Gedling Village Ltd

Gedling Village Care Home

Inspection report

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Gedling
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Tel: 01159877330

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Gedling Village Care Home is a care home that provides personal care for up to 60 people across three floors, in one adapted building. It is registered to provide a service to older people who may be living with dementia or physical disability. At the time of the inspection 51 people lived at the home.

People's experience of using this service: Risks associated with people's care and support were not always managed safely. People were placed at risk of harm as medicines were not managed safely. There had been a failure to learn from incidents. There were not always enough, adequately trained staff available to meet people's needs. Action was underway to protect people from improper treatment and abuse. Overall, the home was clean and well maintained and safe recruitment practices were followed.

Further work was needed to ensure people's rights under the Mental Capacity Act 2005 were protected. Mealtimes were not always positive experiences and improvements were needed to ensure risks associated with eating and drinking were managed safely. People had access to a range of health care professionals, but care plans required more information about people's health to ensure consistent support. Overall, the home was adapted to meet people's needs. Staff had training and told us they felt supported, however, formal supervisions was inconsistent.

Staff were not consistently kind and caring. People were supported to be as independent as possible. People had access to advocacy services if they required this.

People did not consistently receive personalised care that met their needs. People were at risk of receiving inconsistent support as care plans were confusing, contradictory and not up to date. People were provided with some opportunity for meaningful activity. There were systems in place to respond to complaints.

Systems to ensure the safety and quality of the service were not fully effective. Where issues had been identified, improvements had not always been made or sustained. This failure to identify and address issues had a negative impact on the quality of the service provided at Gedling Village Care Home. The management team were responsive to feedback and took swift action to address issues identified in this inspection. People living at the home, their families and staff were positive about the management team and were consulted about the running of the home.

The service met the characteristics of Requires Improvement in all areas. For more details, please see the full report which is on the CQC website at www.cqc.org.uk.
Rating at last inspection: Good (report published on 5 May 2017)

Why we inspected: This inspection was conducted due to concerns we received about the safety and quality of the service provided at Gedling Village Care Home.

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: During our inspection we requested evidence of action planned in relation to staffing, medicines management and risk assessment. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Gedling Village 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 two inspectors and an expert by experience who had personal experience of caring for someone who uses services that support older people.

Service and service type: Gedling Village Care Home 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 did not have a manager registered with the Care Quality Commission. The previous registered manager had left the home in early February 2019. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had been recruited and was due to start work at the home shortly. We will monitor this.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection site visit we reviewed any notifications we had received from the service and information from external agencies such as the local authority. As this was a responsive inspection based upon risk the provider was not asked 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 the opportunity to share this information during the inspection.

During our inspection visit we spoke with four people who lived at the home and the relatives or friends of seven people. We also spoke with six care staff, a member of the catering team, two members of the domestic team, the activity coordinator, two deputy managers and regional manager. We also received feedback from two health professionals who visited the home regularly.

We reviewed records related to the care of nine people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, four 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.

Requires Improvement

Is the service safe?

Our findings

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

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; Using medicines safely;
• People were not always protected from risks associated with their care and support. Risks were not always identified or addressed. For example, one person had moved into the home two weeks before our inspection. Despite them having experienced falls prior to them moving into the home there was no falls risk assessment and no care plan detailing measures to reduce the risk. This failure to identify and assess risk placed people at risk of harm.
• Risks posed by people's behaviour were not always managed safely. Care plans did not consistently contain enough information to enable staff to provide safe support. Staff told us about one person whose behaviour posed a risk to other people. Their care plan did not contain any information about this behaviour or how to reduce the impact upon others. This placed people at risk of harm.
• Opportunities to learn from incidents and accidents had been missed. Although there were systems to reduce, review and learn from incidents, effective action was not always taken to reduce risk. For example, one person had recently fallen. However, at the time of our inspection they had no falls risk assessment in place and no care plan detailing how staff should reduce the risk of falls. This placed them at risk of harm.
• Medicines were not managed safely and people did not always receive their medicines as prescribed. We identified a range of concerns about medicines management. Some people had not been given their medicines as required. This posed a risk to people's health and wellbeing. Medicines records did not always contain the required information to ensure safe administration and this increased the risk of error. Medicines were not always stored safely or at the required temperature and medicines practices were not always hygienic. These issues placed people at risk of harm.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our visit, the regional manager informed us of action they had taken, or planned to take, to address the above areas of concern. We will assess the impact of this at our next inspection.

