Highcliffe House Limited

Highcliffe House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This focused inspection took place on the 10 August 2016 and was unannounced.

At our previous inspections in May 2016 and July 2016, we found evidence of major concerns in relation to the clinical oversight of the service and the quality and safety monitoring of the service.

Our urgent focused inspection carried out on 15 July 2016 was in response to concerning information we received in relation to a serious incident that had occurred the day before resulting in a fatality. We found that the provider had continued not to take action to assess the risks to people's health, welfare and safety and regularly monitor the quality and safety of the service. Staff had not been provided with the required health and safety training, including assessment of risk and had not been provided with procedural guidance to guide them in steps they should take to protect people from the risk of harm. This meant that the health safety and welfare of people using the service was a t risk and the provider was failing to provide a safe service.

We formally notified the provider of our escalating and significant concerns following our urgent, focused inspection 15 July 2016 and ongoing emerging risk shared with us by stakeholders. We placed a number of conditions on the provider's registration which required them to take urgent action to protect people from the risk of harm.

We carried out this unannounced focused inspection on the 10 August 2016.

Highcliffe House Nursing Home is a 30 bed residential and nursing care service providing care, treatment and support, including end of life and care and support for people living with dementia. On the day of our inspection there were 26 people living at the service.

At this focused inspection 10 August 2016, we found the provider had taken some action in responding to assessing the risks to people's safety in relation to the environment and action to arrange for staff to be provided with training in health and safety, including risk management. However, we continued to have major concerns regarding the overall clinical leadership of the service, the lack of action taken by the provider to safeguard people in the management of their medicines, monitoring to ensure people were sufficiently hydrated, pressure ulcer prevention and the lack of monitoring to ensure their complex nursing

needs were being met. This meant that the health, safety and welfare of people with complex nursing needs, continued to be at risk. The provider was not meeting the requirements of the law as they did not monitor effectively the health and nursing care needs of people and identify people at risk of receiving care or treatment that was inappropriate or unsafe.

There was a registered manager who was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, as this is a care home with nursing we found that there was no clinical lead with overall responsibility for clinical governance of the service.

We found continued, on going, major concerns in relation to the management of people's medicines and the overall clinical governance of the service in meeting the nursing needs of people with complex health care conditions. There was a lack of clinical oversight and review of daily health and welfare monitoring records.

People were not receiving appropriate nursing care and monitoring which placed them at increased, serious risk of harm. For example, people assessed as at high risk of developing pressure ulcers were not being repositioned to alleviate pressure to skin. There was a lack of monitoring to ensure people received adequate support to maintain adequate nutrition and hydration to prevent ill health. People were not effectively monitored for pain or receiving adequate pain relief medicines as prescribed.

We found a lack of sufficient measures in place to ensure the safety of people during procedures where staff were required to support people with their moving and handling transfers.

People with swallowing problems and at risk of choking were not always provided with food and drink that was at the correct, prescribed consistency, to protect them from the risk of harm. Care plans for people with dysphagia and at risk of choking did not refer to clinical guidance and correctly detail the required consistency of food and fluid.

People had not been supported by staff to be repositioned, placing them at risk of skin breakdown, stiffness and pain. This demonstrated a significant lack of effective clinical oversight which directly increased the risks to people of not having their care and treatment needs being met and action to mitigate the risks to people's health, welfare and safety of people.
We noted that some people using the service had been assessed as having mental health support needs such as depression and suicidal tendencies. However, there was a lack of sufficient, clear guidance for staff in how these people were to be appropriately supported.

Immediately following this inspection we issued an urgent action letter formally requesting the provider take urgent action to mitigate the risks to people's health, welfare and safety.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

This report only covers our findings in relation to this, focused inspection. You can read the report from previous inspections, by selecting the 'all reports' link for 'Highcliffe House Nursing Home' on our website at www.cqc.org.uk

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service continued not to be safe.

We found on going, major concerns in relation to the management of people's medicines and the overall clinical governance to ensure people's complex health care needs were being met.

Some action had been taken to protect people from the risks associated with the operation of the premises.

Is the service effective?

Inadequate

The service was not effective.

Care and treatment for people with mental health needs, at risk of dehydration, acquiring pressure ulcers, at risk of choking and the planning of their end of life care had not been effectively assessed, planned and responded to. This placed people at risk of not have their health, welfare and safety needs being met.

Is the service caring?

Requires Improvement

This service was not always caring.

Communication with people who used the service was not always done in a way that best suited their needs. One person received no pleasantries or reassurances and aids were not used to seek consent or to explain what staff were about to do.

