HF Trust Limited

HF Trust - Old Quarries

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and carried out on 2nd and 8th June 2016. HF Trust - Old Quarries is a residential care home. It provides individualised support for people with a learning disability. The service is made up of a number of houses and bungalows on the same site where individuals are supported to live as independently as they are able. They can accommodate up to 33 people, there were 29 people living there during our inspection.

Old Quarries is due to close although there is no official closing date. People were uncertain and anxious of a transition to new homes. Staff and people had been consulted but we saw no evidence that needs assessments or transition plans had been updated. This provided an uncertain future for some people living at Old Quarries and this was having a significant impact on those people. After the inspection the provider gave us details of emails and updates people and staff had received between August 2015 and June 2016. There had been two newsletters for staff on redevelopment and staffing arrangements. People had been encouraged to attend meetings with information about the transition plans within the same timeframe. We were told that Old Quarries would update transition plans for everyone by 19 August 2016.

There was a registered manager in post. 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 responsibilities for meeting the requirements in Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not safe. The provider did not have effective systems to assess, review and manage risks to ensure the safety of people. Risk assessment processes were inadequate. Guidance was not available for staff on how to support people safely. Digital and paper records contained different information. Risk assessments were not always completed thoroughly. People's medicines were not always being managed safely.

We found the service was not always effective. Staff were not receiving regular supervision or support. No appraisals had been carried out for any staff within the last 12 months. Staff received on-going training and support to attend external training if they wished to.

The premises were in need of redecoration and were not always clean. A cupboard had fallen off the wall in one person's kitchen leaving a bare wall and a large chunk of plaster was missing from another area. Both of these had been recorded in the maintenance book over four weeks ago but nothing had been done.

The service was not responsive to people's needs. Support plans and risk assessments were out of date and lacked the detail required to provide consistent, high quality care and support.

The service was not well led. The registered manager and provider had governance systems in place to monitor the quality of the service provided. However, these systems had not identified the concerns we

found around medicines management and assessing risks. Staff team meetings were not being held regularly, there was no agenda and the minutes lacked detail. The minutes were of a poor quality with no review or completion of actions.

Sufficient numbers of staff were available to keep people safe and meet their needs. The use of agency staff had, however, reduced staff consistency and this in turn had negatively impacted on people's care. Some people were not being supported to reach their full potential. There was no record of review or progress for some people for many years. Staff told us they aimed to help people live as independently as they were able to.

People using the service were positive about the care they received. We observed staff supporting people in a caring and patient way. Staff knew people they supported well and were able to describe what they like to do and how they like to be supported.

We found 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 that back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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 was not safe.

Risk assessments were not always in place and those that were lacked sufficient detail to safely provide care.

The physical environment was not adequately maintained or clean.

Risks associated with people's health care needs and medicine errors were not always managed properly.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported and did not receive regular supervision to develop and review their day to day practice.
No appraisals had been completed for staff members in the last 12 months.

People were supported in their healthcare needs and staff engaged proactively with health care professionals.

The premises were in need or redecoration and were not always clean.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were supported to access the community and were encouraged to be as independent as possible.

We received some positive feedback about the support provided from people living at the home and other professionals.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Some people had opportunities to engage in meaningful hobbies or activities related to their interests. However, for others it was not always evident that they were supported to take part in any activities based on their needs and wishes.

Daily notes were not completed thoroughly.

Support plans lacked detail required to provide consistent, high quality care.

Is the service well-led?

Inadequate

The service was not well led.

The service had systems and processes in place but these were not being used effectively to assess, monitor and improve quality and safety.

Accurate records were not maintained.

The culture of the home was one of uncertainty and anxiousness as some staff and people were unclear of the future plans with regard to the closure of the home.

HF Trust - Old Quarries

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.

Prior to the inspection we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

This inspection took place on the 2nd and 8th of June 2016. This was an unannounced inspection, which meant that the staff and provider did not know we would be visiting. The previous inspection was completed in March 2014 and there were no breaches of regulation at that time. The inspection consisted of two adult social care inspectors.

We contacted six health and social care professionals, social workers and commissioners. We also spoke to the local GP surgery. We asked them for feedback. We were provided with a range of feedback to assist with our inspection and have included this in the body of the report.

