Care Quality Commission

Calvercare Limited

Woodlands Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 26 27 November and 7 December 2015.

These were unannounced visits The previous inspection took place on 9 May 2013 when the service was found to be compliant.

Woodlands Park Care Centre provides care and accommodation for up to 35 older people who have dementia. At the time of our inspection 26 people were living in the home.

The service had a registered manager. 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.

Summary of findings

Woodlands Park had been without the registered manager for several weeks at the time of our visit and was managed by the senior care staff with support from regional managers. The registered manager was on leave at the time of our visit.

There were several staff vacancies at the time of our inspection. Agency staff were being used to maintain safe staffing levels. We received mixed feedback from staff and relatives. Staff reported that there was insufficient competent staff to ensure people were cared for to appropriate standards. Relatives we spoke with praised the staff and could not fault the care. One relative whose family member had passed away during our visit told us: "I was so relieved when I found this place; the staff are wonderful and work so hard".

The environment was clean and specifically tailored for people with dementia, for example, memorabilia around the home and sensory and tactile items such as rummage bags and textured fabrics.

People were not given care and support that was responsive to their needs and this placed them at risk.

Complaints were not listened to or acted on and this led to a failure to use this information to improve the quality of care received.

We identified areas of concern in relation to records, medicine practice, supporting staff, safety of premises, meeting people's identified needs and poor standards of care in relation to end of life care.

Health and safety audits did not identify safety risks, for example the safety gate at the top of the stairs was left open and people who were mobile were at risk of falling down the stairs.

During the first day of our visit there were only five staff on duty and four of them were agency staff.

People were not always supported by staff who received appropriate induction, training and supervision. The agency staff that were on duty at the time of our inspection had not had an induction. One of the staff members had not worked in the home before, and another one had only worked the previous day at the service.

People's social needs were not being met. The activity organiser told us that due to staffing issues, they worked as a member of the care team and were not able to focus on activities. We did not observe activities during our visit apart from a birthday celebration for a small group of people.

We could find no evidence of effective quality assurance systems in place to assess and monitor the service.

We recommend that further measures are put in place at the service to increase the staffs knowledge of action to take in relation to abuse being suspected.

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 the back of the full version of this report.

Summary of findings

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.

Health and safety audits undertaken did not adequately identify safety risks.

We found there were not sufficient numbers of staff deployed to meet people's care needs.

People's unexplained injuries were not investigated

Is the service effective?

Requires improvement

The service was not always effective.

People were not always supported by staff who had received appropriate induction training and supervision.

Lack of staff impacted on people's mealtimes. Some people who needed assistance with their meal did not get the help they required.

Relatives said they knew how to make a complaint and that staff were kind and caring

Is the service caring?

Requires improvement

The service was not always caring.

Families spoke positively about the care their family members received.

Where people received end of life care, there were no care plans in place.

Is the service responsive?

Requires improvement

The service was not always responsive.

Reviews of care were not always undertaken to reflect the current needs of people.

People's social needs were not meet.

Relatives said they knew how to make a complaint.

Is the service well-led?

Requires improvement

The service did not demonstrate that it was always well-led.

Summary of findings

Quality assurance systems were not effective in assessing and improving the quality and safety of the service provided.

The service did not have an accessible inclusive way of communicating with key staff who work within the service.

Woodlands Park Care Centre

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 inspection took place on 27 November, 28 November and 7 December 2015 and was unannounced.

The inspection team consisted of one inspector and a specialist advisor, who had experience in dementia care, and an expert by experience that had personal experience caring for someone who has used this type of service.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider had a legal obligation to send to us. Notifications are information about certain events and changes that affect a service or the people using it.

The provider completed a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two regional managers, the nominated individual, five staff members including agency workers, and a district nurse who was visiting the service. We checked some of the required records. These included six people's care plans, medicine records for all the people living in the home, six staff recruitment files containing recruitment checks and details of induction, supervision and training. We also looked at accident records and quality monitoring documents.

In addition we spoke with five people who use the service and spoke with five relatives. We used a variety of methods to help us understand the experiences of people living with dementia who could not communicate with us. We observed care practices and the interaction between staff and those they supported. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

People's medicines were not always managed safely. The last monthly delivery of medicine arrived on the evening of 23 November 2015. During the inspection we noted that the medicine had not been signed for as received or booked into the home. This meant that for several days the medicine was left unchecked and if any mistakes had occurred the pharmacy would not have known about this. This could have impacted on people's medicine administration, for example if any medicine had not arrived then it could have left some people without medicine until the pharmacy re-ordered it.

