inspection and stated recruitment was underway. We saw staff tried to engage people in activities such as bingo. This was not appropriate for several people who lacked capacity to take part in the game. There was no attempt to engage these people in more appropriate activity and consequently we observed some people were withdrawn or walking around without purpose throughout our inspection visits. This did not meet their needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager told us people's diverse needs were identified before they moved in to the home. People's religious and cultural needs were accommodated. Local religious groups visited the home regularly.
• There was no evidence that people's rights under the Accessible Information Standard had been considered. This is a set of standards to ensure people have equal access to information regardless of disability or impairment. Information was not available in different formats and we did not observe any adaptations made to accommodate people's individual communication needs. □

End of life care and support

• People's end of life needs and wishes were not properly planned for. Several people had do not resuscitate orders in place. There were no plans in place about their end of life wishes and other people's plans lacked detail. This posed a risk that their end of life needs in relation to pain management, hydration, nutrition and care may not be met.

Improving care quality in response to complaints or concerns
• People felt comfortable raising any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns.
• There was a complaints procedure on display informing people how they could make a complaint. Complaints had been investigated and responded to in an appropriate and timely manner.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

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.

• At our September 2018 inspection we found concerns about leadership and governance. This was a breach of the legal regulations. At this inspection we found continued issues in this area.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• There had been a lack of effective governance which meant areas of concern had not been identified or addressed. The pace of improvement was slow. There had been longstanding issues with the quality of care planning and risk assessment, dating back to 2017. However, effective action had only started to address this with the employment of the new manager in January 2019. This failure to quickly address issues exposed people to the prolonged risk of inconsistent and unsafe care.
• Systems to ensure the safety and quality of the service were not effective. Governance systems had not identified or addressed the issues with safeguarding, safety, consent and person-centred care. Audits completed by the registered manager and provider did not identify the issues found in our inspection. This meant opportunities to address issues with quality and safety had been missed.
• Concerns had not been identified in some areas due to a lack of governance and audit systems. For example, issues with the cleanliness of equipment had not been identified as there was no cleaning schedule for equipment and no audit in place. Issues with the safety of the environment had not been identified as there was no health and safety audit in place. The lack of governance systems exposed people to the risk of receiving poor care.
• Effective action had not been taken in response to known concerns. Many issues found during our inspection were identical to those found at our previous inspections and by the local authority and CCG in January 2019 and the local Infection Control Team in September 2018. For example, the service had ongoing breaches of the legal regulations related to safety, consent and governance. These issues had not been effectively addressed and remained a risk.
• Changes made in response to concerns raised by CQC and external agencies, were not always effective. There had been a focus on improvements to some parts of the environment and paperwork; however, this had not always had an impact upon care delivery. For example, during our inspection we raised concerns about poor quality care provided by staff. The provider responded by updating care plans however, there was no action taken to address poor staff performance and monitor staff practice.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
• The culture of the home was not always person centred. Although the provider had a vision of providing high quality, person centred care, this was not evident throughout our inspection. This had a negative

impact on the quality of care people received.
• The delivery of care was not always based upon best practice. The approach taken to address some issues identified did not demonstrate an understanding or application of best practice. For example, there had been an ongoing breach of the legal regulation related to mental capacity and consent, this demonstrated an ongoing failure to correctly apply the Mental Capacity Act 2005. . This resulted in people's rights not being respected.

Working in partnership with others
• There were limited ways to keep up to date with best practice and work in partnership with others. The registered manager was not part of any forums, they had not had any proactive contact with other local managers for support. The provider had not taken the local authority and CCG up on their multiple offers of support. This had a negative impact on the quality and safety of the service that people received.

The provider failed to ensure good leadership and governance. This was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There had been a failure to notify CQC of some events within the service, which the provider is required to by law. We had not been notified of a DoLS authorisation, nor had we been notified of a safeguarding referral. A failure to notify us as required has a negative impact on our ability to monitor the service and ensure the safety of people living at the home.

The provider failed to notify the CQC as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

• The home had a manager registered with the CQC. They had started in post in January 2019 and people who used the service, relatives and staff were positive about the impact she had. Staff told us she was approachable and a good leader.
• The registered manager, clinical lead and provider had developed new systems and processes, such as a new care plan format and a new provider audit. However, these had not been implemented. We will assess the impact of these developments at our next inspection.
• It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their families were involved in some decisions about the home. Regular meetings were held where people were consulted about activities, food and the decoration of some areas. People and their relatives were invited to share their feedback in regular quality assurance surveys.
• There were regular staff meetings, these were used to share news and information with staff and to discuss areas of concern and improvements needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their care and support or the environment. Regulation 12 (1) (2)

The enforcement action we took:

We took urgent action to impose conditions on the restriction of the provider and we restricted admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the safety and quality of the home were not effective. This had a negative impact upon the quality of the service. Regulation 17 (1)

The enforcement action we took:

We took urgent action to impose conditions on the restriction of the provider and we restricted admissions to the home.