Ms Margaret Morris

The Gables Private Residential Home

Inspection report

161 Morley Road
Oakwood
Derby
Derbyshire
DE21 4QY

Tel: 01332280106
Website: www.gableshome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Gables Private Residential Care Home is a care home providing personal care for up to 28 people aged 65 and over. At the time of the inspection there were 26 people using the service. The service is provided over two floors, with communal facilities being provided on the ground floor.

People's experience of using this service and what we found
The provider did not have an effective system in place to assess and monitor the service, nor were there effective systems to gather and share information, including good practice guidance. This restricted the development of the service to improve quality outcomes for people. Ineffective governance meant there was a lack of records, and records which were in place were not consistently reviewed or audited.

People's safety could be improved through the adoption of a robust system for the assessment and reviewing of potential risks, and through the analysis of accidents and incidents within the service to ensure lessons are learnt. Staff training in topics related to the promotion of people's safety were not up to date.

We have made a recommendation that the provider adopts good practice guidance to improve systems in medicine management to improve systems for the monitoring and recording of medicines.

People's needs were not kept under review, and their care plans not consistently updated. Staff were instructed to provide specific aspects of personal care on set days, which did not support person centred care and choices.

People were not supported to have maximum control of their lives and staff did not always support them in the least restrictive way possible and in their bests interests; the policies and systems in the service did not fully support this practice. Staff were instructed to provide specific aspects of personal care on set days, which did not support person centred care and choices.

The environment was well-maintained; however, improvements could be made to support people living with dementia to orientate themselves. People's dietary needs were met, and people had access to a range of health care services.

People or their family members were not involved in the development or review of their care plans, which meant their views and aspirations for their care were not recorded. However, those we spoke with were complimentary about the care and support they received. People spoke favourably about the caring attitude and approach of staff, and the recognition of their independence, privacy and dignity.

Opportunities for people to engage in social activities, develop interests within the service and the wider community had reduced, as the service didn't currently employ an activity organiser. However, external services were bought in, to provide activities. Staff had limited time to spend with people to engage in

conversation or provide activities, which people, family members and staff commented upon. People were confident to raise complaints should they need to. The provider stated they had not received any complaints.

People were supported by staff who received support through supervision. People spoke favourably about the management of the service, stating the management team were approachable and always available to answer any queries. People's views were sought twice a year through the completion of questionnaires, which showed a high level of satisfaction in the service provided.

Rating at last inspection
The last rating for this service was good (published 15 February 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to the assessment and review of potential risks to people, a lack of person centred care and people's involvement in the planning and review of their care, and poor leadership oversight and governance of the service to monitor the quality of care being provided.

Information as to CQC's regulatory response can be found within the action section at the end of this report.

Follow up
We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
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 caring. Details are in our caring findings below.	**Good**
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 always well-led.	**Requires Improvement**

The Gables Private Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
The Gables Private Residential Home 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commission some people's care at the service. We sought information from Derby Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to place our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and one relative about their experience of the care provided. We spoke with the provider's representative, three members of care staff, the chef, the team manager and deputy manager.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The system for assessing potential risk to people's safety was not robust. Risk assessments did not provide clear guidance for staff as how to reduce potential risk. For example, by detailing any equipment and how it was to be used when supporting a person to move safely.
- Risk assessments were not consistently reviewed, and there were missed opportunities to learn from incident or accidents. For example, a person had experienced a number of falls. This information had not been used to review the person's care plan or risk assessment so that action could be taken to reduce further risk of falls. This meant the person continued to be at risk.
- Personal Emergency Evacuation Plans had not been undertaken. People's bedroom doors had information as to the number of staff required to support the person should they need to be evacuated in an emergency. However, there was no evidence to support how this decision had been arrived at or if it had been reviewed.
- Staff were knowledgeable about the action to be taken in the event of a fire and told us fire drills had been undertaken as part of their fire awareness training. However, there were no records to support fire drills had taken place, the staff involved or any lessons learnt to improve staff's response.
- The front door to the service was not kept locked, this had not been risk assessed to ensure people's safety.
- Staff training in subjects related to the promotion of people's safety, which included emergency first aid, moving and handling of people, safeguarding, health and safety, and fire safety had not been undertaken up to four years ago. The provider could not confirm if the training initially received remained valid. Staff were in the process of being registered to undertake e-learning in these topics.

People were placed at risk as systems were not in place to assess, monitor and review risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems and equipment in the service were maintained by external contractors. These included fire safety systems, gas and electrical appliances, the passenger lift and equipment used by staff to move people safely, such as stand aids.