Medicine administration records were generally maintained appropriately, however, PRN protocols were not available in the medicine folder for people who had as required medicine.PRN is when medicine is used for occasional use.

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

People were not fully protected from risks associated with abuse. The service had procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had received training in recognising signs of abuse however; some of the staff we spoke with had a limited understanding of what abuse was and what they would do about it.

We recommend that further measures are put in place at the service to increase the staffs knowledge of action to take in relation to abuse being suspected.

We observed the fire evacuation procedure and the weekly fire alarm check. Agency workers were not aware of the layout of the building and the emergency procedure in the event of a fire. A list of six fire marshals was displayed at the fire panel; however three of the staff had left the service and were no longer employed by the home. Staff confirmed that no one was identified to take charge in the event of a fire. The signing in book at the front of the care home was incomplete and did not reflect accurately the visitors in the home. Furthermore, agency staff had not signed in and staff reported that they were unclear of the fire policy and procedure. The last fire drill had taken place in July 2015. We were aware that some staff had never participated in a fire drill and the staff member responsible for fire testing confirmed this. We asked staff where the grab pack was stored. Staff confirmed this did not exist. A grab pack is information in the event of fire about a person's abilities in relation to evacuation procedures. At the time of the inspection documentation in relation to fire training and health and safety in relation to reporting defects was not available. However, we were assured that the information was available but unfortunately it could not be found by the two regional managers who were at the premises. The provider was unable to demonstrate to us that effective training in relation to fire evacuation procedures had been provided to staff. This meant that people may have been put at risk in the event of a fire at the service.

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

Where people had been involved in an accident or a fall, staff did not always record this in both the person's daily notes and the accident book. For example one person had repeated falls from their bed during the month of October and November 2015. When we asked staff about how the risk of further harm was managed, they were unable to answer. When we looked at the person's bed, we found that safety rails were not used to prevent further falls from the bed. We asked if this had been explored and were told that the person would climb over the bed rails, however the person was frail and receiving end of life care at the time of our visit which meant that it would not be possible for them to climb over safety rails if they were in place.

We were aware that the person fell from their bed the night before our visit. This did not indicate that staff had assessed ways of managing the risk and planning care to prevent further falls. The person had skin tears and bruising to their lower legs. We found no documentation in the person's daily notes with any reference to how these occurred. However, when we spoke with a senior carer about the person's skin condition they confirmed the person had delicate skin and the skin tears occurred following the falls from the bed. We made the regional managers aware of the concern and they reported this would be investigated.

Accidents and incidents were not recorded appropriately. The accident book was not clear and concise regarding the accident and the management of any injuries. For example, one entry documented that "the lady was found with her

Is the service safe?

head out the door…" The accident record was unclear on review. It did not record if any injury occurred to the person and information was not transferred into the person's daily notes.

We raised our concerns about correct recording with the regional managers who assured us that further training in recording and documentation was planned.

People were not protected against the risks of harm and action was not taken to prevent the potential for or actual harm. For example, a person who was admitted to the home for end of life care did not have any risk assessments in place to manage their condition. On the first day of our visit we observed that the person was lying flat in their bed crying out in pain, with no evidence of a pain management chart. We asked the carer in charge of the home how the person's pain was being managed and they reported: "The district nurse will be in at lunchtime, and then the person can have some pain relief". The senior carer was asked why they could not administer any pain relief and they reported the person was unable to swallow and was unable to take any oral medicine. The staff member stated the person needed a qualified nurse to administer an injection. This meant that the care home was unable to promptly ensure the person's pain was relieved. The person's care plan informed staff to carry out mouth care by way of moistening the mouth with a sponge. We noted that this had not taken place as the mouth care charts in the person's room had not been completed. The only evidence of any mouth care was a dry sponge in the room, and we found the person's mouth was dry and sore. We also found that the person had a full size mattress wedged against the wall and the bed, as there was a gap where the person could have fallen from the bed. We saw the sheets were dirty and torn and the window was left open. The person had cuts and bruises to their arms and legs with no explanation in the care plan how this occurred. We noted that the person had fallen out of bed several times over the past two months. This was confirmed in the accident book, however on three occasions we found this had not been documented in the accident book and only in the person's care record.