The lack of appropriate of support may have impacted on people's comfort and dignity. For example in helping people to be repositioned regularly, the lack of support to receive adequate fluid intake and the possible risk of people suffering from the discomfort associated with constipation left unmonitored and alleviated.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People at risk of dehydration, pressure ulcers and at risk of choking had risks identified. However, there were insufficient action plans in place to guide staff in the steps they should take to mitigate and reduce risks to people's health, welfare and safety.

The clinical oversight and monitoring people of people with complex nursing needs was not consistent in identifying people at risk and responding to people's care and treatment needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider continued not to ensure that the clinical leadership of the service was competent and proactive in monitoring the risks to people's, health, welfare and safety.

People continued to be put at risk because there was a continued lack of systems for monitoring the complex nursing needs of people who used the service.

Highcliffe House Nursing Home

Detailed findings

Background to this inspection

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

This focused inspection took place on the 10 August 2016 and was unannounced.

This inspection team consisted of two inspectors, a pharmacy inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing care and support for an older person.

Prior to our inspection we reviewed the information we held about the service, this included the provider's action plan following our inspection carried out in May 2016 and July 2016 where they told us what they would do to ensure compliance with the law.

We spoke with local safeguarding authorities and reviewed all other information provided to us from other stakeholders.

We spoke with ten people who were able to verbally express their views about the service and eight people's relatives. We observed how care and support was provided to people throughout the day, including the midday and tea time meal.

During our inspection we spoke with the provider, the clinical lead, the training coordinator, the kitchen

manager, two nurses, the senior health care assistant, four health care assistants and a visiting health professional.

We reviewed care records in relation to 10 people's care. We also looked at records relating to the management of people's medicines, risk management, staff training and systems in place for monitoring the quality and safety of the service.

Prior to our inspection we had received information of concern about the service provided; these concerns had been reported to and investigated by the police and the local authority. The local authority has kept us updated.

Inadequate

Our findings

At our previous inspections in May 2016 and July 2016, we found evidence of major concerns in relation to the clinical oversight of the service, insufficient monitoring of people with complex nursing needs and the overall quality and safety monitoring of the service.

We found continued, on going, major concerns in relation to the management of people's medicines and the overall clinical governance of the service in meeting the nursing needs of people with complex health care conditions.

We found that oral medicines were stored safely for the protection of people who used the service and at correct temperatures. However, records showed people did not always receive their medicines as prescribed. When we looked at medication records we found some gaps in records of medicine administration where they did not confirm that medicines had been given as intended by prescribers. This included medicines prescribed for external application. We found numerical discrepancies of medicines where we could not account for them and where records did not confirm people living at the service were receiving their medicines as prescribed. The clinical lead nurse showed us audits of medicines including random numerical counts but this had been ineffective at identifying the discrepancies we found.

There was some supporting information available to enable staff handling and giving people their medicines safely and consistently. When people were prescribed medicines on a when required basis, there was written information available for some but not for all medicines prescribed in this way. This would have provided staff with guidance in how and when to give these medicines to people consistently and appropriately.

Where people were prescribed more than one pain-relief medicine or medicines to manage their psychological agitation there was insufficient information to guide staff as to when these medicines should be administered.

There were additional charts to record the application and removal of skin patches which were being completed. However, for people prescribed pain-relief medicines and who were unable to talk about their pain there were pain assessment tools available to enable staff to give people their pain-relief appropriately and consistently but these were not always being used.

For three people with limited mental capacity to make decisions about their own care or treatment, there

were some records to evidence assessment of their mental capacity. However, it was evident from discussions with the clinical lead that no best interest assessments had taken place with decisions made by those qualified to do so to authorise administration of their medicines which were being given to them crushed or whole in food or drink (covertly). There were records showing that for two people staff had consulted with their GPs but records about further consultations with their relatives, pharmacists and nurses had not been fully completed to evidence that best interest decisions had been fully considered prior to staff instructed to administer their medicines covertly. This demonstrated a failure to consider people's human rights and ensure the arrangements for giving medicines covertly were in accordance with the Mental Capacity Act 2005.

Nursing staff had recently received further training in safe administration of medicines and had their competence in handling and administering people their medicines assessed. The provider's medicine policy had recently been revised. However, nursing staff told us this had not yet been put in place and made available for them to refer to. This meant that staff did not have access to policies and procedural guidance in line with current legislation and guidance to enable staff to follow them.