Using medicines safely

- We identified improvements were needed to medicine management during the inspection site visit. For example, a person's medicine administration record (MAR) had not been signed when a drug had been administered. We asked the provider to investigate the medicine incident. All other MAR charts had been

completed accurately.
● Care plans directed staff to monitor for signs and symptoms of change with regards to specific medical conditions, for which medicine had been prescribed. For example diabetes. However, care plans did not provide information as to what the signs and symptoms staff were to be alert for. For example, hypoglycaemia or hyperglycaemia.
● Staff had not checked the temperature medicines were stored at. This is important as medicines may become less effective if they are not stored as per the manufacturer's guidelines.
● Staff responsible for the administration of medicine had undertaken training in the safe handling of medicine.
● Records for the receiving and returning of medicines via the pharmacist were in place.

We recommend the provider adopts good practice standards described in relevant national guidance, and as referenced within their policies and procedures relating to medicine management.

Systems and processes to safeguard people from the risk of abuse.
● Staff were aware of external stakeholders they could contact about safeguarding concerns, which included the local authority, the police and the Care Quality Commission (CQC).
● People told us they felt safe, when we asked them why, they told us because there were always staff close by if they needed them.
● The providers policies and procedures and local safeguarding protocols were followed.

Staffing and recruitment
● There were missed opportunities for reviewing potential changes to the deployment of staff or staffing numbers. For example, incidents and accidents which recorded people's falls were not analysed, and therefore the role of staff and how they were used had not been considered as a factor to reduce further risk.
● A majority of staff said additional support with meeting people's needs was required, however this was not necessarily by increasing staffing numbers, but through more effective use of staff on duty.
● People's views about their being sufficient staff to meet their needs were mixed. People told us staff did respond when they used their buzzer, whilst others told us they required minimal assistance from staff, as they were able to provide their personal care themselves, and rarely if at all pressed the buzzer. One person when asked if they felt safe, told us "I feel safe here", when asked why they said, "I have a buzzer, but never pressed it."
● Staff told us they didn't always have sufficient time to support people to engage in meaningful activities, including conversation, other than when providing personal care and support.
● Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). The DBS assists employers to make safe recruitment decisions by ensuring the suitability of individuals to care for people.

Preventing and controlling infection
● People were protected from infection. Policies and procedures were in place for infection control and hygiene and were implemented. For example, schedules for cleaning of the service and equipment were in place.
● The provider had received an award, recognising they had maintained for four consecutive years or more, a rating of 5 -very good by the food standards agency. (The ratings go from 0-5 with the top rating being '5').

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.

At the last inspection this key question was rated as good. At this inspection this key question has now 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 initially assessed prior to them moving into the service. Where required the assessment was carried out at the person's current residence, which in some instances included assessing people whilst being a patient in hospital. A family member told us they had been fully involved in the assessment of their relative.
- People's needs were not consistently reassessed, and their care plans were not updated to reflect changes in needs. For example, everyone had an oral assessment undertaken upon admission, however these were not reviewed. One person's record showed they had been diagnosed with a temporary medical condition of the mouth, their mouth assessment and care plan had not been reviewed to ensure it continued to meet their needs. This meant, further reoccurrences of the condition may occur as the person's needs have not been reviewed.

People's assessed needs were not kept under review to ensure their needs were met. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems to enable staff to respond to people's changing needs were not sufficiently effective, to ensure they received the support and care recommended by health care professionals. For example, a staff handover record documented that a person had attended an appointment with a physiotherapist, who had advised the person to undertake a set of exercises. We asked to see the relevant care plan, were told a care plan was not in place. We were told staff had encouraged the person to do their exercises, and they had declined. However, this had not been documented.
- People's health was monitored, and referrals were made to health care professionals where required. A doctor visited the service to carry out routine health checks and respond to any concerns about people's health.
- Key information about people's needs, including their medicine was accessible, and available to share with emergency services should it be required. This included information the person could take to hospital, to provide information to hospital staff about their needs, their health and general well-being.

Staff support: induction, training, skills and experience

- The provider had identified staff training in areas related to the promotion of people's safety, health and

welfare required updating. This was confirmed by the training matrix.
● The training records showed staff training in some areas, which included first aid, health and safety, fire awareness and safeguarding had not been updated since 2016 and 2017.
● The provider had accessed the services of training through e-learning, and some staff had begun to access this training, other staff were waiting for e-mail accounts to be set up.
● Staff were supported through regular supervision, which is a one to one meeting with a member of the management team, and provides an opportunity to reflect upon their work practices.

Adapting service, design, decoration to meet people's needs
● The environment had not been designed to support those people living with dementia.
For example, a person was approached by a member of staff, who asked them if they were coming through to the dining room as it was lunchtime. The person responded, "I didn't realise what the time was, it's difficult to keep track of time." The person said this whilst looking about the lounge. There were no clocks in the lounge, or calendars to support people in identifying the date, and time.
● The service had two bathing facilities, both required people to be supported by staff into the bath, by the use of a bath hoist. This meant, people could not bathe without the support of staff and therefore their independence was compromised, as expressed by a member of staff. The service did not provide any showering facilities.
● The service was designed to encourage people to spend time together in one of the two communal lounges, and we saw the majority of people sitting together.
● People had the option of spending time in the garden, and provided areas of interest, which included an aviary. There were tables and chairs on the veranda, which was accessed from the main lounge, and gave a panoramic view of the garden.