There was no information in the daily notes or any risk assessment regarding the person being unable to swallow. We asked to see the GP's notes in relation to not giving the person any fluids due to swallowing difficulties; however these could not be found.

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

We asked why a full size mattress was wedged against the person's bed and why the person did not have safety rails to prevent them falling out of bed. We were told the home does not have any safety rails that would fit the person's bed.

On the second day of our inspection we noted the person was still in pain we raised the issue with the senior carer who contacted the district nurse. The district nurse arrived soon after our request and gave the person some pain relief. We raised our concerns with both regional managers and reported our concerns to the local safeguarding team.

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

During the second day of our inspection we were aware that four beds had the wrong size mattresses on them and had an unsafe gap between the mattresses and the top of the bed. This space presented a risk of people's head entrapment in the bed. We asked the maintenance person if safety checks were carried out regarding beds and mattresses and they confirmed this did not take place. However, this was brought to the attention of the regional manager and they ordered new mattresses whilst we were present. The mattresses were delivered later that day.

We recommend that checks of mattresses and their suitability are carried out and documented on a regular basis.

The service did not follow safe recruitment practices. We looked at personnel files and recruitment procedures used at the service.

Whilst permanent staff had received an induction we could find no evidence of how this was managed with agency staff. Agency staff were booked at short notice on both days of the inspection. Two agency staff arrived later than the start of the shift, at approximately10am and confirmed that they were booked that morning. There was no system in place to indicate who had been booked. The rota did not reflect the staff that were on shift in the building. The provider failed to plan staffing levels effectively.

Inadequate

Is the service safe?

We found that staffing levels could not meet the needs of people. On both days of the inspection people were at risk because of not receiving appropriate care due to insufficient skilled staff. For example, Our observation during lunch time showed staff appeared to be rushed and had little time to positively interact with people. One person was observed removing flowers from a vase and attempting to drink the water. We had to intervene to ensure the person's safety, as staff were not available to intervene.

This is a breach of Regulation 18 HSCA (RA) Regulations 2014

One member of staff had overall responsibility of running the home whilst administering medicine and ensuring the needs were met of extremely frail people who were receiving palliative care. The member of staff was clearly exhausted and they confirmed this. At the end of the first day of our visit the member of staff was responsible for administering the evening medication; they became visibly upset and reported they needed to take a break. We reported our concerns about safe administration of medicines to the regional manager who was visiting the service on the first day of our inspection

We were aware that the safety gate at the top of the stairwell was not always closed; this left an open area that people could fall down. We reported our concerns to the regional manager who assured us this would be resolved.

This is a breach of Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment.

Requires improvement

Is the service effective?

Our findings

Relatives spoke positively about the care their family members received. One relative commented: "Care has been superb compared with other homes X has been in."

All the relatives we spoke with said that staff were friendly, caring and treated people with respect and dignity. One relative stated: "It's a family home, not just a care home".

People were not always supported by staff who received appropriate induction, training and supervision. We noted the service used agency staff on a regular basis however; there was no formal induction in place. The day we visited we were aware that two agency staff had only worked in the home on one other occasion and did not know the layout of the home or the people they were supporting. For example we asked the member of staff how they would support a person who was receiving end of life care. They could not comment and did not understand what was meant by end of life care.

We noted that two members of staff had not completed their essential training. We spoke with the regional manager and they confirmed this was due to one member of staff being 'bank' and the other one on maternity leave. Other members of staff we spoke with confirmed they had received training. We were unable to confirm what training agency staff had received. We found that the care home did not have any information regarding agency workers and their suitability and training. The regional managers were aware of this and confirmed they will look into this.

Staff reported they had received regular supervisions. We looked at the supervision policy which stated supervisions were to be carried out every two months. However, this was not evidenced on the supervision matrix we viewed. One staff member could not remember when their last supervision had been.

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

We observed people's meal times in the dining room. The food looked appetising and well-presented and drinks were available for people. The menu was printed mid-morning and displayed on the tables and we were told that people had a choice and were asked their preferences on the day. People were not supported to have a meal of their choice by organised and attentive staff. Minutes of the staff meeting on 28 September 2015 documented that a person who had moved into the care home had asked for egg and sausage for breakfast, and the chef said the person could not have this. However, the manager reminded staff during the staff meeting that people should have a choice regarding their meals.