This demonstrated a continued breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of clinical oversight and review of daily health and welfare monitoring records. When asked staff gave differing views and demonstrated a lack of knowledge as to whose responsibility this was. Therefore we were not assured that people's needs were sufficiently monitored and changes in their care and support needs appropriately identified to mitigate the risks to their health, welfare and safety.

We found a lack of sufficient measures in place to ensure the safety of people during procedures where staff supported people with their moving and handling transfers. One person had recently fallen from a hoist. The hoist was not properly set up, and there was not enough room in this person's room to use the hoist safely and effectively. We noted that their moving and handling risk assessment had not taken into account the additional risk of the unsuitable environment and the assessor had recorded the environment as safe. The person who sustained the fall told us this incident had impacted on their confidence and that they worried constantly about having to be transferred using the hoist. We observed staff when using the hoist and saw them struggling to move furniture in this person's room when trying to manoeuvre and accommodate the use of the hoist. Staff told us they had reported their concerns about the lack of space and the physical pressure this put on them but that no action had been taken to reduce the risk of injury to both the person being supported and the staff. The provider confirmed that staff had raised this as an issue of concern with them previously but that no action had been taken in response. his demonstrated a failure to take action to reduce the risk of harm.

We observed that the majority of people who used the service remained in bed. For some of these people there was a lack of information recorded in their care plans which would provide evidence of an assessed rationale for their staying in bed. We observed six people unable to mobilise independently remain in the same position throughout the day of our visit. These people had not been supported by staff to be repositioned, placing them at risk of skin breakdown, stiffness and pain. This demonstrated a significant lack of effective clinical oversight which directly affected the health, welfare and safety of people.

We noted that some people using the service had been assessed as having mental health support needs such as depression and suicidal tendencies. However, there was a lack of sufficient, clear guidance for staff in how these people were to be appropriately supported. For example, one person who was referred to in their care plan as; 'very aggressive' and 'mood is very variable and changing in seconds.' [Person] can

become very angry, verbal and physically aggressive towards staff'. The guidance provided for staff in response to episodes of distressed reactions was for staff to; 'administer Lorazepam in the first instance when required to calm them down.' This is a medicine used to treat anxiety and agitation. We were not assured that planning for people who presented with distressed behaviours in relation to situations or others was appropriate in taking account of their best interests, respectful of their dignity and had been assessed in consultation with specialist mental health care professionals.

One person who with multiple complex health care needs and who was nil by mouth, received enteral feeding and was being nursed in bed. We observed that from 10.30am to 18.00pm their position in bed remained unchanged. Their care plan stated that they required regular mouth care with water or pineapple juice to freshen their mouth. We observed an empty glass with a dry mouth sponge which remained on their bedside cabinet in the same position throughout the day. We noted this person's mouth was very dry and their tongue sticking to the roof of their mouth.

Entries in this person's monitoring records stated that they were asleep on checks carried out by staff. However, no other entries were made to the records to demonstrate any other care support had been provided. This person was very wheezy and made gurgling noises indicating fluid was collecting in their throat. Their care plan stated that this was an indicator of breathing difficulties and guided staff to ensure this person was supported into a seating position, to administer inhalers and if breathing difficulties persisted to administer a nebuliser. This support was not provided in accordance with their plan of care. We also noted this person had recently been treated for a chest infection caused by aspiration which could indicate a neglect of care.

One person had a stoma in situ. A stoma is an opening on the front of the abdomen (tummy) which has been surgically created to divert the flow of faeces and urine into a pouch (bag) which sits on the outside of the abdomen. There was no care plan in place to guide staff in the care of the stoma and a lack of evidence provided to assure us that their condition was being monitored. There was no provision for any record to be made of the day to day care which would have evidenced consistency and continuity of care. This demonstrated a continued failure to assess and mitigate the risks to the health, welfare and safety of people who used the service.

This demonstrated a continued breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Our findings

There was a lack of effective systems in place to ensure the safe management of people's nutrition and hydration needs were met, in particular for people with swallowing difficulties, those at risk of choking and people at risk of dehydration.

People with swallowing problems and at risk of choking were not always being provided with food and drink that was at the correct, prescribed consistency, to protect them from the risk of harm. Care plans for people with dysphagia and at risk of choking did not refer to clinical guidance and correctly detail the required consistency of food and fluid. We observed a kitchen assistant offering cake to people who required a thick pureed diet. One person recently discharged from hospital and who had a detailed discharge summary that gave information as to their high risk of choking and provided guidance for staff as to the most appropriate diet texture and consistency. This had been transcribed incorrectly into their plan of care and did not record the importance and relevance of the recommended texture. We noted that food provided on the day of our visit was of the incorrect wrong texture and placed this person at risk of choking.