During our visits we spoke with four people using the service. Because we were unable to speak with many people because of their communication difficulties or learning disabilities we spent time observing what was happening in their home. We spoke with nine staff, including the registered manager, the provider's director of quality and improvement and seven care staff. We looked at the care records of five people living at the service, six personnel files, organisational records, staff rotas and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Although people we spoke with said they felt safe, we identified concerns where safety was compromised and people were at risk.

Risks to people's health and safety had not been assessed appropriately and the provider was not doing all that was reasonably practicable to mitigate any such risks. Support plans, daily notes and risk assessments were brief and had not been reviewed regularly to assess changing needs. It had been identified that one person was at risk of being malnourished and dehydrated. They were unable to make a meal and hot drink and could be at risk of injury if not supported whilst using the kitchen. However staff were supporting this person to have sufficient food and drink and supported them whilst working in the kitchen. There was no information or guidance to support staff on how they managed these risks. One person's personal care, medication and mobility assessments indicated they had not been reviewed since 13 September 2012. We could not be satisfied that the information recorded would enable staff to support this person safely. At the time of the inspection the service was using a high number of agency staff. The lack of information and guidance in records increased the risks to people.

Staff did not have a good understanding of their responsibilities for reporting and recording accidents, incidents or concerns. Written accident and incident documentation did not contain enough detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were not recorded on body maps and monitored for healing. We looked at records and there had been a total of 14 accidents, incidents and near misses in 2016. A Health and Safety report completed between 1st January 2016 and 30th April 2016 by HFT regarding events that had happened in their care home stated "Figures are quite high for incidents where violence is identified at Old Quarries due to one person living there who developed a pressure sore and this caused a number of aggressive incidents". This information was submitted to CQC post inspection.

Medicines management records and practices were not managed safely. There were 278 recorded medicine errors between February 2014 and March 2015 and 61 recorded medicine errors between June 2015 and June 2016. Examples of areas that had been identified included people being given medicines they hadn't been prescribed and missed doses. The errors had not been properly investigated, we were unable to find records that appropriate actions had been taken to help prevent the same errors from happening again. The registered manager had taken steps to reduce medication errors and this had resulted in a significant reduction. In an audit conducted May 2016 a manager had selected a category that included the following statements "Recording of medication is of an inconsistent standard" and "Medications are not generally administered as required or on time". The registered manager had seen this audit but had not yet ensured that all actions had been taken to address these concerns. After the inspection we received an explanation that these were pre-populated sentences within the audit and that some improvements had been made.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Policies and procedures were available to everyone who used the service. Staff confirmed they attended safeguarding training updates. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, CQC and the police.

People and staff confirmed there were sufficient numbers of staff on duty. However four members of staff had left employment since January 2016 and shifts were being covered by agency staff. This was unsettling for people with complex needs who benefited from consistent staffing. In addition to the permanent staffing levels in each home additional staff was provided where people needed escorts in the community and where somebody might require 1:1 supervision. The provider was holding a recruitment day and people who used the service had been asked if they would like to attend so that they could be involved with this process.

Each bungalow at Old Quarries had an on call system for staff so that they were supported in an emergency. The phone number was located on the wall in each office. Staff said that the on-call manager was available for advice, covered vacant shifts and did 'sleep in' shifts to cover staff sick absence.

New employees were appropriately checked through robust recruitment processes to ensure their suitability for the role. Records showed us that people had a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people. We looked at records for six staff which evidenced that staff had been recruited safely.

Regular health and safety checks and schedules were in place for infection control, manual handling, water temperatures, emergency lighting, checking of first aid kits and electrical equipment. Relevant policies and procedures were in place for health and safety. All staff had received fire safety training and people had personal emergency evacuation plan (PEEP). These contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in the event of an emergency. These were kept in each individual bungalow. There were regular fire safety checks in place.

Requires Improvement

Is the service effective?

Our findings

Formal supervision had lapsed and staff had not received support in their day to day practice. Records and an email from the registered manager confirmed there had been no appraisals for any staff within the last 12 months. One staff member had not received supervision since April 2015. This meant the registered manager was not formally monitoring staff performance, supporting the staff to work together as a team and allaying their concerns about the future of the home and their own jobs. Staff morale was understandably low.