We saw the maintenance person also worked as a carer assisting with people's meals. However, they wore clothes that were covered in paint as they had previously attended to the maintenance of the home earlier in the day. This meant that people were at risk because of food hygiene practices. Staff wore plastic aprons whilst assisting people with their meal, however, support at meal times was not adequate and some people had their food put in front of them but were unable to eat it without help. This meant the food was left to go cold before staff came to support them with their meal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interest or it is necessary to keep them from harm. We saw the service had made appropriate DoLS applications to the supervisory body for people who lived in the home. However, no copies of the applications were available and no record or instructions in the care plan to inform staff and visiting professionals of the applications and the reasons why the referral had been made.

Requires improvement

Is the service effective?

People's rights were not protected because staff lacked an understanding about the implications for their care practice in relation to the MCA. This is important legislation which establishes people's rights to take decisions over their own lives whenever possible and to be included in such decisions at all times. Staff did not demonstrate a good understanding of the MCA and did not know whether people had the capacity to make informed decisions or what practices and procedures they should follow. We also noted that not all staff had completed the relevant training.

We did not always see that consent had been sought, for example to having photographs taken and placed in care plans. People or their legal representatives were not involved in care planning and; we did not see any attempts to show that people confirmed they agreed with the care and support provided.

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

People had access to health and social care professionals. We spoke to a district nurse on one day of our inspection who visited the care home when people needed care from a registered nurse. We asked the district nurse if they felt end of life care was being managed effectively. They said they felt it was being managed as they visited on a daily basis to support people who required nursing intervention.

Requires improvement

Is the service caring?

Our findings

People's privacy and dignity was not always respected and promoted. For example, one person had their clothes on inside out and was wearing underwear over the top of their day clothes. We pointed this out to staff and they informed us "They always do that". We were not aware that the staff attended to the person's clothing as a priority. For example, they continued with the task they were doing before the person's clothing was dealt with. This did not respect the person's dignity living with dementia. However, we saw staff knocked on doors and sought consent before entering people's rooms.

Throughout our visit staff were observed addressing people by their first name and seeking to interact with people in a supportive manner.

People were not supported at the end of their life to have comfortable, dignified and pain free care. People's preferences and choices for their end of life care were not clearly recorded, communicated, kept under review or acted on.

People and staff were not supported by palliative care specialists. Staff training records showed that staff had not completed end of life care training. This meant that people could not be confident in the service's ability to support people who required end of life care.

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

Regulations 2014.

The home was clean, bright and spacious and had recently been redecorated. People could personalise their bedrooms how they wished.

People's records did not include information about personal circumstances and how they wished to be supported.

People's friends and relatives were able to visit without being restricted by visiting hours.

Visitors told us the home kept them informed and would let them know if their family member had a fall or was not feeling well.

One visiting relative told us they felt the staff worked hard and they always seemed cheerful. They went on to say how lucky they were to find the home.

During our visit we asked for evidence of methods of seeking people's feedback about the service however, none could be provided.

We observed how staff interacted with people to see if people were actively involved and given choice and independence. We found no evidence that people were supported to express their views and be involved in making decisions about care, treatment and support. For example, reviewing of individual files did not contain information that people or their relatives were actively involved in care reviews.

Requires improvement

Is the service responsive?

Our findings

People were not supported effectively to take part in social activities. On the first day of our inspection there was no planned activity programme for the week or an activity schedule for the coming month. We saw a singalong birthday celebration for a small group of people in the afternoon, however there was no activity on the second day of our inspection. The activity organiser stated that they had supported the care team assisting with personal care instead. They said they were unable to focus on activities. The activity organiser had undertaken an NVQ in care but had not received additional training to develop skills and knowledge as an activity organiser. There was lack of person-centred activity planning and meaningful activities. In addition the documented information relating to individual life stories, preferences and people's choice was limited and incomplete. Some people had information about hobbies and interests recorded but we found no evidence that they engaged in these activities. We observed the people were left sitting in their chairs all day with very little interaction from staff. People with advanced dementia that were cared for in bed were isolated and not provided with appropriate one to one interaction or sensory stimulation.