Staffing and recruitment
• There were not enough staff to meet people's needs and ensure their safety. This was reflected in our observations and comments from people and their families. One person said, "I don't think there are enough staff." A relative told us they had been asked to, "Keep an eye on people," by staff as there were not always enough staff around to supervise communal areas.
• The provider used a tool to calculate how many staff were needed. However, this tool was not always based upon an accurate assessment of people's needs. Furthermore, staffing rotas showed that staffing

levels fell below the specified amount on some shifts. This meant there were not always enough staff to respond to people's needs and ensure their safety.
• Staff were not always deployed effectively. During our inspection we found a person in an undignified state calling for help. As there were no staff present on the floor we had to go downstairs to seek assistance for the person.
• There were not always trained staff available to meet people's needs. There was not always a member of staff on shift at night that was trained to administer medicines. This posed a risk that people who were prescribed 'as required' medicines for pain relief and symptom management may not get them in a timely manner. This placed people at risk of suffering unnecessary pain and distress.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection, the regional manager informed us action was underway to ensure there were enough, sufficiently trained staff to meet people's needs. We will assess the impact of this at our next inspection.
• Overall, we found safe recruitment practices had been followed. However, records did not evidence that all pre-employment checks had been completed as required. The regional manager told us a full audit of staff files would be completed and action would be taken to address any deficiencies.

Systems and processes to safeguard people from the risk of abuse
• Overall, people told us they felt safe. One person told us, "You do feel safe here. The staff are not rough." Staff knew how to recognise and report abuse. The management team had acted quickly to identify potentially abusive practices and were in the process of investigating some concerns. Action had been taken to safeguard people whilst investigations were undertaken. Allegations of abuse had been reported to the local authority safeguarding team when required.

Preventing and controlling infection
• Overall, the home was clean and hygienic. Some areas of the home, such as carpets required replacement to enable effective cleaning and promote the control and prevention of infection. This work was planned.
• Staff had received training in infection prevention and control and how to prevent the spread of infection such as effective hand washing. There were audits in areas such as, infection control and food hygiene. The Food Standards Agency had inspected the home in March 2018 and given it a food hygiene rating of five, which means 'very good'. We observed the kitchen area to be clean and well maintained and staff followed food hygiene procedures.

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.
• Further work was needed to ensure people's rights under the MCA were fully protected. Capacity assessments had not always been completed to reflect people's decision-making abilities. In addition, some care plans contained contradictory information about people's capacity. Despite this, we did not find any evidence that people were subject to unnecessary restrictions upon their rights. The registered manager told us capacity assessments would be reviewed and implemented as needed.
• 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. Applications for DoLS had been made where appropriate and any conditions imposed upon DoLS authorisations had been complied with.
• Where people had capacity to consent, they were supported to make informed choices and staff respected their decisions. One person told us, "They (staff) always ask for my permission."

Staff support: induction, training, skills and experience
• People and their relatives told us staff knew what they were doing when supporting them or their family member.
• Records showed staff had sufficient training to enable them to meet people's needs. Staff were generally positive about the training they had, although commented more face to face training would be good. Records showed staff had received training in areas such as, health and safety, moving and handling and fire safety. Some staff also had training specific to people's individual needs. New staff were provided with an induction period when starting work at Gedling Village Care Home. Induction included training and shadowing more experienced staff.
• Staff had not consistently had regular supervision of their work. This meant opportunities to monitor staff performance may have been missed. The management team had identified this and had started a programme of supervision.

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 the home. The management team told us this information was used to develop care plans. However, we reviewed care records of people who had recently moved into the home and found they did not always contain key information needed to ensure their safety and wellbeing.
• Although nationally recognised assessment tools were used, these were not used consistently or effectively. For example, risk assessments had not been completed when people were potentially at risk of falls or weight loss. Where risk assessments had been completed recommended actions had not always been followed.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they had enough to eat and drink and said the food was good. One person told us, "The food is very good. I get biscuits for snacks. The food is warm and you get a choice."
• The mealtime experience was not always positive. Although staff ate their meals with people who lived at the home there were very limited social interactions. Support from staff was focused on tasks and meal times were quiet with few conversations.
• People were not protected from the risk of weight loss. There had been some delays to seeking professional advice when people lost weight. Consequently, the GP was reviewing all people who had lost weight. Despite this we found that people were still not always weighed at the required frequency, and when people were at risk of losing weight their food and fluid intake was not effectively monitored. Therefore, it was difficult to establish if they were eating enough.

Adapting service, design, decoration to meet people's needs
• The home was adapted to meet people's needs. Aids and equipment had been installed throughout the home. This enabled people with mobility needs to navigate around the building and there was a call bell system to ensure people could request staff support. There were communal lounges and dining areas on each floor which meant people had space to spend time socialising with friends and family.
• Dementia friendly signage was used throughout the home to help people find their way around.

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. One person commented, "I could see the doctor if I wanted. I see the hairdresser and have asked to get my feet checked out."
• Care plans required further information about people's health needs to ensure staff provided effective support. An external health professional informed us of a concern that staff did not always record professional advice in care plans. This placed people at risk of inconsistent and potentially unsafe support.
• There were systems to share information across services when people moved between them. The electronic care planning system could produce an information pack should people be admitted to hospital. However, these were not in place for some people who had recently moved into the home. This posed a risk they may not receive person centred support.