We observed insufficient monitoring of people's food and fluid intake. In particular for people assessed as at risk of inadequate intake of nutrition and hydration. Our observations showed us two people who were showing physical signs of potential dehydration with dry mouths and lips. Records we reviewed for one of these people indicated that over a three day period they had consumed a maximum of 430mls of fluid and a minimum of 85mls within a 24 hour period. This significantly low intake of fluid placed them at risk of dehydration which had the potential to impact significantly on their health and wellbeing. For this person we also observed a half glass of water remain in the same position in their room from 10.45am until 5.00pm when it was finally refreshed. No assistance was provided by staff to help then consume this drink.

We noted that fluid monitoring charts had not been fully completed to calculate within a 24 hour period the amount of fluid a person at risk of insufficient fluid intake had consumed. Therefore the effectiveness of these charts was in question at identifying and providing evidence that action had been taken to protect people from the health risks associated with insufficient fluid intake and at risk of dehydration. This demonstrated a lack of clinical oversight and a lack of action taken to mitigate the risks to people's from inadequate hydration and to sustain life and health.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The principles of the Mental Capacity Act (MCA) 2005 had not been applied and issues of people's capacity had not been considered fully in relation to people whose medicines were being administered by nursing staff covertly. Where these people lacked capacity to consent, best interest assessments had not been carried out by those qualified to do so and the relevant people consulted, such as relatives prior to nursing staff instructed to administer medicines hidden in food and drink. This meant that action had not been taken to protect people's basic human rights and this action had not been assessed and considered a form of restraint.

A review of the provider's training matrix which recorded training staff had been provided with showed us that of the eight nurses employed, only five nurses had been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 and related Deprivation of Liberty Safeguards (DoLS). Approximately only two thirds of all health care assistants including senior health care staff had also attended this training. We were therefore not assured that all staff in particular nursing staff employed to assess people's needs and lead other staff in taking action to safeguard people from the risk of harm and ensure protection of their human rights, understood their roles and responsibilities with regards to the Mental Capacity Act 2005 and related Deprivation of Liberty Safeguards (DoLS).

This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Our findings

We received mixed comments when we asked people how caring staff were towards them. Comments included, "They are friendly, talk to me but I can't hear.", "Some will never be carers, they have no compassion but some others are very kind and try more than others.", "The staff are wonderful, they are here to help you. Some are a bit rough and ready. You get newer ones and they are not quite sure of their jobs.", I think they are wonderful, always pleasant, kind with the patients they have. I can't speak highly enough of them." and "One of the staff tells me 'you are either hoisted or stay in bed', she's alright but a bit sharp."

A review of one person's care records indicated that they had a severe hearing impairment. This required staff to write questions down on to a note pad which was located beside their bed and was used to aid communication with the person. This person's care records indicated that they became distressed when staff attempted to support them with personal care. We noted that the written communication within the note pad was brief, with no pleasantries and only used to inform the person what was available to eat and not used to seek consent or explain to the person the care and treatment they would receive. When asked staff were unable to provide us with any explanation as to why this form of communication was not used prior to supporting with personal care, to reassure this person and considered as a positive tool for alleviating their distress.

We observed interactions between staff and people who lived at the service and found this to be friendly and caring. Care and nursing staff were observed to respect people's privacy by knocking on doors and ensuring people received personal care supported in a dignified manner. However, the lack of care in supporting people to be repositioned regularly, whilst spending long periods of time in bed, the lack of support to receive adequate fluid intake, inadequate mouth care and the possible risk of people suffering from the discomfort associated with constipation left unmonitored and alleviated may have impacted on their comfort and dignity.

Inadequate

Our findings

We found a continued lack of suitable systems in place to determine assessment of nursing needs, the planning of care and risk assessments, including the monitoring of people's nursing needs to ensure that people's needs were effectively planned, monitored and reviewed.

This service was recognised as a service for people to be referred to, to access specialist end of life care. However, care plans used for providing staff with guidance to enable them to deliver appropriate, personalised and safe nursing care and emotional support for people at the end of life was woefully lacking in recorded assessment of people's needs, wishes and choices. For example, care planning in relation to mouth care, skin care, nutrition and hydration, repositioning to prevent pressure ulcers and pain management was lacking in evidence of clinical monitoring and recorded guidance for staff to mitigate risks and provide safe and effective nursing care. This also included a lack of clear guidance to enable staff to meet people's needs in order to deliver the best care possible according to their current assessed needs and in a manner that maintained their dignity and comfort.