This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care plans were not kept up to date to reflect people's changing needs. For example, one person's care plan review dated 23 November 2015 indicated that the person was mobile and walked with a stick. However, on 22 November 2015 the GP reviewed the person and confirmed the person required end of life care. We observed the person, and when asked staff confirmed the person was immobile and was cared for in bed. We found the tissue viability checklist for this person was last reviewed on 29 April 2013.

People did not receive consistent co-ordinated, person centred care when they moved between different services. For example, one person was admitted from hospital for end of life care. The care records contained a summary of needs from social services but no hospital discharge plan or pre-admission assessment information undertaken by the care home. We saw in the person's main care plan that the person did not want to be resuscitated, however, it was documented that the person had dementia. We could find no evidence that an assessment of capacity had been carried out prior to the decision about resuscitation. We discussed this with both regional managers on the second day of our visit. They said that they will look into this.

There was no direction for staff on how the person's end of life care was to be managed. We found medical advice and treatments were not followed or implemented in good time. The person was unable to take fluids orally and staff had been advised by the doctor, to carry out regular mouth care. This was not documented in their care plan and we found no evidence that this had taken place; a dry sponge was in the room and mouth care charts not completed. It was also evident that the person was in distress and pain, and was grimacing and calling out. The person was unable to have pain relief until the district nurse visited later that day.

We raised our concerns with the regional manager and the local authority.

We looked at how the provider received and investigated complaints. Information for people and their relatives was in the service user guide about how to make a complaint. One visitor we spoke with said: "Over the 3 years x has been here I have had no complaints; if I had any to make I would have no problem in taking them to the manager". Relatives said there was a 'friends and family meeting' every quarter with an agenda and minutes. They said they were updated with developments that affected the home and at which they could raise issues and suggestions. There were also periodic questionnaires circulated for people living in the care home. However, we were unable to have access to this information during our visit, as this was only able to be accessed by the registered manager who was not available during our visit.

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Requires improvement

Is the service well-led?

Our findings

The provider had clear aims and objectives for the service in their philosophy of care. The document highlighted that staff should be trained in specialist dementia care. However, this was not evident during our visit when we asked to see agency staff training. We were unable to access this information and the regional managers were unable to confirm if agency staff had had any training in dementia care. We brought this to the attention of the regional managers and they confirmed they would look into this.

Quality assurance systems were not in place to monitor the quality of service being delivered and the safe operation of the home. For example, people on end of life care had not been monitored by staff to address their changing needs. Staff had not received essential training to ensure people were cared for by staff that are competent and knowledgeable. Where incidents and accidents had happened there was repeatedly no action plan to address this.

We looked at staff meeting minutes for 2015 and found no action plans had been created to address the areas where improvements could be made.

Health and safety audits undertaken were not able to identify safety risks. For example, the open gate at the top of the stairs and people with gaps between the mattress and the top of the bed frame.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke to a permanent member of staff who told us: "I am stressed because of agency staff not knowing what to do". This was evident during our visit as one agency staff had not been to the home before and a permanent member of staff was responsible for inducting the agency staff member. We found the care home's own staff member was not provided with a structured induction plan to follow with the new member of staff.

The service did not enable and encourage open communication with people who use the service, those that matter to them and staff. There was no accessible tailored and inclusive ways of communicating with staff and other key people in the organisation. For example, in the absence of the registered manager important documents were unable to be located by the regional managers. This meant the service could not operate in a safe inclusive way without access to key information.

We pointed out to the regional managers that this posed a risk to all people who used the service. They confirmed they will look into this as a priority.

The service had notified CQC about significant events, as required by the relevant regulations. We used this information to monitor the service and ensure they responded to keep people safe.

At the inspection, we discussed our findings with the regional managers and the nominated individual. We found that they were committed and passionate to drive improvements to ensure the highest quality of care was delivered at Woodlands Park Care Centre. During the final day of the inspection after the prior feedback from our findings, the responsible individual put an extensive action plan in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's social needs were not being met.** **Regulation (9) (1) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **We did not see that consent had been sought, for example having photographs taken and placed in care plans.**

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate induction, training and supervision.** **Regulation (18) (2) (a)**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Assessing the risk to the health and safety of service users of receiving the care or treatment.** **Regulation (12) (2) (a)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided. Regulation (17) (1)
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Safety gate located at the top of the main stairwell was constantly left open by staff Regulation (1) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.