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

Areas of the service were in need of redecoration and were not clean; this was mostly evident in the main building. A cupboard had fallen off the wall in one of the communal kitchens leaving a bare unpainted wall and a large chunk of plaster was missing from another area. Mould was visible around a window frame in a bathroom but this had not been noted. The radiator in the dining room was extremely hot to touch and could not be switched off. The maintenance book had not been completed thoroughly so we were unable to see what had or had not been completed. There was no evidence that the maintenance book was regularly audited, as a result issues were still outstanding and not being followed up.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received on-going training and support, which included a mixture of online training and attendance at external training courses. The systems for recording staff training were colour coded to highlight when training was due. Staff said they 'had lots of training' and that it was 'good'. There were extra training days available to staff if they wished to attend. Specialised training had been given to staff if required, this included dementia awareness and end of life care.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures in place regarding the MCA and DoLS. Everyone's mental capacity had been assessed and records confirmed this. DoLS applications had been made appropriately for some people and the registered manager was awaiting further contact from the local authority regarding the outcomes. Staff had received training on MCA and DoLS and they were able to describe the principles and

some of the areas that may constitute a deprivation of liberty.

People were able to choose what they would like to eat. This was discussed with staff and people in each area. Menu planners were visible in each bungalow. Pictures of food were on the wall to show what people were having for dinner as a visual aid. People were encouraged to help with the preparation of food, laying the table and clearing up once people had finished eating. Each bungalow had separate meal planners. People who needed assistance to eat were supported by staff and this was recorded in people's support plans.

Previously there had been inconsistencies in monitoring fluid and food intake for those people who may be at risk. One person had serious health issues and had lost a significant amount of weight within a small timeframe. A daily health file had been introduced in April 2016 to monitor these issues. Records showed us that staff had reacted to concerns after a complaint from a professional had been raised. One staff member told us, "I feel this situation is being managed better now". We looked at the file for this person and saw that fluid and nutrition intake, energy levels and weight were now being monitored and reviewed.

Every Thursday people had the choice to attend the service café club. The café club is a social gathering where people are able to enjoy a lunchtime meal together in the main building. During our lunchtime observations at the café club, people were able to choose where they wished to sit to eat. Some people sat on sofas and others at tables. The food was well presented and people seemed to enjoy their meals. People had helped to prepare lunch by cutting vegetables in the kitchen. This was supervised by a staff member and one person told us "I like helping to cut the vegetables and serve people their food". People were encouraged to help with preparing meals and setting the table. Lunch in the café was relaxed and where people needed support with eating this was given discreetly with respect and dignity. Within each home people were involved in choosing meals and these were displayed on a wall planner to show what was on offer.

People had contact with health and social care professionals and this was documented in their care plans. People could access doctors, opticians and dentists when required. In each care plan support needs were available for staff with regard to attending appointments and specific information for keeping healthy. There was detailed information for how people may need support for immunisations, medication needs and general health and lifestyle. A list of professionals and medical contacts involved were included in the care plans but this information lacked detail and contact numbers were often missing. Risk assessments regarding how to support good health were not always available.

People had a separate health file which gave extra information on how to support people with specific health conditions. One person had recently been identified as at risk due to losing a significant amount of weight. Plans had been implemented and their weight was now being monitored. This information was not available on our first day of inspection.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, "The staff are nice; they help me to go out sometimes". Staff knew about the people they supported. They knew more about them than their immediate needs including their personalities and things they like to do. They told us about their likes and dislikes and what made them happy. However, this was not always documented in support plans. Where possible, people were being supported by a small team of permanent staff which enabled relationships to form. This was not happening for everyone at the time we visited because agency staff were being routinely used.

We saw some positive interactions with people from some of the staff, who were clearly trying hard to provide the care required. One person asked for a drink and a staff member immediately got up to do this. The service operated a keyworker system, where a staff member was identified as having key responsibility for ensuring a person's needs were met. Staff told us this system allowed them to get to know the person they were keyworker for well and ensure the needs of the person were met. Each keyworker was responsible for planning and facilitating people's person centred plans which involved a meeting with people to review and update changing needs.

Staff spoke about promoting people's rights and supporting them to increase their independence and make choices. People were offered choices about food, social activities and how they spent their time. Some people could communicate their choices verbally and others used objects or pictures to select an option. One person had pictures of food on their weekly meal planner. Staff told us that people were encouraged to be as independent as possible. People were encouraged to access work placements in the community.

People's bedrooms were personalised and decorated to their taste. Some people showed us their rooms, and were pleased to talk to us about their hobbies and interests. One person said "I like collecting tobacco tins; I have just been to buy one. The man in the shop knows me well and will order me ones I do not have". This was documented in care and support plans. Another person who liked cars was in the car park area playing with a remote control car.