Supporting people to eat and drink enough to maintain a balanced diet
● The chef catered and provided diets to meet people's needs, which included diets to support people with specific health conditions such as diabetes.
● People's dietary needs were assessed, and their weight was kept under review.
● Drinks and snacks were served regularly throughout the day.
● People spoke positively about the meals, a group of people told us they preferred to eat in the dining room as it was a sociable occasion. One person when asked if they enjoyed their food said, "Put it this way, I always leave a clean plate." A second person said, whilst laughing. "Meals are good, probably too good".

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA
● Practices adopted by the provider meant some people were not confident to express their views about specific aspects of their personal care. For example, people did not always feel they could decline a bath on the days allocated to them by the provider.
● Applications to deprive a few people of their liberty had been submitted and were being processed by

external and independent organisations.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- The independence and privacy of some people was not promoted, due to the bathing facilities provided.
- Aspects of people's independence, such as moving around the service was promoted. Staff ensured that people's walking frames were placed next to them, to enable people to get up and move around independently.
- People who did not require support with their personal care told us their independence was respected. One person said, "I'm a very independent person, I get myself up and dressed in the morning. The staff know and respect my independence."

Ensuring people are well treated and supported; respecting equality and diversity
- Staff had limited time to sit and talk with people for a meaningful length of time, this was confirmed by staff who told us this was an aspect of their role which they would like to improve, however their other duties prevented them due to time constraints.
- People spoke positively about the kindness and caring attitude of staff. One person said, "It was a difficult decision for me, moving into residential care. However, the support and care I receive here means I made the right decision." A second person said, "Staff are quite good, they're both pleasant and kind."
- A majority of staff had worked at the service for many years and had developed supportive and trusting relationships with both those who used the service and their family members.
- The consistency of the staff team had a positive impact on people's care, as staff were aware of their needs as they knew people well. This enabled staff to identify any changes in people's health or welfare, and make the appropriate referrals to other agencies.

Supporting people to express their views and be involved in making decisions about their care
- A majority of people told us they were encouraged to make day to day decisions regarding their care, people told us they got up and went to bed when they wished. However, some people told us they felt obliged to have a bath when asked by staff, as they were aware they had allocated days for bathing.
- A family member told us staff had fully understood how emotional the decision had been to place their relative into residential care, and that staff had been supportive towards them when their relative first moved into the service. They said, "They [staff] were as good for me as they were for [relative]."
- Information about advocacy services, and other services specific to those accessing care were available in the entrance foyer, either displayed on the wall or in the form of leaflets for people to take with them.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People or their family members had not contributed to their care plans, and therefore there was no assurance that the care provided was as they wished it to be, taking into account their views and expectations of care. People's care plans had not been signed by them or a family member.
- People had restrictions placed on them by outdated practices. For example, the provider had a 'bathing rota', this was displayed on a wall, which showed each person by room number was allocated two bath days a week. We spoke with people about the approach to bathing, one person referred to bathing as special days. They said, "Special days, I don't like baths, I prefer showers. We asked if they were able to decline a bath, "Not really, I don't think they [staff] would like it, if I said no."
- Staff did not consider the potential impact of their requests on service users. For example, a member of staff approached a service user, mid-morning when sitting in the lounge after breakfast. They asked them if they wanted a bath, the person looked at themselves and responded that they were already dressed. The service user did accompany the member of staff. We spoke with the management team, as to how this could impact on people's understanding of the time of day, especially those living with dementia, who may upon being asked to have a bath when already dressed may think it was evening and were preparing for bed.
- People's care plans had documents attached that were completed monthly and recorded any events relevant to the care plan. However, the events were not evaluated or analysed or used to update care plans. For example, a person's records identified poor quality sleep during the night, with the person instead often choosing to sleep in the lounge. The care plan had not been reviewed, or potential links made, that the person's sleeping routine could be linked to other concerns, such as their falling during the day as they were tired.

People were not involved in the development or review of their care plan, to enable them to have maximum choice and control of their lives. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People or their family members had provided information about their lives, for example, family and work history, hobbies and interests which had been documented. This provided staff with insight as to a person's life before they moved to the service.
- People's care plans did not record their strengths, and how staff were to promote their independence. However, people we spoke with told us staff knew them well, and always encouraged them to maintain their independence.
- A family member told us whilst they weren't involved in the review of their relatives care plan, they were fully involved in their care, and were always kept informed of any changes either in person or by telephone.