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

Ensuring people are well treated and supported; equality and diversity
• People were not always provided with kind and caring support. Feedback about the approach of staff was mixed. Some people were positive about staff. One person told us, "They (staff) have all been kind to me." In contrast other people talked about an inconsistency in staff approach. People used terms such as "rude," "snappy" and "pushy" to describe the behaviours of some staff. Visiting professionals also shared this view about the conduct of some staff members.
• The regional manager had identified some issues within the culture of the staff team and had started to address this.
• People told us most staff knew them and understood what was important to them. One person told us, "Staff know what I like and don't like." During our visit we observed staff talking with people about their previous hobbies and interests. However, we found some care plans lacked information about what was important to people, which posed a risk of inconsistent support. The management team had identified this and were working on improving person-centred information in care plans.
• People were supported to keep in touch with families and friends. People's families told us they were welcomed into the home. The deputy manager had worked with a person to support them to move to the home to be closer to their family. The staff supported them to meet their relative regularly and this relationship had blossomed.
• Relationships had developed between people living at the home. For example, three people had become close friends and met daily. Staff had provided additional seating in one person's bedroom so they could spend time together.

Supporting people to express their views and be involved in making decisions about their care
• People told us they felt listened to and said they were supported to make day to day choices. One person told us, "If I say I don't like that, then it's respected." Several people and their families told us they were involved in developing their care plans. However, this was not consistent. The deputy manager had identified this as an area for improvement.
• Overall, staff demonstrated a good understanding of how people communicated. The management team had started work on developing visual resources to help people to make choices and told us they were working with staff to implement this.
• Further work was needed to ensure care plans contained clear information about how to communicate with people and how to involve them in decision making.
• People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

Respecting and promoting people's privacy, dignity and independence

• People's right to privacy was respected by staff. People felt staff listened to them and treated them with dignity, for example, by closing the bedroom door whilst they were helping them to get dressed. A relative told us, "Staff knock on the door. They have to do a lot for [name]. They talk to [name]. They (relative) is less frustrated than they used to be."

• People were supported to be as independent as possible. The deputy manager shared stories of people who had grown in independence while at Gedling Village Care Home. One person's health and mobility had improved so much they moved back into the community. When they moved out they insisted on getting the bus home! Another person loved going shopping but was no longer able to understand how to use money, so the staff took them out regularly and supported them to pay for items.

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; End of life care and support

• People did not always receive a personalised service. Routines were sometimes based upon what was easiest for staff rather than people's preferences. People from the second floor were brought downstairs to the ground floor each day. Staff told us that this had just become an expected routine, so unless people stated otherwise they were just brought downstairs for the day without meaningful consultation. Staff also told us they "kept" people who were at risk of falls in the lounge so that they could observe them. We observed people being moved around the home with minimal consultation.
• People were at risk of receiving inconsistent support. Care plans were confusing, contradictory and not up to date. For example, records showed one person required specific support with their continence. There was no guidance about how staff should support them in this area. At the time of our inspection three people did not have any care plans in place at all. This meant staff did not have access to information to guide their practice. This placed people at risk of inconsistent support.
• Further work was needed to ensure people were given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives. Although there was evidence that some people had shared their wishes, there was no evidence for others. For example, one person was coming towards the end of their life, but their care plan contained very little information about their preferences. This meant there was a risk people may not receive person centred care at the end of their lives.
• The deputy manager told us they were working towards meeting the Accessible Information Standard. Information was available in alternative formats and they were in the process of developing photographic resources to help people make choices.

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

• People were provided with some opportunities for activity; however, we received mixed feedback from people. Some people told us they had enough to do and could get involved with activities if they wished. However, in contrast, others told us there were times, such as weekends, where activities were very limited. A relative commented, "The home could do with more activities and distractions for people. More often than not, there are very few activities."
• The provider employed an activity coordinator. They told us they organised group activities and events. There were also activities led by external specialist companies, such as, exercise classes and group entertainment. People's diverse needs had been considered in the design of activities. For instance, there were activities that were specifically designed to appeal to men.
• During our inspection, we observed people on the ground floor were engaged in a knitting group and a

jigsaw puzzle. However, on the top floor there were long periods when people were sat without any stimulation other than the television. A member of the management team told us they were working on improving the opportunities available to people.
• People's diverse needs were identified before they moved in to the home and care plans contained details of any support people required to ensure their needs were met. People's religious and cultural needs were accommodated. Local religious groups visited the home and staff supported people to attend local places of worship if they wished. The deputy manager was proactive in supporting older people's diverse sexual needs.