We attended the "Voices to be heard" meeting in the main house which was an opportunity for people to discuss any issues. People were able to choose if they wished to attend. On the agenda was the up and coming EU referendum. People were able to ask questions and were told they would be supported to vote. There was an easy read copy of 'how to vote' available to people if they required it. One of the people who lived in the service chaired the meeting explained what it meant to stay in Europe and explained that people needed to consider what it meant for them if the UK remained in and the impact this would have. One person said "I enjoy chairing the meeting and talking about things as a group". Everyone who attended was given time to speak.

During the meeting and at other times throughout our inspection there were occasions when improvements could be made to ensure people were treated with dignity and respect at all times. One person said that staff did not always say "good morning" or "good night" and that staff used their phones and smoked whilst at work instead of being with them. Those staff on duty said that they would ensure the whole staff team

was aware of the issues raised. People were asked to report staff that used their phones or smoked whilst on duty. One staff member did not knock on a person's door and walked in the room without asking and on another occasion we overheard staff discussing people's issues in front of others.

People were supported to dress accordingly to their individual tastes. They looked well-presented and well cared for. People's choices around clothes and what they liked to wear was documented in their support plans. People were encouraged to help with looking after their clothes.

Staff had received training on equality and diversity. We saw the provider had planned to meet people's cultural and religious needs and care records confirmed this. People's care records included an assessment of their needs and support needed to maintain cultural aspects of life. For example, one person loved watching 'songs of praise and would often sing along to songs'. Staff we spoke with understood their role in ensuring people's equality and diversity needs were being met. Staff told us people were supported as individuals. For example one person followed the Christian calendar and was supported to celebrate Birthdays, Easter and Christmas. People could choose if they wanted to attend church and were supported by staff if they wanted to go. This was clearly recorded in their support plans.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. The move-on to other homes had not been well planned and some staff said "People have been told too early about the closure of the home, and suitable accommodation has not been found for people to move to". Records showed us that people's needs, wishes and choices were not respected when moving between services. We were unable to find any transition plans for people moving on. This was having a negative impact on staff and people who use the service.

Staff were concerned about people moving out of Old Quarries and said "One person is due to move to an upstairs flat and this will be difficult for them as they have lived here for a long time in a downstairs room" and "I feel like people will be moved to different places and they will be living with people they don't know rather than those they have been here with".

Each person using the service had a support plan which was personal to them. Some of the information recorded about people was not regularly updated, therefore they did not always reflect peoples current needs. Support plans were kept on the provider's care computerised system, we found on the whole these were up to date. There were paper versions of support plans in each house across the site, we found these did not reflect the support plans on the computer. Staff were able to talk knowingly about each person, but there was a risk that staff not familiar with each person could be misled by the records. Examples of this included; one person's support plan stated they liked to "go out gardening" and "enjoys trips to the shops". This person was funded for enhanced hours to achieve this. During our two day inspection this person was seen sat in the conservatory on their own. Staff said this was what the person wanted to do. Another example was some sections of one person's care plan had not been reviewed for two years, but should have been reviewed every 12 months. One support plan had been completed six years ago, and there was no evidence of review-by day two of the inspection this had been reviewed and updated.

We found daily recordings lacked detail on what care was being provided. For example, two daily notes said "See support plan", they didn't tell a story or describe that person's day. This would make it difficult for staff to know how to support people effectively. It was not always possible to determine what people had been doing or how they were being supported. For example; we could not find any information in the daily notes regarding personal care. This increased the chances of changes not being identified and enabling the support plan to be updated where necessary. A senior member of staff told us they were aware the plans needed updating.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people said there were enough activities on offer at the service and were able to access the community. We watched people getting into vehicles to go out. One person had been out for a walk and to the pub for a drink. One person told us how they enjoyed swimming; horse riding, shopping and going to the pub on a Friday".

A group of people told us about being involved in a project called the "Big Hat Cabaret" that was being run in Swindon. This enabled them to get involved in acting, comedy and dance. The group were due to perform in public in the weeks after the inspection.

Records of compliments and complaints were available to look at. The complaints had been investigated and had outcomes. There had been no recent complaints. The registered manager said "There had been five complaints in the previous year". One of the complaints was regarding staffing levels but this had been resolved. People were able to make complaints if they wanted to and an easy read form was available if needed. A complaints policy was in place and people told us they knew how to complain if they needed to. During the "Voices to be heard meeting" one person asked to make a complaint about staff and the member of staff facilitating the meeting stated they would be supported with this one the meeting had finished.