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.
● The provider was not aware of the AIS. However, we found people using the service were able to access and understand the information in the formats provided. We found improvements could be made to the accessibility and sharing of information in key topics, such as safeguarding as this was not displayed for ease of access.

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, a family member and staff commented on the activity organiser who had resigned their post, which had meant people's opportunity to take part in activities had reduced. One person said, "[Activity organiser] always took me out to the local park and shops, I really miss that. It seems a long time since I went out." The person went onto say, "I do attend the church services held here, which I enjoy, I really enjoy singing the hymns."
● Staff spoke of the limited time they had to spend with people, outside of the provision of personal care. The few interactions we did see where staff spent time talking with people was limited. For example, a member of staff sat with a person talking about the articles in the newspaper they were reading for a few minutes, but had to leave the person to answer the telephone.
● Opportunities for taking part in activities was provided by purchasing services. For example, we saw a number of people engaged in physical exercises both on a one to one basis and in a group, people were seen laughing and joking with each other, and was enjoyed by those who took part.
● A few people occupied themselves, by listening to music, watching the television or reading newspapers they had had delivered.
● Family members and friends were encouraged to visit. A person spoke of how their relative frequently took them out for meal, which they enjoyed. Visitors were seen arriving at the service throughout the day, taking their relatives and friends out.
● People were able to make external calls by way of the pay phone in the entrance hall, whilst some people had an independent land line in their bedroom. We were told some people kept in touch with family and friends using electronic hand-held devices.

End of life care and support
● The service was not supporting people with end of life care at the time of the inspection. People's records included information as to their next of kin, and general practitioner in case staff needed to contact someone in an emergency.
● People's care plans referenced if a person had a Do Not Attempt Cardio Pulmonary Resuscitation in place.
● Staff would liaise with family members and seek the support from health care professionals in the event of someone requiring end of life care.

Improving care quality in response to complaints or concerns
● The provider had not received any complaints since the previous inspection, however we were told people or family members had raised minor issues, which had been dealt with, however these were not recorded.
● People and the family member said they were confident if they had a complaint that it would be listened to and acted upon, as they had confidence in the management of the service. One person told us, "I've no complaints, and never have had. If I did I would speak out, I know any issues would be dealt with, I am confident in that."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider did not ensure a culture of person-centred care. People and their family members were not involved in the development and review of care planning, and the practices within the service such as designated days for bathing, did not reflect person centred care.
- The provider did not have in place a system to assure themselves as to the quality of the service, in order to identify issues and make improvements. We were informed some audits did take place, for example medicine audits. However, there were no records to support this.
- The provider had not reviewed staffing levels for in excess of 20 years, and a system to review staffing levels based on people's need was not in place, to ensure their needs were met.
- The provider did not have a system to identify any themes or trends occurring within the service, for example learning from accidents and incidents through analysis and review.
- We were informed that meetings involving managerial staff did take place, and that plans for future development, including environmental improvements had been discussed. However, there were no minutes kept, or an action and development plan in place to record the actions decided upon and the timescales for their implementation.
- The provider did not have oversight of information gathered through staff supervisions, as members of the management team who carried out supervisions, were themselves not supervised. This restricted staff's ability to influence the development of the service.
- The provider did not have a system in place to share information with staff, and to review the quality of the service being provided, for example through team meetings. This meant staff's ability to contribute and influence the service was limited. Staff told us they would welcome the introduction of staff meetings to enable them to share their views and make improvements to the service.
- Some good practice guidance had been accessed whilst some was referenced in policies and procedures. However, the information had not been shared with the staff team or implemented to improve quality outcomes for people.

The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's representative who facilitated the inspection was aware of the improvements required, although these were not documented, and were themselves seeking knowledge from external resources, such as Skills for Care, to enable them to bring about change, and drive improvement.
● Staff were aware of planned changes to the management of the service, and were hopeful this would bring about positive change.

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
● We were advised there had been no incidents which were reportable under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, truthful information and a written apology.
●The personal facilitating the inspection was aware of, and systems were in place, as outlined in the policy and procedure, to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's views and that of family members were sought twice a year, through questionnaires. The information was collated, and we saw a majority of questionnaires showed a high level of satisfaction with the service. However, the results were not shared with people or their family members. We were told that the provider was considering a 'You said, We did' approach, to sharing information, to be displayed within the service.
● People and the family member spoke favourably of the management of the service, they told us members of the management team were approachable, and answered any queries raised with them.
● The provider had an open-door policy and people we spoke with were aware of who managed the service.

Working in partnership with others
● The provider worked with commissioners of local authorities when people's needs changed and their package of care needed reviewing, where the persons care was funded.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's assessed needs were not kept under review to ensure their needs were met. People were not involved in the development or review of their care plan, to enable them to have maximum choice and control of their lives.

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 placed at risk as systems were not in place to assess, monitor and review risk.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Warning Notice