Improving care quality in response to complaints or concerns
• Most 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.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Systems to audit the quality and safety of the service were not always effective in identifying and addressing areas for improvement. For example, medicines audits had not identified the issues we found at our inspection. Medicines were not managed safely and people did not always receive their medicines as prescribed. Although medicines audits had been conducted, effective action had not been taken at address issues found. Consequently, we found the same issues highlighted in consecutive audits. Furthermore, although issues had been identified in the most recent audit no action plan had been developed to ensure these were addressed. The failure to identify and address areas of concern placed people at risk of harm.

• Systems to review and learn from accidents and incidents were not fully effective. Although falls were reviewed by the management team each month, action was not always taken to reduce future risk. Furthermore, the provider did not have an accurate overview of incidents and other events in the home. Incidents were not always recorded effectively which meant the provider was unaware of some incidents. Consequently, the provider was unable to assess if adequate action had been taken. This meant there was a risk that opportunities to improve the safety of the home had been missed.

• Action had not always been taken in response to known issues. Prior to our inspection the provider notified us of an incident resulting in a person being injured by another person living at the home. In the notification the provider advised the care plan had been updated in response to this incident. However, during our inspection we found there was no behaviour support plan in place. Consequently, measures in place to ensure people's safety had not been implemented effectively. This failure to take effective action placed people at risk of harm.

• Where issues had been identified, action taken did not always ensure the safety and quality of the service. During our inspection we found there were not always staff on shift who were trained in medicines management. The deputy manager was aware of this and told us they had recruited a new member of night staff who would be medicines trained. However, there was no formal interim plan in place and informal measures were not sufficient to ensure people received their medicines as required. This failure to take effective action placed people at risk of suffering unnecessary pain and distress.

• Records of care and support were not consistently accurate or up to date. Missing information in care plans and incomplete risk assessments put people at risk of receiving inconsistent and unsafe care. Furthermore, records such as food and fluid records, and records of repositioning, did not always evidence people had been given the care they required.

• There were insufficient processes in place to ensure that care plans were implemented when people moved into Gedling Village Care Home. One person moved in to the home five weeks before our inspection. They had been assessed as being at high risk of malnutrition. Despite this there was no nutrition care plan in

place and staff were not monitoring their food intake. This had not been identified before our inspection. This failure to ensure that staff had access to accurate and up to date information about people placed them at risk of receiving inconsistent and potentially unsafe support.
• Sensitive personal information was not stored in line with the legal regulations. Throughout our inspection medicines records, containing sensitive personal information, were stored on top of the medicines trolley in a communal area, this was, at times, unattended. This posed a risk that information could be accessed by people living at the home or visitors.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• 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 and on their website. We checked our records which showed the deputy manager had notified us of events in the home as required. This helps us monitor the service.
• The service did not have a manager registered with the Care Quality Commission. The previous registered manager had left the home in early February 2019. A new manager had been recruited and was due to start work at the home shortly. We will monitor this.
• Throughout our inspection the management team were responsive to feedback and took swift action to address areas of concern. After our visit they provided us details of action taken to reduce risk.
• People living at the home, families and staff were overwhelmingly positive about the management team. A relative told us, "[deputy manager] is fantastic. From what I see it's well managed." A member of staff commented, "[deputy manager] is very involved. They are fair and they treat people equally."

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The provider had a vision for the home which focused on providing person-centred care to people. Staff we spoke with had not been involved in the development of the vision, but it had been shared with them and was displayed in the home.
• Overall, people and their families were positive about the home, staff and management team. A relative told us, "It is well managed. Day to day care is excellent. Carers seem comfortable in their jobs here." However, some relatives commented that there had been a decline in the quality of care at the home, and this was also reflected in our overall findings.

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. A relative told us, "There's regular meetings for residents and relatives. But staff can be approached at any time." Meetings were held where people were consulted about activities, food and the decoration of some areas. People were also given the opportunity to raise any issues or concerns at these meetings. People and their relatives were invited to share their feedback in regular quality assurance surveys.
• There were regular staff meetings for all designations of staff, these were used to share news and information with staff and to discuss areas of concern and improvements needed.

Working in partnership with others
• The team at Gedling Village Care Home worked in partnership with other organisations to ensure people got the care they required. Feedback from visiting professionals was mixed. Although they commented positively on some aspects of the service they told us they had some concerns about the negative attitude of some staff members.

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 did not always receive a personalised service that met their needs and they were at risk of inconsistent support. Regulation 9 (1)

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. Medicines were not always stored or managed safely. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to ensure people's safety, staff were not always deployed effectively to ensure people's needs were met. Regulation 18 (1)

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 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the home were not effective. This had a negative impact on the quality and safety of the service. Regulation 17 (1) (2)

The enforcement action we took:

We served a warning notice detailing our concerns and telling the provider to become compliant with this regulation within three months.