There had been three compliments in the last year. The parents of one person living in the home thanked them for making them feel welcome when they had visited, for the support they received on Christmas Day and the overall work and progress with regards to moving on to an alternative placement.

Inadequate

Is the service well-led?

Our findings

The organisational records, staff training database and health and safety files were organised and available. Policies and procedures were in place and easily accessible. Guidance documents for staff were detailed and all in one place to see. Examples of these included a lone working policy and shift related work schedules. However, the service was not well-led in other areas.

The culture of the home was one of uncertainty for the future. The Old Quarries is due to close and people will move into a more community setting, however there is no official closing date. Staff said "People have been told too early about Old Quarries closing but even now there is no closing date". Some people we spoke to were unsure and anxious about their transition to other services. One person said "I know where I am going and was asked if I would like to visit which I did and I like it". Another person said "I don't know where I am going yet". One staff member we spoke with said "We are not being told what is happening about Old Quarries closing, I received a letter yesterday about the move –on, but that was different to what I have been told". One other staff member said "I don't know what is happening with the move or whether I will have a job by the end of it".

Staff and people knew who the registered manager was but did not feel "well managed". One staff member said "He is very busy at the moment and he's never here. We can make an appointment by email to see him and he would see us". Another staff member said "He is never here; I go to other managers for support". Staff said they felt the introduction of the cluster managers [this is a level of management below the current registered manager] would be beneficial. The registered manager also managed another care service.

Some internal auditing and quality assurance systems were not planned or carried out on a regular basis. As a result the registered manager and provider had not identified errors and omissions in people's care records. The outcome of one audit from May 2016 stated "Assessment and support plans are out of date and staff members are unaware of individual's support needs and are unable to explain people's preferences and aspirations". One person's support plan in the bungalow was on the computer and as a paper version, the paper version was out of date. This increased the risk of their changing needs not being met, and people being put at avoidable harm.

Staff team meetings were not held regularly, there was no agenda and the minutes lacked detail. The minutes were of a poor quality with no review or completion of any actions identified. The whole service audit completed by the registered manager in May 2016 stated "Staff did not regularly attend the meetings and there was no evidence to ensure that staff who had missed the meetings had read the minutes at a later date". This meant that not all staff views were heard and listened to and they would not be up to date with news and future plans.

There had been a high number errors in medicines administration, the registered manager had failed to investigate these thoroughly. This meant people were being put at unnecessary risks,

The registered manager had failed to monitor that staff were receiving regular supervision and appraisals, as

a result staff had only received supervision inconsistently and none of the staff had received an appraisal in the past 12 months.

The registered manager had failed to monitor the on-going maintenance issues across the site, the outcome of this was areas of the service being in a poor state of repair over and unacceptable period of time.

Written accident and incident documentation did not contain enough detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were not recorded on body maps and monitored for healing. We saw no evidence that the registered manager had taken any action to address this, therefore it was unclear whether incidents and accidents were avoidable and whether there were any patterns or themes.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lot of positive communication and input from other professionals including the local GP surgery who said "The communication is really good and the doctor visits regularly". "One commissioner said "Overall I have no concerns with the level and quality of support provided".

The registered manager knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received notifications made by the service appropriately.

The registered manager and senior managers were responsive to our concerns during our feedback and assured us they would take action. However we were concerned about the ability of the registered manager to take these forward without access to considerable further resources and support from the provider.

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 How the Regulation was not being met: People did not always receive care and treatment that was centred on their needs. Regulation 9 (1) b of the Health and Social Care Act 2008. (Regulated Activities). Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not being protected against the risks associated with their care and treatment. Regulation 12 (2) (a) People who use services were not protected against the risks associated with medicines management. Regulation12 (2) (g) Accidents and incidents were not investigated to ensure positive outcomes. Regulation 12 (2) (b) Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008. (Regulated Activities). Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment How the Regulation was not being met:

The registered person did not ensure the premises were adequately maintained and cleaned.

Regulation 15 (1) (a) (e) of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the Regulation was not being met: The registered person had not ensured staff were receiving supervisions and appraisals. Regulation 18 (2) (a)

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 You are failing to comply with Regulation 17, Regulation 17 (1) (2) (a) (b) (c) Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

warning notice