One person we identified as nearing the end of life did not have a completed end of life care plan in place. The form within their care records for this purpose was found blank. There was also no evidence provided that would demonstrate that their pain had been assessed as their pain assessment tool was also found to be blank.

Care planning for people with mental health needs including those living with dementia was limited. Care plans did not sufficiently guide staff in responding to and supporting people appropriately who presented with distressed reactions to situations or others.

This demonstrated a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people to be left isolated in their rooms for long periods of time with little interaction from staff other than to provide personal care. There were limited activities taking place outside of the communal areas to support the high number of people isolated in their rooms. People told us, "We haven't had much activities lately, the activities ladies seem to be right busy running around after us, they are short of carers", "Sometimes I get bored, relatives come to see me but there's not much else happening" and " Sometimes they play cards or scrabble with me, about once a fortnight." However, another person told us, "Yesterday two men came in to entertain us, one on the piano and one singing. Sometimes we play bingo."

Care records evidenced people being referred to access specialist health professional support such as GP, physiotherapist and dieticians. A visiting dietician told us that they received appropriate referrals and that staff reported back to them that they were following recommendations they had made. We noted from a review of two people's care records that they had been referred to a dietician following increases in weight which presented a risk to their health and wellbeing. However, other than referral to their GP we found a lack of referrals for people who presented with anxiety, possible depression and suicidal tendencies. We were not assured that timely action had been taken o support people with their mental health care needs.

Inadequate

Our findings

At our comprehensive inspection carried out in May 2016 we found that the provider did not have a clinical lead appointed for the service which meant there was no one with clinical leadership skills and overall responsibility for monitoring nursing standards and responsible for monitoring the complex nursing needs of people who used the service. The provider is also the registered manager but does not have a nursing qualification.

We found at this inspection the provider had appointed a clinical lead in post with the responsibility of monitoring the standards of nursing care including a responsibility for the clinical oversight of the service.

We found that there was a continued lack of clinical oversight which monitored the quality of the nursing support provided to people with complex nursing needs and a continued lack of action taken to mitigate the risks to people.

Nurses told us and a review of records confirmed that nursing staff continued not to receive regular, planned, clinical supervision. This meant that nursing staff were not supported with opportunities to plan for their clinical professional development and their competency assessed. We continued not to be assured that effective action had been taken to assess the competency of nurses and support their revalidation as required in meeting nursing codes of practice. This also had the potential to put people's health, welfare and safety at risk as the competency of nurses was not assured.

This demonstrated a continued breach of Regulation 18 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At out last inspection in May 2016 we found that the management arrangements for auditing people's medicines were in need of improvement. We found at this inspection monitoring and auditing of people's medicines remained in need of improvement. Further work was needed to provide robust quality and safety monitoring of the service. The clinical lead nurse showed us audits of medicines including random numerical counts but these had been ineffective at identifying the discrepancies we found in the management of people's medicines.

This demonstrated a continued breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last urgent, focused inspection on 15 July 2016 we found that there was a lack of action taken by the provider to assess environmental risks to people and others. We asked the provider to take urgent action to make improvements as we found major concerns following a recent incident which had resulted in a fatality. We found some action had been taken by the provider to improve the safety of the environment. For example, window restrictors had been fitted to all windows. Action had been taken to organise and arrange for staff to be provided with training in health and safety, including risk management. The provider told us they were in the process of gathering quotes to have work carried out to have radiators covered to reduce the risk to people from hot surfaces which would protect people from the risks of scalding.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The principles of the Mental Capacity Act (MCA) 2005 had not been applied and issues of people's capacity had not been considered fully in relation to people whose medicines were being administered by nursing staff covertly.

The enforcement action we took:

We issued a Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not assess and protect people against the risks by way of doing all that is practicable to mitigate any such risks in the management of their medicines.

The enforcement action we took:

We issued a Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider failed to ensure the nutritional and hydration needs of people were met to sustain life and good health.

The enforcement action we took:

We issued a Notice of Proposal to restrict admissions to the service and to impose conditions on the

provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider failed to assess, monitor and mitigate the risks related to the health, welfare and safety of people.

The enforcement action we took:

We issued a Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that nursing staff were provided with clinical supervision with opportunities to plan for their clinical professional development and their competency assessed. This also had the potential to put people's health, welfare and safety at risk as the competency of nurses was not assured.

The enforcement action we took:

We issued a Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's registration.